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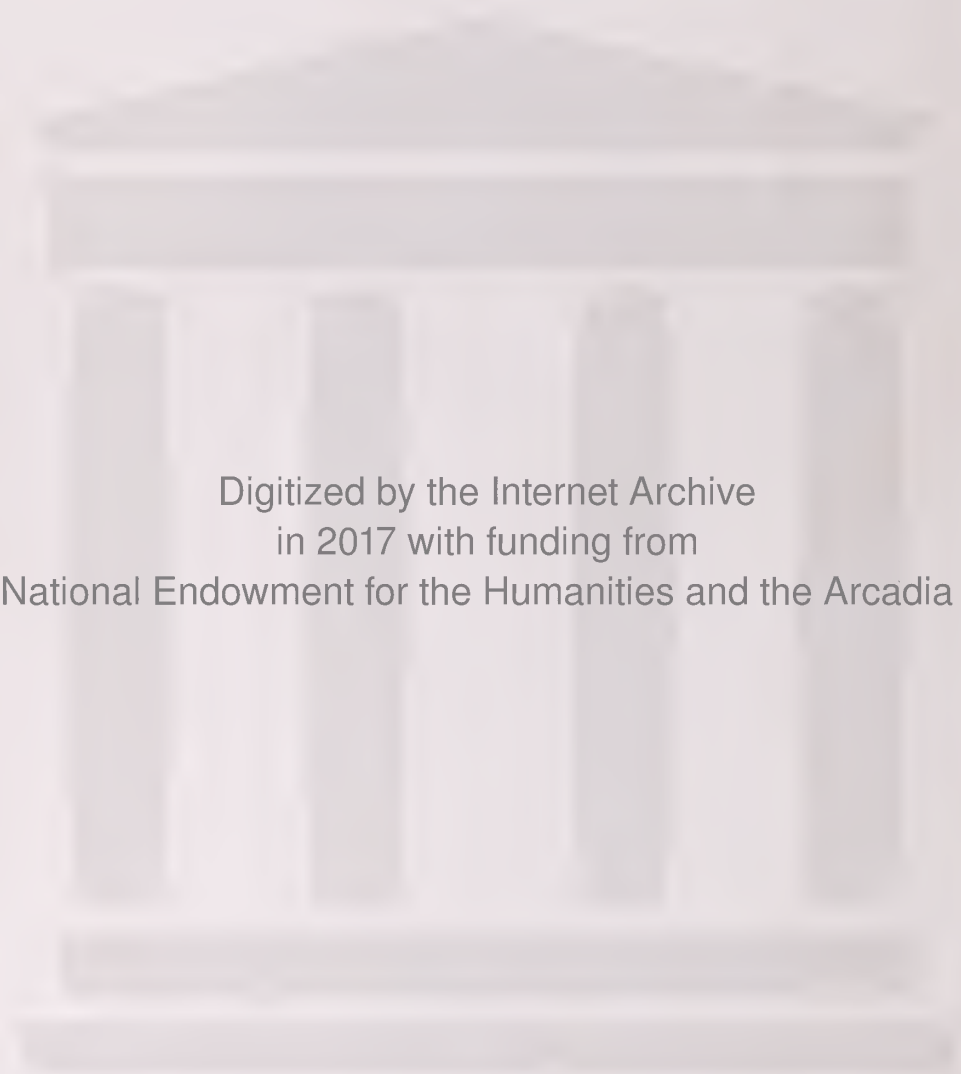

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by

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President's Page

MEDICAL STUDENTS' DAY

The "Medical Students' Day" was instituted by the Texas Medical Association and the 1953 program carried out in cooperation with the Dallas, Harris, and Galveston Counties Medical Societies. Subjects vital to the practice of medicine were presented during a one-day visit to each of the three medical teaching institutions which are Southwestern Medical School of the University of Texas, Dallas; Baylor University College of Medicine, Houston; and the University of Texas Medical Branch, Galveston. The speakers were officers of the Texas Medical Association who have had long experience in the practice of medicine and who feel that these indoctrination talks to students serve a useful purpose to these future physicians.

In order to promote a closer liaison with the young men and women who will be the doctors of Texas, the subject matter presented was selected to be of the most practical help. The subjects discussed together with a brief summary of each were as follows:

"You and the Medical Society" covered in detail medical organization at the county, district, state, national, and world levels. The relation to medical practice of each of these organizations was dwelt upon, and the importance of membership and active participation in the affairs of the county medical society was emphasized.

"Your Practice and Public Opinion" covered the broad aspects and application of internal and external public relations. The impressions gained by people as related to the manner with which the individual doctor's office is kept and conducted were pointed out. Organized public relations programs at the medical society level were discussed.

"The Business Side of Your Practice" stressed the importance of having a clear understanding with the patient concerning the cost of a medical or surgical service before it is performed and concerning the terms of payment for said service. If this is done, most misunderstandings between the physician and patient will never exist. Further remarks on fees, office help, billing procedures, and the effects on public relations of the cost of medical care were made.

"Your Responsibility as Doctors" included the judicious use of a heritage of scientific knowledge to the end of furnishing the best medical care possible to all of the people and achieving progress in medicine with each passing year. The individual physician's primary responsibility is to his patient, to give the very best his training, ability, and judgment can offer toward meeting and solving each patient's problems. The physician's responsibility as a citizen is a role he cannot afford to leave unfilled; he must see that the community in which he lives is a good one. A physician is dedicated to the service of mankind and should accept civic as well as medical obligations. The physician's first medical organization responsibility is working to make his county society effectively mean everything for which organized medicine stands.

Hope has been expressed through letters from medical college deans, faculty members, and senior students that this program be presented each year by the Texas Medical Association. Some quotations from these letters follow:

"Your stimulating and challenging message brought us all to the realization of the vast responsibilities which lie before us. We are most indebted for the insight into this oft neglected sphere of medical education."

"We think that a session of the sort that was held so successfully here might well be arranged every other year if the Texas Medical Association would feel so inclined."

"I certainly feel that these meetings which have been held at the various schools in Texas comprise a very needed basic concept in the training of the doctor for the future."

"I recently visited twenty of last June's graduates now interning from New York City to Florida. Every one of their many questions could have been answered at Saturday's meeting and identical ones were. I think this is a firm step forward in practical medical education and its continuance highly desirable."

George Tunnell M.D.

TPR diagnotes

REPORT OF PUBLIC RELATIONS COMMITTEE: Upcoming January 23 Presidents and Secretaries Conference should be of high interest. Important to note that meetings are becoming more popular each year – better attended. Third conference should surpass all previous. Program calls for morning and afternoon sessions – morning to cover operation of Texas Medical Association's key boards, councils, and committees, and afternoon session to offer latest report on VA medical care from national viewpoint. New added feature to this year's meeting will be "Hospitality Room" at Driskill Hotel. Room will serve as downtown headquarters both Friday and Saturday, January 22 and 23.

It is important that names of newly elected officers in county medical Societies reach central office promptly following election, so that they may be included in annual "Working Together" booklet. Also needed to correct Association mailing lists and in preparation for annual session meeting of House of Delegates.

Medical Students' Days at Houston and Galveston, December 11 and 12, enthusiastically received by almost 300 medical students from Baylor University College of Medicine and University of Texas School of Medicine. Meetings were held in cooperation with Galveston and Harris Counties Societies. Success of these meetings pointed out appreciation of students and need of such a project. Students' response on evaluation cards encouraging – mailed early after meeting.

Evaluations of meetings were interesting – recommendations for additions to programs ranged from "cost of setting up practice" to "more on ethics – I don't know what is really meant by fee-splitting." All agreed that programs were excellent. More stress on business side, legal aspects, and public opinion dominated requests.

Public relations program for 1954 now officially approved by Board of Trustees. Program stresses society interest and meeting attendance, strengthening lines of communication internally, "Medical Students' Days." On the external side: broadening of four-point program of last year.

ON THE NATIONAL SCENE: A joint project of American Medical Association Department of Public Relations, Bureau of Health Education, and Committee on Medical Motion Pictures makes available interesting TV programs for use of state and county medical societies on a public service basis. Films combine humor and fact with professional know-how to hold audience. Those interested should write central office in Austin.

Defense Department's proposed legislation for medical and other scholarships in connection with federal service is receiving final check before presentation to Budget Bureau for approval. Bureau approval is necessary if plan is to be presented as administrative bill – proposal can be offered by any member of House or Senate, however.

Essential provisions of plan: (1) Any medical, dental, nursing, or veterinary student accepting scholarship to be obligated for one year of federal service for each year of scholarship study. (2) School tuition to be paid direct – student expenses also to be covered. (3) Scholarships limited to four years and not open to premedical students or others preparing for professional courses. (4) Deans to make recommendations, but final selection by Department of Defense.

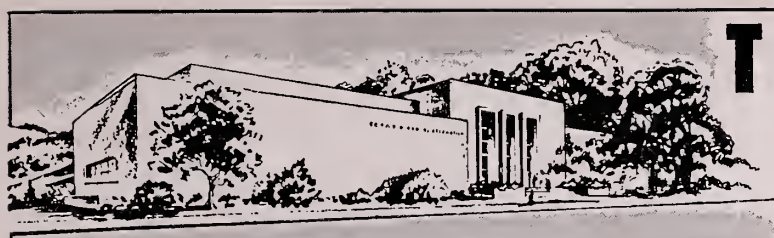
According to department spokesman, there are two objectives: (1) to meet military needs after expiration of doctor draft in 1955, if regular draft does not produce enough officers; (2) to interest young officers in regular military careers to maintain the corps at the necessary level. Current regular medical officers make up only 25 per cent of Medical Corps total.

Dr. W. L. Portteus, Indiana State Medical Association, has authored an excellent small brochure explaining fees and what they are based on for distribution to his patients. Brochure is based on answers to questions brought up by patients over many years. Those interested may get further details from central office.

National news on the home front: Ninth National Conference on Rural Health to be held in Dallas, March 4 through 6. Excellent opportunity to show Texas Medical Association's interest in improving health conditions in this predominantly rural state.

FROM OVER THE STATE: Interesting article in December Progressive Farmer by Dr. Chester Callan, Rotan, chairman of Committee on Rural Health of Texas Medical Association and member of Nolan-Fisher-Mitchell Counties Medical Society. Article is titled "TMA Works for More Rural Doctors" and is excellent public relations vehicle as well as enlightening report.

The Woman's Auxiliary statewide project to help overcome the distressing shortage of nurses received a boost from Cameron-Willacy Counties Medical Society, which has voted $150 yearly for the local auxiliary's nurse scholarship fund.



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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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LIVING PRINCIPLES

Resolutions and a new year are as inseparable in the American mind as bread and butter. With the twelve months now beginning, perhaps no better resolution could be adopted by each American than the determination to *apply* the principles of government, economics, and social behavior to which most Americans automatically subscribe.

The men who framed the Constitution of the United States provided for a representative democracy based on broad participation by the citizenry. They set up checks and balances between the executive, legislative, and judicial arms of the federal government to keep one branch from usurping power. They provided for a system of free economic enterprise in which private property could be amassed by individuals from whom it could not be taken without due process of law; for free export and import of articles from state to state; and for a three-way system of economic control in which the free employer, the free worker, and the free customer counterbalance each other. Finally, a bill of rights to guarantee such freedoms as worship, speech, assembly, and press reports was made a part of the Constitution. Between its numbered paragraphs, although not in so many words, were the undergirding moral and ethical principles of the great religions, without which such a constitution could but fail.

Those who labored in Constitution Hall to draw up a document to shape the future of the new republic had doubts as to whether the people actually were capable of self-government. Benjamin Franklin said: "You now have a republic—if you can keep it." He and the others who earlier had penned the Declaration of Independence, in stating one inalienable right to be "the pursuit of happiness," recognized that happiness cannot be conferred, that happiness and security must be created by each who seeks it. This is still true.

Blessed as we are by being part of a land where great principles have been laid down, our greatest liability is lethargy and the perhaps un-

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COLLEGE OF PHYSICIANS
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conscious reluctance to accept these principles for application in our own individual situations.

We cannot have a government by the people unless we in Texas take the trouble to pay our poll taxes and then vote on election day. We cannot have individual freedom while condoning irresponsible name-calling or intolerance. We cannot apply one rule to "the other fellow" and another to ourselves.

The beginning of a new year should be a time of soul searching. If we are in earnest about believing in government of the people, by the people, and for the people; if we honestly think that free enterprise can bring greater goods and services to more people; if deep down in our hearts we have concern for all our fellow creatures—if we pay homage to such principles, let us resolve to live them in this year ahead.

JOURNAL ARTICLES INVITED

For years the bulk of the scientific articles published in the TEXAS STATE JOURNAL OF MEDICINE have been presented first on the program of the annual session of the Texas Medical Association. The typical annual session in recent years has yielded up to 100 essays, of which the majority have been published in subsequent issues of the JOURNAL. The 1954 annual session is being planned around a new format which will offer perhaps half as many papers for possible publication.

Mathematicians will conclude correctly that during the forthcoming year a greater opportunity than ever for acceptance of direct contributions to the JOURNAL will prevail. Nevertheless, it is not expected that the procedure of screening manuscripts or the high standards for acceptance will be modified.

The editorial staff and its advisers will be pleased in the next few months to review papers which were well received at a district or county medical society meeting or which were prepared especially for the JOURNAL. Suggestions for preparation of manuscripts may be obtained from the JOURNAL office upon request.

THE FIGHT CONTINUES

In 1953, Texans contributed more than $2,500,000 to fight poliomyelitis through the March of Dimes. The National Foundation for Infantile Paralysis is now staging its 1954 drive, January 2-31, to conquer poliomyelitis by raising money for personnel, equipment, facilities, and medical research.

Progress toward the conquest of the dreaded disease is being made, but at a terrific cost. Gamma globulin has been found to provide marked temporary protection against paralytic poliomyelitis and possibly to modify the severity of the disease during the late stages of the incubation period, but gamma globulin research must continue. More recently, a vaccine has been developed. Its effectiveness in preventing paralytic poliomyelitis will be tested in a mass vaccination project beginning in February. The estimated cost of $7,500,000 for this study will be financed by the national foundation.

Since 1938, when the national foundation was brought into being, 87 per cent of all March of Dimes collections in Texas has been used to care for patients in the state and only 13 per cent to assist in the national program.

To date, the National Foundation for Infantile Paralysis has given more than $200,000 in research grants to six Texas institutions, and the Southwestern Poliomyelitis Respiratory Center at Houston is one of six in the United States supported by March of Dimes funds. In addition, more than 3,000 scholarships and fellowships, forty-five to Texas residents, have been given by the national foundation.

Physicians have a wide scope of friends and acquaintances whom they can urge to support the drive as they themselves are doing. They can encourage their wives to join the Mothers' March on Polio, and their children can be useful in school drives. In addition, they can make every effort to learn more about the disease, its cause and cure, and do their share to halt poliomyelitis in the near future.

CURRENT EDITORIAL COMMENT

THE PHYSICIAN, CRIME, AND THE COURT

The medical profession has never been interested in the social and economic problems referable to crime. However, today it seems wise for us, as good citizens of the community and as members of a profession which must treat both the criminal and his victim without being influenced by either guilt or innocence, to acquaint ourselves with these problems.

It has been estimated that the national bill for crime is $28 billion; of this $20 billion is for gambling, $7.5 billion for organized crime including racketeering, and $500 million for conventional crimes. This is a multibillion dollar drain upon our national resources; the slogan "Crime Does Not Pay" apparently is not proving very effective. Statistics show that young people are major contributors to crime. In 1950, 30.5 per cent of arrests were of persons younger than 25 years of age. These youths were charged with 54.1 per cent of robberies, 61.6 per cent of burglaries, 45.4 per cent of larcenies, and 67.3 per cent of automobile thefts. Approximately one-half of the crimes against property were said to have been committed by members of this same age group.

The interest of lawyers in familiarizing themselves with medicolegal problems, as indicated by their participation in the law-science program sponsored by the Schools of Law and Medicine of the University of Texas, should be a challenge to the medical profession. A physician frequently has to appear in court as a witness on behalf of either the prosecution or the defense. Without knowledge of legal procedures he often is embarrassed by questions propounded by the opposing attorneys. He frequently does not take time to become familiar with the legal processes and medical problems involved before going on the witness stand. The results are not only embarrassment to himself but failure to convey to the jury a clear concept of the problems on which it is to render a verdict. Apparently it will be necessary for us, as physicians, to appear in courts more and more, and it behooves all of us to meet this responsibility by increasing our knowledge of legal procedure as it applies to expert testimony. Insufficient knowledge of the case, poor techniques in presenting testimony, and testimony by unscrupulous doctors will cause the public quickly to lose faith in the medical profession.

A few physicians as pathologists and toxicologists contribute to the solution of crimes. The great need today, however, is prevention of crime and institution of research to determine better methods of punishment. The medical profession is in a better position than any other group to contribute constructively to these programs. Such efforts must not be considered only in the fields of the pathologist and the psychiatrist. Malnutrition, disease, and physical defects are medical problems frequently affecting the lives of persons who are either criminals or potential criminals. It has been said that "the most inspiring experiment of modern times in criminology and penology is that proceeding at the new Federal Correctional Institution at Seagoville, Texas." (Seagoville is a "prison without walls" with a minimum of physical and mental barriers. There one finds an atmosphere relaxing, alert, purposeful, and calm instead of the usual one of tenseness, intrigue, repression, and regimentation.) Thus, we see that the seeds of research are growing in our state. As a profession, let us contribute our part in the cultivation of these efforts and actively assist in the development of sociologic programs aimed at the prevention of crime.

R. H. RIGDON, M. D.,
Department of Pathology,
University of Texas Medical Branch,
Galveston, Texas.

ORIGINAL ARTICLES

THE ANTICOAGULANTS

MARVIN DUNN, RAYMOND HENRY, JOHN RIBBLE, CHARLES SANDERS, and K. P. WALKER, Dallas, Texas

Under the Direction of Andres Goth, M. D., Dallas, Texas

UNTIL the past few years, the fight of the physician against thromboembolic disease has been based on two procedures, venous ligation and early ambulation. These devices have met with only limited success because of the widespread basic dysfunction in the vascular tree. Thromboembolic diseases are based on a number of interrelated factors,[56] among which are (1) generalized lesions of the vascular tree; (2) pressure changes and rate of blood flow; (3) characteristics of the formed elements; and (4) coagulability of the plasma. All these are so balanced as to cause the blood to remain fluid in its channels and also to prevent extravasation of fluid from the capillary network. Any interruption of this in a positive direction likely will result in intravascular thrombosis, while tilting the balance the other way might well prevent such phenomena.

Indeed, there now are available to the medical profession such anticoagulants which may be used in thromboembolic disease. A group of Scandinavian workers in 1935 were the first to present clinical data that such drugs were of definite therapeutic use.[33] Led by Jorpes, these clinicians administered anticoagulants to some 900 patients, 138 of whom they claimed would have died without their use.

There is one factor which must be considered in the administration of anticoagulants. Improperly controlled therapy will lead to hemorrhage. The incidence of such bleeding ranges from 0 to 33 per cent of all cases treated with anticoagulants.[56] However, as research progresses, an understanding of the various drugs has come about with subsequent alterations in the mode of treatment. The main guide in all therapy is based on the calculation of coagulation and prothrombin times. It is well to mention that prothrombin time is used only in patients being treated with drugs affecting liver function—for example, Dicumarol—while clotting time is instrumental in determining the action of such drugs as heparin.

Clotting time is measured by a number of methods including: the Lee-White, the Howell, and the capillary methods. They are all based on the same four factors: (1) the sample should not be contaminated with tissue substance; (2) clean glassware should be used; (3) room temperature should be optimal for determination; and (4) consistent amounts of trauma and surface contact should be exerted on every part of the sample, if any degree of accuracy is to be achieved. Prothrombin is a plasma protein chemically behaving as a euglobulin. Its production is thought to be solely in the liver, with vitamin K playing an important role in its manufacture. Activity of this protein is determined by taking oxalated plasma and adding relatively large amounts of ionized calcium and thromboplastin.[45] In this way all the clotting factors are in excess with the exception of prothrombin, and the clotting time then is a reflection of the prothrombin concentration. This test is often performed on diluted plasma (usually 12.5 per cent), since this adds greater sensitivity to the reaction with accordingly more accurate results.[2]

Proper treatment requires an understanding of the coagulation mechanism. Although there is a great deal of controversy over the various factors involved, the Quick theory, for the sake of expediency, will be discussed herein, since it provides the necessary framework in explaining the physiologic action of these drugs. Quick postulated that some damage to the endothelium causes lysis of the platelets, liberating probably thromboplastinogenase, which reacts with a plasma factor, probably thromboplastinogen, to form thromboplastin. This product added to ionized calcium, accelerator globulin, and prothrombin results in thrombin, an enzyme which allows fibrinogen to form fibrin. Thrombin also causes lysis of platelets and, thus, the cycle repeats itself.

The concept of treating thromboembolic disease by employing methods which afford diminished coagulability represents a physiologic approach to the problem. Indeed, it may even be considered an attack on the etiologic agent, though truly this would involve elimination of the factor responsible for the disease. Nevertheless, this approach seems to be the most desirable, for the more closely a therapeutic effort fits into the body physiology, the greater the chance for its success without toxic effects.

The authors are students at Southwestern Medical School of the University of Texas and prepared the article under the direction of Andres Goth, M. D., professor of pharmacology.

The relationship between coagulability of blood and thrombosis is not clear. Similarly, the mechanism of anticoagulant action is obscure. Anticoagulants seem to act in one of the following ways:[54] (1) decreased metabolic production of a coagulant; (2) increased metabolic production of an anticoagulant; (3) direct inactivation or destruction of a clotting factor; or (4) release of a stored anticoagulant. Though it is thought that Dicumarol (one of the major anticoagulants) acts to decrease metabolic production of a coagulant and that heparin (a second major anticoagulant) produces direct inactivation or destruction of a clotting factor,[4] there is no conclusive proof that these are the only important actions of these drugs. Much still is unexplained, and the avenue of investigation is the only road to such knowledge.

Therapeutic indications for the anticoagulants in general are (1) acute thrombophlebitis; (2) phlebothrombosis; (3) recurrent thrombophlebitis; (4) pulmonary and peripheral thromboembolism; (5) prophylaxis to prevent thromboembolism postpartum, postoperatively (particularly in pelvic surgery), and when threatening thrombosis is suggested by hypercoagulability and previous history of thrombosis; (6) coronary thrombosis and myocardial infarction; and (7) diseases with multiple small vessel thrombosis.[56]

HEPARIN

Heparin was discovered accidentally[34] by Jay McLean of Johns Hopkins University in 1916 while he was working with William Howell. It was first isolated from heart and liver[34] and given the name of heparin in 1918 by Howell and Holt[28] because of its abundant occurrence in the liver. By 1924 Howell had so purified the product that 1 mg. would prevent coagulation of 40 cc. of cat blood at 0 C. for twenty-four hours.

Heparin is a normal physiologic compound found in the metachromatic granules of the mast cells of the body[35] and is particularly abundant in the liver and lungs. These cells are located near blood vessels and capillaries, and the contents of the granules can be emptied directly into the blood stream.[35] The heparin structure is that of a mucoitin polysulfuric acid with a disaccharide repeating unit in the molecule. The molecular weight is in the neighborhood of 17,000.[35] Heparin is one of the body's most acidic substances,[3] but mild activity causes the molecule to lose its anticoagulant activity.[54] It carries amino groups with strong negative charges[54] which are essential to its activity.[53]

Heparin is not absorbed from the gastrointestinal tract and is not effective if administered sublingually.[43] Intravenous, intramuscular, or subcutaneous injections are the only effective means of giving the drug. Repository forms and intravenous drip have been used to circumvent the usual rapid disappearance of the drug from the circulation.

Heparin is probably inactivated by an enzyme,[54] since it is eliminated so rapidly, but it is also excreted in the kidneys to some extent as uroheparin.[7] This may be of only slight importance as it has been shown to disappear just as rapidly in nephrectomized animals.[6] The extent of a heparin-inactivating enzyme is unconfirmed, but heparin-protein inactivating complexes have been described,[4] though also unconfirmed. It has been proposed that body resynthesis of thromboprotein removes heparin, thus eliminating excretion, enzymes, and protein complexes as routes of dissipation.[4] The use of carinamide to reduce tubular excretion by the kidneys has been shown to increase the duration of heparin action.[41]

Deposits of heparin have been found in the liver, lung, spleen, and kidneys of experimental animals.[54] However the main supply remains in the blood.

The exact mechanism of action of heparin has not been established fully, but it is known that it acts before fibrinogen can proceed to fibrin in the clotting process. It has been shown to act at three points: (1) blocking the activation of prothrombin, probably through a plasma cofactor;[51] (2) acting as an antithrombin, also most likely through a plasma cofactor;[26] and (3) producing a decrease in platelet number[54] and preventing their agglutination,[51] possibly through the action of the first two mechanisms.[54] These effects on the blood clotting process produce prolonged clotting times.[32] One theory for the action of heparin is that by combination in the tissues with a thromboprotein and lipid substance, the heparin releases another factor which has been shown to be a powerful anticoagulant.[4]

Other actions of heparin include its having detoxifying effects on digitalis, cobra venom, and Congo red;[19] causing the clustering of chylomicrons and the packing of red blood cells after a heavy fat meal, resulting in a decreased sedimentation rate and hematocrit level;[61] inhibiting the action of hyaluronidase;[62] producing profound effects on low density lipoproteins in blood, resulting in low blood levels of these compounds and retarding the development of atherosclerosis in experimental animals;[24] and relieving markedly the pain due to angina pectoris far beyond its effective anticoagulant duration of activity.[24] No fibrinolytic activity for heparin has been proved.[9]

Heparin probably is released normally from the mast cells in anaphylactic shock,[23] during stress reactions,[5] and after irradiation,[64] resulting in a prolonged clotting time.

The action of heparin is effective in five to ten minutes following administration of moderate doses

and is dissipated completely within six hours.[30] The duration of the action is proportional to the dosage, but the compound is so effective that doses prolonging the action beyond six hours are dangerous in the first hours of administration.[30]

All toxic effects are due to extension of the physiologic actions of the drug. Large doses are not toxic, nor do they affect wound healing.[33] The only danger is that of hemorrhage or hematoma at the site of injection.[60] Some cases of severe sensitivity to heparin on first injection have been reported, but usually sensitization takes place gradually. Such reactions may be due either to the heparin or impurities. Test doses should be used on persons with allergic tendencies.[23]

Quantities as small as .1 micrograms of heparin will cause a slight increase in the prothrombin time.[4] Heparin achieved official status on November 1, 1950, with the USP unit described as the quantity of heparin sodium required to keep 1 cc. of plasma in a fluid state. The USP standard of potency is a minimum of 100 USP units per milligram.[17] Biologic methods of assay are necessary at the present time. The purified heparin sodium in 1 mg. quantities will prevent clotting for twenty-four hours in 500 ml. of cold cat's blood.

The determination of clotting time long has been accepted as the basic method for testing the action of heparin on the blood. However, determination of plasma antithrombin levels recently has been prescribed as a better test in this evaluation.[27] Dicumarol and Tromexan, other common anticoagulants, have no demonstrable effect on the blood antithrombin levels. It is said that only approximately 15 per cent of United States hospitals have laboratory facilities for the accurate testing of blood in patients receiving anticoagulant therapy.

Dependence on the body weight as a guide to dosage has been shown to be grossly inaccurate.[42] Test dosages should be given and coagulation time or some other suitable determination made to test the dose effectiveness. Usual therapeutic doses consist of 50 to 100 mg. injected intravenously every four to six hours.[48] Therapeutic increases in clotting time, which by the Lee-White method is five to ten minutes, are considered to be three to six times more than the normal level. The main disadvantage of using heparin lies in its cost, which is about $9 per day usually.

Sterile solutions of heparin sodium with varying strengths for intravenous use, sterile preparations with repository adjuvants (procaine and butacaine) to prolong the effect intramuscularly or subcutaneously,[44] and sterile preparations with vasoconstrictors and repository adjuvants combined still further to prolong effects of heparin are available commercially. The latter preparation may prolong the effect for as long as seventy hours.[54] The commercial products all are extracted from animal tissues.

The principal conditions in which this drug is contraindicated are subacute bacterial endocarditis, hemorrhagic diathesis, increased capillary fragility, purpura, bleeding lesions, and heparin sensitivity. It should never be used in cases which cannot be kept under careful observation for hemorrhage, or when clotting time determinations are not readily available.

Heparin is rapidly neutralized by protamine[45] in approximately equal amounts and by toluidine blue.[54] Aureomycin reduces the concentration of heparin in serum and increases the coagulability of the blood by some antiheparin activity.[64] Local anesthetics also will precipitate heparin.[39]

DICUMAROL

The story of Dicumarol began in North Dakota in the winter of 1919-1920 when cattle were dying of a mysterious hemorrhagic disease. Roderick and Schofield showed in 1928 that the etiologic agent of the disease was in the spoiled sweet clover ingested by the cows.[50] These men also showed that the prothrombin activity was decreased tremendously. Link and his associates undertook in 1933[56] to isolate the anticoagulant responsible for the disease. It was they who established that 12.5 per cent plasma was best suited to the study of drug action on the prothrombin time.

Campbell in 1938 isolated the first crystals of the compound which was identified in 1940 as 3,3′ methylenebis (4-hydroxycycoumarin) (fig. 1). This discov-

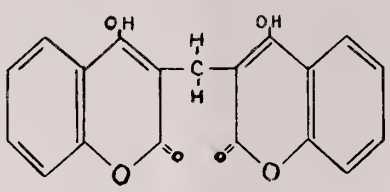

FIG. 1. Chemical structure of Dicumarol.

ery produced a relatively economical, effective anticoagulant which was destined to play an important part in anticoagulant therapy.

Dicumarol is absorbed from the gastrointestinal tract slowly, maximal absorption occurring at six hours after ingestion and complete absorption at twenty-four hours. The drug passes into the plasma, where it is bound to the plasma proteins, and its effect on prothrombin activity is first noted some eight to twenty-four hours after administration.

The effect of the drug lasts from twenty-four to forty-eight hours after the first decrease in prothrombin activity. Salicylic acid has been shown to be a degradation product of Dicumarol. This mechanism is obscure, but an enzyme system is thought to be

chiefly responsible. Other metabolic products of Dicumarol still are unknown, and all these are thought to be excreted through the urine and feces. Conflicting evidence exists as to the urine excretion of Dicumarol per se.[25] Hausner and others have demonstrated the molecule in the urine of rats. The molecule has been shown to be present in the liver, kidney, and lungs in the highest concentrations. The plasma Dicumarol concentration is higher than that of any tissue, although the unbound concentration is low.[56]

No certainty can be attached to the mode of action of Dicumarol. The fact is well known, however, that prothrombin concentration is diminished with Dicumarol administration. Quick believed this to be a competitive inhibition phenomenon in which Dicumarol replaces vitamin K as the prosthetic group in the enzyme responsible for the prothrombin production.[47] Another theory is that Dicumarol influences the production of altered prothrombin.[37]

In addition to its effect on prothrombin, Dicumarol also decreases the formation of accelerator globulin early in treatment;[20] increases or decreases fibrinogen level, depending on the dosage;[29] may act to inhibit the activity of obscure clotting factors; and in vivo can inhibit the adhesiveness of platelets.[65]

Most of the effects of Dicumarol overdosage are due to hemorrhage, with hematuria being the first sign of bleeding.

Dogs poisoned by Dicumarol showed, besides hemorrhage, toxic lesions of the small vessels, acute glomerular swelling, and toxic lymphoid tissue reaction.[15] It is to be emphasized that in man and animals no liver damage has ever been proved when only therapeutic doses have been given.

The responses to Dicumarol are far too varied to allow one to follow an empirical dosage chart.[56] Link said: "We never administer the anticoagulant without determining the prothrombin level... when I learn that a clinician has induced a frank case of hemorrhagic sweet clover disease of cattle in man, my usually buoyant spirits are bruised." Maintenance dosages are likewise determined from prothrombin levels. It is well to mention that the optimal prothrombin level sought in such treatment is still a center of tremendous controversy, and no definite statement regarding this will be made in this paper.

Dicumarol is prepared in capsules and in powdered form for oral administration.

The most important contraindication for its use is in liver disease. If damage is known to exist, therapy must be guarded. Active bleeding from any source is always a contraindication for anticoagulants in general.

Cases of subacute bacterial endocarditis usually are not treated with anticoagulants, since their use may prevent reinforcement of vascular wall injury by an organizing thrombus. Rupture of the vessel wall and perhaps fatal hemorrhage may result from such treatment.[56] Some avoid use of Dicumarol in renal disease, but as yet the evidence is inconclusive.

Vitamin K is the most useful antagonist of Dicumarol, since it may return blood prothrombin levels to a near normal level in twelve to twenty-four hours. There is considerable debate over the exact types of vitamin K most effective in combating hemorrhagic states caused by Dicumarol. Most types have proved effective, although massive doses may be required. The mechanism is probably that of displacement of Dicumarol in the prothrombin enzyme.[47] It is to be noted that vitamin K administration does not affect blood levels of Dicumarol.

Transfusion of whole blood is considered good therapy in combating Dicumarol overdosage.

Methyl xanthines antagonize the action of Dicumarol, though the mechanism is not clear.[52] When they are given with Dicumarol, the effect of the latter is strongly suppressed.[56]

COMPOUNDS RELATED TO DICUMAROL

Dicumarol has many related compounds, although none seem to be as effective as it is.

Phenylindandione has the advantage of reducing the prothrombin blood level for the first two or three hours after administration,[31] but this effect is only temporary; the main effect results some twenty-four hours after administration, and its similarity to Dicumarol coupled with some toxic side effects make this drug undesirable.

Compound 42 was studied by Link and his associates with the idea in mind that here might be a good anticoagulant. It was soon found to be an excellent rat killer because of its hemorrhagic phenomena. In fact, it is one of the best, since it is almost completely specific for rodents.

TROMEXAN

The compound known as Tromexan was synthesized by Rosicky by weakening the methylene linkage of Dicumarol and adding a carboxyl radical. This was done in an effort to improve the absorption of Dicumarol, assuming that the difficulty was in the splitting of the coumarin molecule. The result was a new anticoagulant having certain favorable properties.[14]

The structure for Tromexan is 3,3′-carboxymethylenebis (4-hydroxycoumarin) ethyl ester (fig. 2).

This compound is completely absorbed from the gastrointestinal tract in most persons.[12] The magnitude and time of the peak level of Tromexan in the plasma is variable, but is generally achieved in one to

six hours after administration. Dicumarol reaches its peak in twelve to thirty-six hours.[12, 14] Tromexan is not excreted in the urine, but several of its metabolic products are.[12, 14] Renal insufficiency still is a contraindication to Tromexan, even though the hyperreactivity in such subjects cannot be explained on the basis of decreased excretion.[12, 13] It is not extensively localized in tissues relative to plasma. The decline in the level of Tromexan in plasma after intravenous injection is rapid—about 25 per cent per hour. The

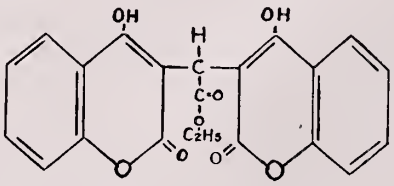

FIG. 2. Chemical structure of Tromexan.

Dicumarol level in plasma declines under the same circumstances at about 40 per cent per day. The actual rate, however, varies from individual to individual, but each person has a distinct pattern. As is true of both Tromexan and Dicumarol, the rate of decline in plasma level is inversely proportional to the dose; the larger the dose, the slower the decline in plasma level.[12]

The mode of action for Tromexan is essentially the same as for Dicumarol. There is little correlation between persistence of the drug in the body and peak prothrombin response. Peak plasma levels of Tromexan also are correlated poorly with prothrombin response.[12] Giving repeated doses of it will cause a cumulative effect on the prothrombin level, even though the drug remains in the plasma for only a few hours after administration. Dicumarol still has a high plasma level when the prothrombin time begins to respond.[12] On discontinuation of Tromexan therapy, an average of one to two days elapse before the prothrombin time returns to normal. With Dicumarol, this time is about four days.[12, 14, 58] Clinical trials have shown that when comparable prothrombin levels are maintained, Tromexan is as effective as Dicumarol.[13, 14, 63]

This compound is one-fifth as potent as Dicumarol, but has only one-twentieth the toxicity. Vitamin K and transfusions are used to combat overdosage, as with Dicumarol.

Tromexan therapy is difficult to control because of the rapid and sometimes unpredictable changes in prothrombin time, even when regular daily doses are given. In general, however, a daily determination of prothrombin time will reflect the effect of the previous day's medication, so that dosage may be altered accordingly.[12, 13, 14, 58] These dosages may vary with the individual patient. Split doses have been found to avoid much of the fluctuation in prothrombin levels.[12, 13, 14, 58] In general, an initial dose of 900 to 1,200 mg. is given, followed by a daily maintenance dose of 300 to 600 mg. The drug is packaged as uncoated scored tablets of the pure compound.

Grossly, Tromexan has the same indications, contraindications, antagonism, and method of administration as Dicumarol.

SALICYLATES

In early reports salicylates were described as the etiologic agent of hemorrhagic phenomena in salicylate-treated patients.[18] Investigation has shown them to be degradation products of Dicumarol, and this has prompted further work in the field.[6] The mechanism of action centers around the reduction of prothrombin in the blood.[19] Field has shown that, as in Dicumarol antagonism, vitamin K will raise the blood prothrombin level in salicylate overdosage.[22] It is now standard treatment to give the vitamin in all cases in which large doses of salicylates are used. In many countries where malnutrition and starvation are rampant, cases of hemorrhagic disease due to salicylate ingestion are commonplace, and in these places particularly, vitamin K is indicated.

The mechanism of action is still unknown and consequently is a center of controversy. Field, Spero, Link, and others[22] stressed their belief that salicylates act only when vitamin K function is impaired, and that these agents have a low affinity, compared to Dicumarol, for the site of vitamin K action. However, the evidence is inconclusive, and until further proof is gathered, salicylate action will remain a mystery.

ALPHA-TOCOPHEROL

The action of alpha-tocopherol (vitamin E) on coagulation is interesting, but of no practical value in man as yet. Three main effects have been demonstrated: (1) It acts as a vitamin K–like substance, since vitamin E deficiencies cause hemorrhagic states in experimental animals.[54] (2) It acts as an antithrombin, preventing the formation of fibrin from fibrinogen.[21] (3) It has been shown to have antithromboplastic activity.[36] Since these actions have been demonstrated only experimentally in laboratory animals, the use of vitamin E as a therapeutic agent in man is yet to be determined.

SULFONAMIDES

Sulfonamides affect prothrombin levels of the blood much the same as Dicumarol. However, their action is thought to be on the bacteria in the gastrointestinal tract, which play an important role in vita-

min K synthesis.[11] Administration of vitamin K in conjunction with sulfonamidex therapy will decrease the likelihood of hemorrhage.

ANESTHETICS

Anesthetics like chloroform are notorious for causing liver damage, which results in reduction of blood prothrombin and fibrinogen levels. Recovery usually occurs in about a week, with both levels returning to normal.

TRYPSIN

A new and possibly revolutionary drug has now come into limited use. This is trypsin. First crystallized by Northrup, it is a protein with a molecular weight of 35,000, containing aspartic and glutamic acids, arginine, and lysine. The Armour Laboratories have perfected a highly purified crystalline trypsin called Enzar, upon which many studies have been made.

$L.D._{50}$ studies have shown a tremendous species difference; for example, $L.D._{50}$ for guinea pigs is 80,000 Armour units per kilogram of body weight; for mice 40,000 Armour units per kilogram; for rabbits 5,000 Armour units per kilogram; and for cats 4,000 Armour units per kilogram. These studies were based on rapid infusion and high drug concentration. When trypsin was administered in a concentration of 3,000 Armour units per cubic centimeter at a rate of 6 to 10 drops per minute, rabbits tolerated 250,000 units and dogs, 1,250,000 units with no ill effects. It is evident that concentration and rate of infusion are keys to the problems of administration.

A circulating trypsin inhibitor has been found to combine with 97 to 99 per cent of the trypsin to form a stable, irreversible compound. Some 1 to 3 per cent of the trypsin remains free to act. However, the action of the trypsin inhibitor is depleted accordingly by the chemical combination, and this may be of some clinical importance. In such diseases as pneumonia, typhoid fever, rheumatic fever, tuberculosis, hyperthyroidism, malignancies, and anemias, trypsin inhibitor levels, along with fibrinogen levels, rise. Since Enzar reduces these trypsin inhibitor and fibrinogen levels, it seems that administration of Enzar provides a method which alters the natural history of a disease.

The specific action of trypsin is based on the hydrolysis of circulating proteins and their products—fibrin, prothrombin, fibrinogen, thrombin, globulin, and albumin in that order. Thus, in the presence of a fibrinous clot, trypsin acts to dissolve the clot. If no fibrin is present, 300 units of the drug in 20 cc. of blood will result in clotting; but if 400 units are added to another 20 cc. of blood, the latter will be incoagulable. At first this would seem to be an almost hopeless dilemma, but upon closer inspection, it is seen that all available trypsin was utilized in the first tube to convert prothrombin to thrombin. In the second 20 cc., there was an excess of the trypsin, and this caused fibrinogenolysis. Thus no clotting occurred. Had fibrin been present originally, the drug would have acted to form a soluble polypeptide from the fibrin, with digestion of the clot resulting. It is well to note that extreme caution has to be used in administering this drug, since small changes in concentration cause such varying results.

A problem is posed by the formation of the polypeptide from the fibrin. Increased vascular permeability and, perhaps, some intestinal spasm result. Because antihistamines decrease vascular permeability, it has been postulated that they should be used along with trypsin.

Trypsin also activates fibrinolysins by conversion of profibrinolysins, but one of the most important actions is on the individual blood cell. Tryptic action on surface protein elements causes increased volume, increased mechanical fragility, and increased osmotic fragility of the red cell. Also, the red cell becomes agglutinable, but the presence of a reverser substance, for which the cell manifests the stronger affinity, erases this as a clinical problem. All these actions on the cell affect the oxygen carrying capacity in such a way as to contraindicate the drug in congestive failure. Cyanosis also has been reported, and it has been explained on a basis of methemoglobinemia. Leukocytes are affected by action on surface proteins also.

The study of trypsin is far advanced in experimental animals, but the greatest test of all, the one on man, has not been adequately made. Until this drug has been used thousands of times with excellent results, judgment must be reserved.

SUMMARY

This paper has served to acquaint the reader with a knowledge of anticoagulants, their uses, and their successes. But it is to be stressed that they are no panacea for thromboembolic disease. There are those who would say anticoagulants are the answer; there are others who would as dogmatically state they are useless. Between these two lies the investigator who would be as the politician and tread the middle of the road. Herein may lie the most ideal approach to this drug therapy. Anticoagulants have been used extensively, but they are still young as a group and still growing in number. The pharmacologist and the clinician will have to study this problem a great deal further before a definite conclusion can be reached.

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Experiences with Long-Term Anticoagulant Therapy

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THE value of anticoagulant therapy in thromboembolism has been proved, without doubt, by numerous investigators in this country and abroad. The treatment has been confined mostly to the acute thrombotic diseases and embolic complications. However, there is a large group of patients in whom the danger of thromboembolism may be present for a period of months, years, and even a lifetime. In such cases the prolonged use of anticoagulants appears logical as a prophylactic measure. The general recognition of the value of such treatment has been greatly hindered by fear of their toxicity, which is unwarranted because the untoward reactions encountered are due more to mismanagement than to the dangerous properties of the drugs. The literature discussing the value of prolonged anticoagulant treatment is sparse; however, Wright,[6] Nichol,[4] and Shapiro[7] have reported favorably on this subject.

A similar opinion was expressed by us in a previous publication.[3] Since that time our group has been expanded to include 78 patients who have now been observed over a period of up to five years. It is the purpose of this presentation to elaborate on our further experiences with such therapy.

The minimum of two months' treatment was arbitrarily selected for the inclusion of cases in this group. During the time of the study, a considerable number of persons received anticoagulants for a lesser period; they either were considered to be unsuitable or refused such prolonged therapy.

METHODS AND COMPLICATIONS

Successful and safe long-term anticoagulant therapy first must entail certain basic principles: (1) a trustworthy patient and family who will follow explicitly directions as to dosage and as to the need to observe carefully the early signs of intoxication should they develop; (2) a reliable laboratory with well trained technicians who are able to perform the prothrombin test with a minimum of error; (3) a physician who understands thoroughly the indications, contraindications, dosage, and toxicity of the drugs. Although hospitalization is desirable for acutely and seriously ill patients, it was not considered necessary in our average case. In many persons the treatment was started while they were at home; the majority were entirely ambulatory from the onset. Practically all patients of our series were able to continue their usual activity whether it be a trade, a profession, or household duties.

At the beginning of the anticoagulant therapy a graphic chart was prepared for each patient and continued during the entire time of his observation. This chart showed the prothrombin time in seconds, the percentage of prothrombin depression, and the daily dose of anticoagulant administered. The Link-Shapiro modification of the Quick prothrombin method was used in this study. Special precautions were taken to standardize the technique and to eliminate errors as much as possible. Each new batch of thromboplastin (Simplastin*) was compared carefully with the previous one to assure uniformity of action. Little variations from the normal standards were encountered during the entire time of observation. The normal prothrombin time ranged from 13 to 15 seconds. The identical method of prothrombin determination was used for hospitalized patients to make the transition to home care safe and simple. Blood tests initially were performed daily, then every three to four days, and after a short time once a week. Finally, when the patient's prothrombin level had become stabilized, the tests were done only every two weeks and occasionally even at longer intervals, but usually the two week schedule was followed rigidly.

The ideal drug for prolonged anticoagulant treatment should be administered orally, be well tolerated by the gastrointestinal tract, be without toxic effect on the parenchymal organs, depress the prothrombin level evenly for prolonged periods, be easily neutralized by available antidotes, and be relatively inexpensive. Heparin and its derivatives are not suitable for prolonged anticoagulant therapy for obvious reasons. Tromexan also is not too useful for this purpose because of its transient effect which causes wide swings of the prothrombin time and necessitates frequent blood tests. Phenylindandione resembles Tromexan in its action but the effect is more prolonged. Both Tromexan and phenylindandione should be given twice daily for their optimum action. This is more cumbersome than Dicumarol and Cumopyran administration, which requires only daily dosage. Dicumarol still appears to us at this time to be the drug of choice for prolonged anticoagulant therapy. Cumopyran is almost equally useful for this purpose; however, the prothrombin depression is more difficult to maintain and the effective dosage is more variable. Therefore, the drug requires more careful supervision, especially during the initial period of treatment. It has been used only when patients became resistant to Dicumarol.

*Chilcott Laboratories.

There is no need for indiscriminate change from one anticoagulant preparation to another. It is much safer to restrict oneself to one or two drugs and to prescribe them only in one size tablet or capsule. In our group of patients, 50 mg. of Dicumarol or 25 mg. of Cumopyran tablets were used exclusively.

Our graphic chart proved helpful for the calculation of the dosage. Immediately after each prothrombin test the total dosage for the following period was calculated on the basis of the previous amount administered, the change of the prothrombin time, and the tendency to further prothrombin depression or elevation; this quantity was then evenly divided into daily doses. The patient was instructed to write the number of tablets or capsules prescribed for each day on a calendar and to mark it off after taking the drug. The total dosage of Dicumarol varied from 0 to 100 mg. daily and 200 to 700 mg. weekly, and that of Cumopyran from 0 to 75 mg. daily and 100 to 500 mg. weekly. So far none of the patients has become resistant to both drugs. In case this should happen a shift to phenylindandione probably would be attempted. It is usually stated that menstruation, febrile diseases, and various drugs such as aspirin, digitalis, and antibiotics influence the prothrombin time, necessitating a change of anticoagulant dosage. This has not been brought out in our series. Fluctuation of the prothrombin level does occur for obscure reasons but is not related to the above mentioned factors.

Usually the earliest sign of anticoagulant toxicity is microscopic hematuria, followed later by gross bleeding from the kidneys and by subcutaneous hemorrhages. Gastrointestinal, respiratory, and intracranial hemorrhages have been reported in severe prothrombin depression. However, in the presence of coexisting disease, such as peptic ulcer, diverticulosis, coryza, bronchiectasis, tuberculosis, and encephalomalacia, the former complications may occur even with small doses of anticoagulants. We have observed several cases of epistaxis and hemoptysis in the presence of infections of the upper respiratory tract. One patient with a history of a traumatic olecranon bursitis developed a hemorrhagic effusion in this bursa. Another patient, with an endocervical carcinoma, experienced metrorrhagia. From such observations the contraindications to anticoagulant therapy is self-evident. In addition to various hemorrhagic states, such as occur in hepatic and renal disturbances and in blood dyscrasias, the existence of any lesion that may bleed is a contraindication to such therapy. However, under certain circumstances these toxic effects will have to be balanced against the dangers of thromboembolism.

The bleeding tendency is best counteracted by vitamin K_1 (Mephyton*) given in a dose of 25 to 50 mg. intravenously and repeated as indicated by the prothrombin level. Other vitamin K preparations are relatively ineffective. Modest dosage of vitamin K_1 is advisable to prevent the shortening of the prothrombin time below the pretreatment value. This has occurred in our experience contrary to previous reports denying this possibility. Smaller doses of vitamin K_1 also will avoid the development of refractoriness to anticoagulants. Blood transfusions are ordinarily not needed since the introduction of vitamin K_1.

Apart from the hemorrhagic manifestations the toxic symptoms of Dicumarol and Cumopyran have been mild. There were no adverse effects upon the hematopoietic, hepatic, and renal functions. A future communication will deal with these in greater detail. Individual doses of Dicumarol exceeding 150 mg. sometimes produced nausea, indigestion, and lightheadedness. For this reason the drug was administered daily in small amounts instead of every few days in larger quantities as recommended by Shapiro.[8] In none of our cases did the drug have to be omitted or reduced because of such effects.

INDICATIONS

Not considering rare disorders such as essential thrombophilia, hepatic vein thrombosis (Budd-Chiari), thrombotic obstruction of the abdominal aorta (Leriche), and pulmonary hypertension due to recurrent embolization (Ayerza's syndrome), prolonged anticoagulant therapy should be considered in three groups of diseases: (1) chronic, recurrent, and migratory peripheral thrombophlebitis; (2) cardiac diseases with intracardiac, coronary, pulmonary, and systemic thromboembolism; and (3) cerebrovascular thromboembolism.

Peripheral Thrombophlebitis.—One of the most common complications of posttraumatic, postoperative, and postpartum states as well as medical disorders requiring prolonged bed rest is peripheral phlebothrombosis and thrombophlebitis with or without pulmonary embolization. It has been stated by Wright[9] that "patients who have had one pulmonary embolus, if untreated, have a twenty per cent chance of death from subsequent pulmonary emboli." Therefore, anticoagulants are generally accepted as the treatment of choice should such phenomena occur. However, there is no agreement about the duration of such therapy. Unfortunately, no clinical criteria and laboratory tests are available that would indicate when the danger period has passed. For this reason it seems advisable to give the drugs for several months instead of a few weeks, especially in persons with persisting obstruction of the venous blood flow or in those with disorders favoring blood coagulation. It is also possible

*Merck & Co.

that such therapy will contribute materially to the complete restitution of the normal circulation because it may hasten the disintegration of the blood clot.[9] If thrombophlebitis recurs or migrates, there is certainly an indication for the long-time administration of the anticoagulant drugs provided that Buerger's disease, malignancy, and blood dyscrasias are not present. In the latter conditions the drugs are useless and perhaps even contraindicated. Finally, there is a group of persons with peripheral edema, varicose veins, ulcers, and eczema who are considered to have residual venous insufficiency while actually having a persistence or recurrence of the thromboembolic disease. Such persons complain of pains and cramps in the legs, spells of fever, cough, and expectoration. Clinical examination may show localized phlebitis, recent or past pulmonary infarctions, accelerated blood sedimentation rate, and elevated white blood cell count. In such cases the prolonged anticoagulant therapy will have the most gratifying effect.

Cardiac Disease with Thromboembolism.—The occurrence of intracardiac, pulmonary, and peripheral thromboembolism constitutes one of the serious complications of various heart diseases mostly in the presence of congestive heart failure. Fortunately, this does not occur frequently enough to warrant routine anticoagulant treatment; however, under certain conditions, for example in mitral stenosis with auricular fibrillation, the incidence of clotting phenomena and embolism is great, especially if one episode already has occurred. It has been estimated that the recurrence rate after two attacks of embolism is almost 100 per cent.[10] Under such circumstances the introduction and maintenance of a hypocoagulable state is indicated as long as such a danger period persists.

The value of anticoagulants in acute myocardial infarction is firmly established by the reports of the Committee on Anticoagulants of the American Heart Association. In our series, Dicumarol therapy, once started, was continued indefinitely, whenever possible, with the purpose of lessening the chances of future coronary thrombosis. Such prolonged treatment is especially justified if a history of previous coronary occlusion or pulmonary or systemic embolization exists, or if angina pectoris, congestive heart failure, or cardiac aneurysm develop after the acute attack.

The use of prolonged anticoagulant therapy in selected cases of coronary insufficiency, although not universally accepted, has proved to be of definite value in our estimation. This opinion is shared by other groups of investigators.[4, 6, 7] Such treatment has been given only to patients whose anginal attacks were severe, sustained, or frequent or had other characteristics of impending infarction. A decrease or disappearance of pain was observed in practically all cases following this therapy, even in those who previously had failed to respond to the conventional drugs. The mechanism of such action of the anticoagulants is not clearly understood. A vasodilating property and a promotion of the coronary blood flow has been suggested.[5] The treatment in some patients has been maintained continuously for forty months without any deleterious effect, nor has anyone in this group developed an acute myocardial infarction.

Cerebrovascular Thromboembolism. — Apart from the prevention of cerebral emboli, following various cardiac diseases, anticoagulants are useful in certain cases of cerebrovascular thrombosis. In recent years the diagnosis of chronic progressive occlusion of the carotid, vertebral, and basilar arteries has been made more frequently on the basis of clinical signs, symptoms, and angiography.[1] In such cases the use of Dicumarol and related drugs seems to be logical. The acute cerebrovascular accident so common in clinical medicine is frequently due to a thrombus involving one of the smaller vessels of the brain. The use of anticoagulants in this condition must be introduced only after the presence of cerebral hemorrhage is ruled out. Unfortunately, the distinction between the two entities is extremely difficult, irrespective of the various symptoms and signs generally mentioned in the differential diagnosis. Therefore, the use of Dicumarol in cerebrovascular diseases carries a greater risk than in other vascular occlusions. However, anticoagulants have shown gratifying results in patients with recurrent attacks of cerebrovascular thrombosis.

RESULTS

The results of prolonged anticoagulant therapy are difficult to evaluate because of the great variations in the course of thromboembolic diseases. Furthermore, this treatment requires close medical supervision of the patient which might in itself be a factor improving his prognosis. Nevertheless, the following results appear convincing as to the efficacy of such therapy.

Seventy-eight patients received anticoagulants over a period of two to sixty months totaling 823 months, with an average of ten months per person. There were 23 cases of coronary thrombosis, most of which were recurrent or complicated. The period of treatment varied from two to thirty-nine months and averaged thirteen months. In this group there were 2 failures. One patient, as mentioned in a previous communication,[3] sustained a fatal recurrence during the time of a 25 per cent prothrombin depression. Another, a 65 year old white man, was placed on Dicumarol after his third heart attack and had been asymptomatic for a period of twenty-two months when cortisone was administered because of a severe shoulder-hand syndrome. A fatal coronary thrombosis followed within a few

days even though his prothrombin level was within a therapeutic range. This death, perhaps, can be attributed to the steroid hormones, which may produce a hypocoagulability even in the presence of a prothrombin deficiency.[2]

Eighteen patients with recurrent cerebral thrombosis and 3 with multiple cerebral emboli received treatment from two to sixty months and averaged twelve months. None experienced any further episodes during treatment; 4 had recurrences after cessation of therapy.

In 18 patients with chronic, recurrent, or migratory peripheral thrombophlebitis the results were uniformly good. Duration of treatment varied from two to fourteen months but was usually limited to four months.

Eight cases of congestive heart failure with pulmonary and systemic emboli were treated with anticoagulants for two to forty months and averaged twenty-two months. No vascular episodes recurred during the time of treatment.

There were 8 patients with severe coronary insufficiency who received the drugs from two to forty months and averaged twelve. All experienced partial or complete relief of angina, many exhibited electrocardiographic improvements, and none sustained a coronary thrombosis during the time of treatment.

SUMMARY

The experiences of prolonged anticoagulant therapy in a group of 78 patients have been described. The simplicity and safety of such treatment in ambulatory cases has been demonstrated. The efficiency of such drugs in the treatment and prevention of various thromboembolic diseases has been evaluated.

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THE SURGICAL TREATMENT OF CARDIOSPASM
Preliminary Report

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THE term "cardiospasm" has been used frequently to indicate a benign obstructive lesion at or near the junction of the esophagus with the stomach, usually associated with marked enlargement of the esophagus. Probably because the cause is obscure, there has been disagreement concerning the name which best describes the condition. In 1940 Ochsner and DeBakey[12] published an extensive review of the literature and concluded that the term "achalasia" is preferable. The word "mega-esophagus" was used by Wangensteen in the title of his recent paper,[14] but in subsequent discussion he suggested that "dystonia" is better. Fortunately, in spite of disagreement regarding the etiology and a name for the lesion, there is at this time a satisfactory crystallization of opinion about definitive surgical treatment. A satisfactory operation for cardiospasm has become available and recognized none too soon, because many of the surgical procedures carried out during the past five years have been followed by serious complications.

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UNSATISFACTORY TECHNIQUES

With the advent of good anesthesia for thoracic operations and the availability of antibiotic drugs, it became common practice to open the lumen of the esophagus in the lower part of the chest and to carry out various surgical procedures on the esophagus and the stomach. The most common indication was malignancy of the cardiac end of the stomach or the esophagus. The results of this type of surgical intervention were encouraging, and it is not surprising that thoracic surgeons had no fear of dealing with the ap-

parently simpler condition of a benign stricture involving perhaps less than a centimeter of the lower esophagus. Obviously, the constricted lumen could be enlarged by making a longitudinal incision and closing it transversely. Such an operation was first carried out by Wendel[15] in 1910. I performed this operation on 3 patients in 1946 and was immensely pleased with the immediate results. Dysphagia was relieved, and within a few weeks the size of the esophagus in each case was reduced to almost normal proportions (fig. 1). During the next four years, I operated on 6 other patients in a similar manner. In 1948 Kay[8] reported that he had done this operation in 17 cases and was pleased with the results.

In 1912 Heyrovsky[7] proposed an anastomosis between the fundus of the stomach and the dilated esophagus to by-pass the stricture, and his operation was subsequently modified by Gröndahl,[5] who described a cardioplasty which was analogous to the plastic operation at the pylorus performed by Finney. The latter method was used in a number of cases by Ochsner and DeBakey,[13] Bell,[1] and Grimson and his co-workers.[4]

As the years passed, it became evident that something was wrong with these operations which made a generous opening between the esophagus and stomach with destruction of the sphincter mechanism. Five of my 9 patients who had had the Wendel cardioplasty returned with evidence that the reflux of gastric juice into the esophagus had done considerable damage. All had definite signs of esophagitis and several had severe bleeding from ulceration. The following case report is instructive.

B. B., a 70 year old white woman, was observed in February, 1951. For eleven years she had had dysphagia which had been only slightly and temporarily relieved by dilatation. The esophagus was huge. A Wendel cardioplasty was carried out, and convalescence in the immediate postoperative period was uneventful. The patient was discharged two weeks after the operation but was readmitted the next day with evidence of massive gastrointestinal bleeding. During the next two years she received approximately fifty transfusions. Resection of the lower esophagus and acid-bearing portion of the stomach was advised, and this procedure was done by a surgeon in another city.

The description by the pathologist (Dr. Alfred E. Rhodes) of the specimen was as follows:

"The specimen consisted of a tubelike segment of the lower esophagus with the adjacent portion of the stomach. The esophageal portion was edematous. The lining showed an irregular superficial ulceration 2 cm. in its largest diameter at the level of the cardia. The base and edges of the ulcer showed grayish-white tissue. The lining of the esophagus showed numerous patches of white, thickened tissue.

"*Microscopic Examination:* Sections showed a portion of the esophageal and stomach wall partially covered by stratified epithelium and stomach mucosa. Proximal to the stratified squamous epithelium for some distance the whole esophageal lining was necrotic as was also the underlying tissue, which contained many fragmented leukocytes and deeper, round cell and granulocytic infiltration. Much of the connective tissue and muscular wall of the gastric portion of this section showed hyalinization.

Diagnosis: Necrotic and chronic fibrosing esophagitis with degenerative changes in the wall of the cardiac portion of the stomach."

It became obvious that one could not apply the experience with partial gastric resection and esophagogastrostomy to the management of cardiospasm. Such operations for cancer were accompanied not only by an automatic bilateral vagotomy but also by a resection of all or most of the acid-secreting portion of the stomach. Reflux esophagitis was absent or minimal, and in any event, the patient could be told that he was better off with the substernal discomfort than to be dead of cancer. The addition of vagotomy to the operation of cardioplasty for cardiospasm appeared to offer some promise of ameliorating the peptic esophagitis, but Kay[9] informed me that he had tried it and observed it to be unsatisfactory. Wangensteen[14] tried a radical procedure, consisting of resection of the lower end of the esophagus and most of the stomach with end-to-end anastomosis and a pyloroplasty to favor emptying after the concomitant vagotomy. His patients were satisfied, but at the time of presentation of his paper, Wangensteen was inclining toward the more conservative procedure about to be described.

HELLER PROCEDURE

As early as 1913 the German surgeon Heller[11] had described his operation of extramucosal cardioplasty. This was a Ramstedt procedure at the cardiac rather than the pyloric end of the stomach. Heller made two longitudinal incisions in the muscular layers of the stomach and esophagus, on the anterior and posterior aspects of the cardia (fig. 2). Heller told how from the first day the patient could eat bread, meat, and potatoes; previously, he had been able to ingest fluids only, had a foul breath, and was losing weight.

It is difficult to understand why this brilliant result did not cause the operation to become generally popular. As a matter of fact, it was used considerably, since Ochsner and DeBakey[12] in 1940 were able to collect 104 instances of Heller operations. Recurrence of symptoms took place in 14 cases, and there were 4 deaths. Two of these deaths were due to infection which followed tearing of the mucosa, 1 to perforation following subsequent dilatation, and 1 to pulmonary embolism. Considering that all or most of these operations were done through the poor exposure obtained by the abdominal approach and all were done in the preantibiotic era, the record is far from black. A little later the British surgeon Maingot[11] reported using Heller's operation in 39 cases with 37 excellent results.

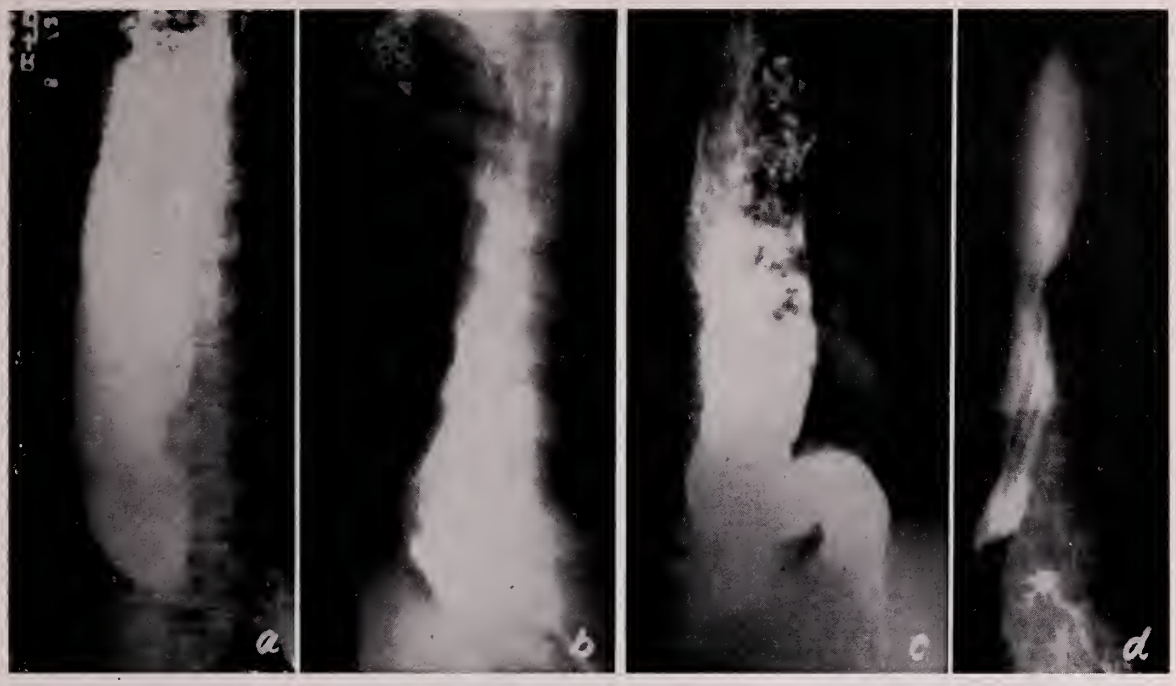

FIG. 1a and b. Roentgenograms of the esophagus showing marked dilatation due to cardiospasm before operation (*a*) and reduction in size only twelve days after a cardioplasty of the Wendel type.

c and d. Roentgenograms of the esophagus made before operation and nineteen days postoperatively showing relief from cardiospasm obtained by the Wendel operation.

Nevertheless, in 1951 at the meeting of the American Association for Thoracic Surgery, DeBakey[2] discussed Kay's paper[10] on achalasia of the esophagus as follows: "The fact that this operation was proposed by Gottstein approximately fifty years ago, first performed by Heller almost forty years ago, subsequently modified by a number of other surgeons, and abandoned and revived from time to time, strikes me as significant. Such considerations in the historical development of an operative procedure usually reflect dissatisfaction with its ultimate results as well as with its rationale. For these reasons, it would seem desirable in the current revival of this operative procedure to provide additional facts for its rationale. The question which needs to be answered is why is it a better operation now?"

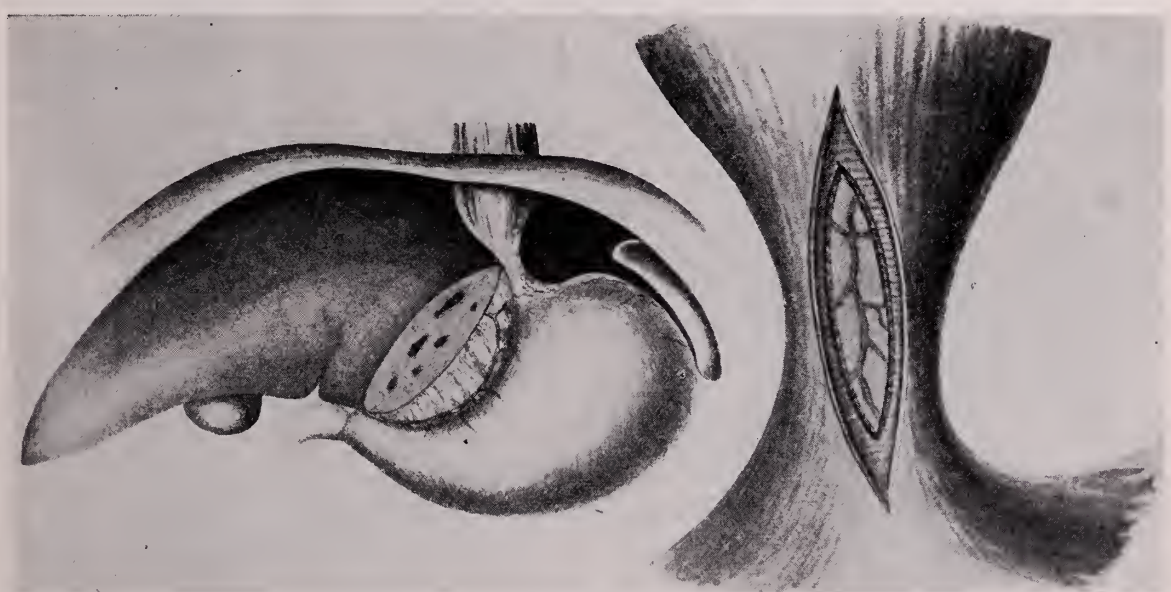

FIG. 2. Copies of the illustrations from Heller's article on cardiomyotomy[6] showing theoretical exposure by the transabdominal approach and the two extramucosal incisions into the esophageal and gastric walls.

After discussing my experience with the Heller operation, I shall try to answer Dr. DeBakey's question.

I have performed Heller's operation on 9 patients. The technique has been as follows. Through a posterolateral incision, the left thoracic cavity is entered through the eighth interspace (fig. 3). The eighth rib is transected posterior to its angle. The pleura

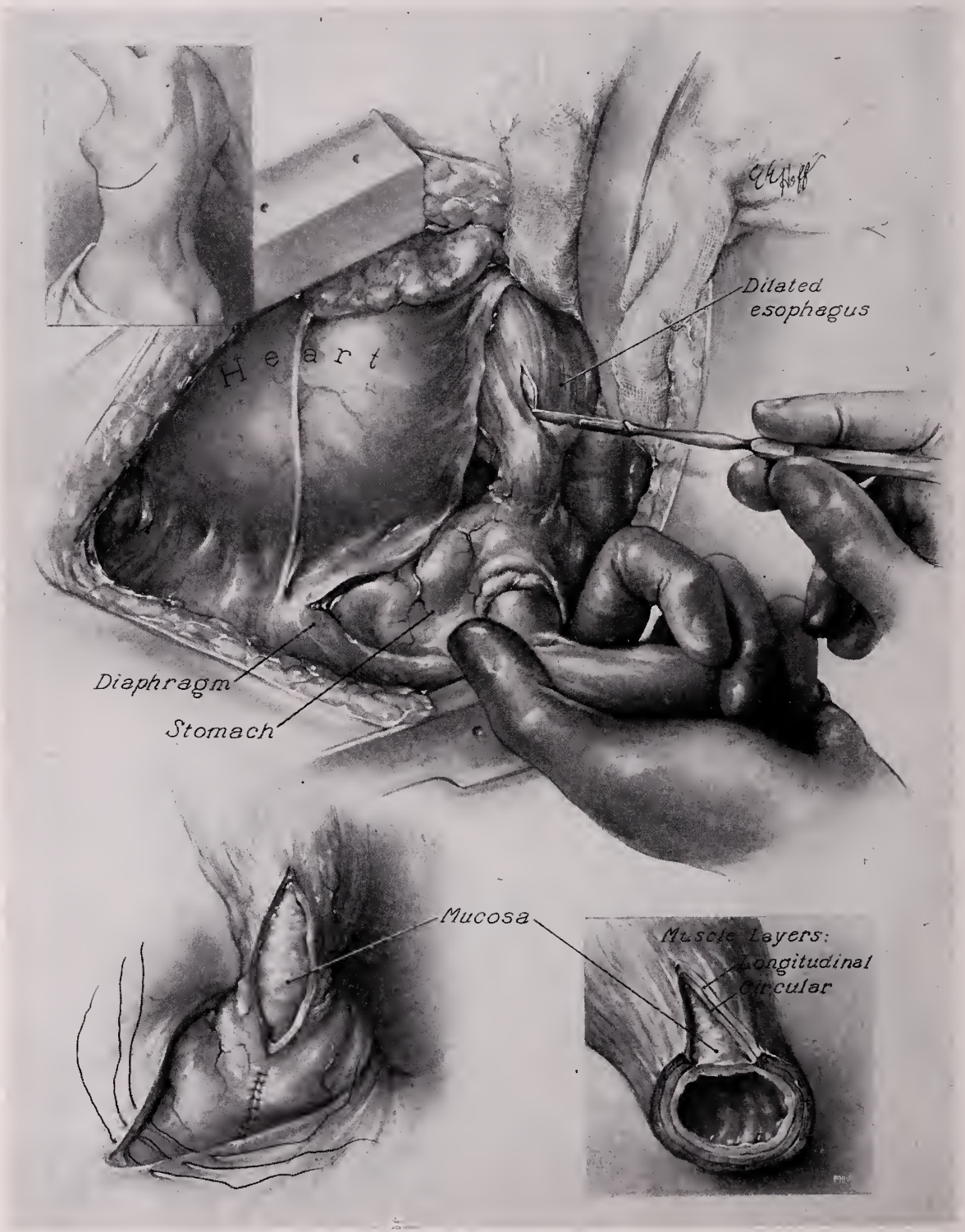

FIG. 3. Diagrams illustrating the technique of cardiomyoplasty, modified Heller method.

overlying the lower part of the dilated esophagus is divided and reflected. A short incision is made in the hiatus of the diaphragm to permit visualization of a portion of the stomach. The proposed line of the longitudinal incision, measuring between 4 and 5 inches in length, is cleared of areolar tissue and vascular channels. Beyond the proposed incision in the muscular coats of the stomach, a small incision is made into the lumen of the stomach through which the left forefinger is inserted. This finger explores the area of stricture and is passed through it if possible. With the finger as a guide to prevent injury to the mucosa, the serous and muscular coats of the stomach and the muscular wall of the esophagus are incised. The finger immediately appreciates the relaxation which has been produced. The opening into the stomach is then closed, the incision in the hiatus is repaired, and the chest is closed without drainage after the instillation of penicillin. The patient is fed intravenously for a few days, during which time the bare mucosa should have become agglutinated to the adjacent structures. Nausea and vomiting during the immedate postoperative period might result in rupture of the esophagus at the operative site.

There has been no mortality or important morbidity attributable to the operation. In 1 patient the operation was done for palliation in the presence of complicating carcinoma of the middle portion of the esophagus.[3] The subsequent autopsy in this patient, who died of perforation of the carcinoma into both main bronchi, gave an excellent opportunity for examination of the adequacy of the Heller procedure. The obstruction had been completely relieved.

The other 8 patients have had gratifying clinical results (fig. 4) and several have been followed for more than a year.

In answer to Dr. DeBakey's question, "Why is the Heller operation better now?" one might first say that it was never as bad as implied, since, it will be recalled, there were only 14 recurrences of symptoms and 4 deaths in 104 collected cases. It is likely that the thoracic approach leads to a more thorough operation, since the incision through the esophageal musculature can be made adequately high. Furthermore, all of the factors which make modern thoracic surgery safer are operating to make the patient receiving the Heller operation today surer of leaving the hospital without misfortune.

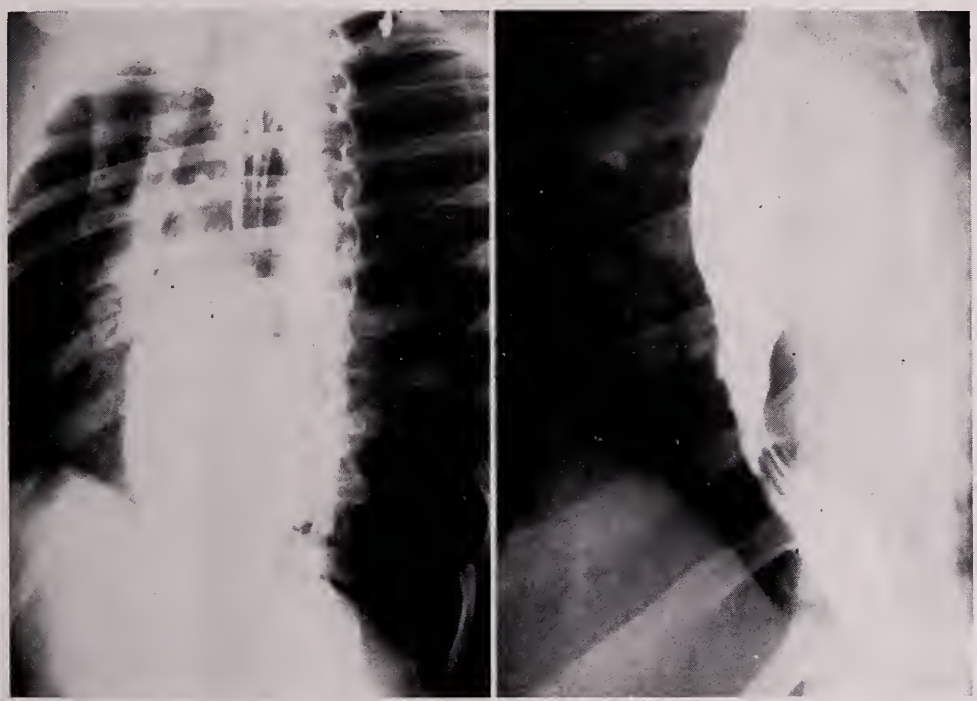

FIG. 4. Roentgenograms made before operation and three months postoperatively showing cardiospasm treated by the Heller operation.

HYDROSTATIC DILATATION

Finally, a word should be said regarding hydrostatic dilatation. It is probable that gastroenterologists and endoscopists will continue to give relief to a certain number of patients with cardiospasm for some time to come. However, as they note recurrences of strictures and find their patients drifting off to other clinics, it is likely that they will recommend definitive surgical

correction (the Heller operation) with increasing frequency.

SUMMARY

Personal experience with 18 cases of cardiospasm (mega-esophagus, achalasia, esophageal dystonia) has been presented. Cardioplasties of the Wendel type were done in 9 cases with unsatisfactory end results because of the incidence of esophagitis and peptic ulceration. Extramucosal cardiomyotomy of the type proposed by Gottstein and first performed by Heller has been carried out in 9 cases with gratifying results.

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ABSTRACT OF DISCUSSION

DR. H. T. BARKLEY, Houston: I am happy that the problem of cardiospasm is being brought to our attention. In this connection I cannot resist the temptation to say something about the role of emotional disturbance in etiology and stress the importance of the psychosomatic approach. The patient probably will develop other gastrointestinal symptoms unless the psychosomatic factor is considered.

In my opinion hydrostatic dilatation does not cure cardiospasm; I have seen the condition worsened by dilatation. At the same time, cardioplasty is not without hazards. I have been impressed with the thickening of the muscularis at the cardia causing a constricting ring. Extreme mega-esophagus must be resected. It appears that the Heller procedure offers the safest relief of cardiospasm and its symptoms.

Recently I have seen a patient with cardiospasm and carcinoma, indicating the need for endoscopic examination of all patients with cardiospasm before any type of therapy is considered.

DR. DENTON A. COOLEY, Houston: Dr. Lam apparently has discarded esophageal bougienage in treating achalasia of the esophagus. I agree that repeated gentle dilatations with the Hurst mercury-weighted bougie was a nuisance to the patient and for the most part unsatisfactory. On the other hand, the results with the hydrostatic dilator (Plummer, Negus) have been much more encouraging, and recent reports from the Mayo Clinic and from clinics in England substantiate this point. I believe the technique of hydrostatic bougienage continues to have a place in treatment of the debilitated patient. In patients with an enormously dilated esophagus, however, one should perhaps use the cardiomyotomy of Heller or in some cases esophageal resection. The long-term results with Heller's operation are definitely better than those with cardioplasty because of the absence of acid-pepsin reflux, but I also have seen reflux esophagitis in patients after cardiomyotomy. In my opinion selection of treatment in achalasia of the esophagus should depend upon the clinical findings in the individual patient, and all patients should not necessarily be treated alike.

Chest Surveys

A Joint Committee on Diseases of the Chest, established by the American College of Chest Physicians and the American College of Radiology, has adopted a report suggesting guiding principles on the problems involved in routine chest roentgenograms in hospitals and mass chest surveys. This pooling of ideas is expected to be a continuing process, and an exchange of opinion is invited by Dr. Leo G. Rigler, Minneapolis, and Dr. Otto L. Bettag, Chicago, co-chairmen.

The current report, which has the approval of the board of regents and the board of chancellors respectively of the two organizations, recommends that each physician be encouraged to have chest roentgenograms of all of his patients; that every patient admitted to a hospital have a routine chest examination; and that follow-up for each suspected lesion seen in chest surveys should assure the patient's coming under medical supervision.

The report points out that routine chest roentgenograms are useful in screening normal from abnormal chests, but that *even 14 by 17 inch films are diagnostic aids only and should not take the place of complete clinical examinations.* Insofar as financial resources and qualified personnel permit double reading of chest roentgenograms, this procedure will increase the percentage of positive diagnoses, but a check mechanism should be instituted to eliminate the false positives. It is noted that the number of lesions overlooked in screening examinations because of clothing is so small as to make it feasible to conduct such examinations with the patient fully clothed.

The importance of continuous monitoring of all personnel associated with photofluorographic equipment to determine radiation exposure and prompt measures to correct faulty techniques or imperfect equipment permitting excessive exposure is stressed.

The committee agreed that interpretation and reporting of roentgenographic findings is a medical matter and should be handled by a responsible physician compensated like any other physician practicing his profession.

Contributions to the Memorial Library of the Texas Medical Association pay appropriate tribute upon the death of a person close to the medical profession. A card of acknowledgment and a memorial book plate help to perpetuate the memory of the deceased. Further information may be obtained from the Library, 1801 Lamar Boulevard, Austin.

SURGICAL TREATMENT OF MITRAL AND AORTIC STENOSIS

Results of 115 Valvotomies

DENTON A. COOLEY, M.D.; MICHAEL E. DeBAKEY, M.D.; RAY H. SKAGGS, M.D.; and DON W. CHAPMAN, M.D., Houston, Texas

DURING the past five years remarkable advance has been made in developing surgical procedures for the relief of congenital and acquired stenosis of the mitral and aortic valves.

TECHNIQUES

Mitral Stenosis

At the beginning of this century Brunton[4] and Samways[16] proposed that mitral stenosis, being a mechanical obstruction to blood flow, should be amenable to surgical correction, and in 1923 Cutler and Levine[12] reported the first clinical attempts at mitral valvotomy. During the ensuing years these and a few others (Allen and Graham, Pribram, and Souttar[11]) operated upon 10 patients with mitral stenosis, 2 of whom survived the operation and only 1 of whom was improved. The latter patient was operated upon by Souttar[18] to whom credit belongs for performing the first successful commissurotomy. This single case did not justify the prohibitive operative mortality of 80 per cent in the entire group, and further clinical trials were not soon forthcoming.

Recently with the inspiring leadership of Smithy,[17] Bailey,[1] Harken,[14] and Brock,[3] the surgical relief of mitral stenosis has become feasible and is now accompanied by a relatively low operative risk. The improved results have been obtained by controlling the degree of mitral regurgitation occurring after the stenosis is overcome by valvotomy. In most of the earlier attempts valvotomy was done by introducing a valvulotome into the heart in order to punch out more or less at random a piece of the stenotic valve. In the few instances where this aim was accomplished, a severe and usually fatal degree of mitral insufficiency was the consequence. With better understanding of the mechanism of valve action, a technique of valvotomy by incision at the point of fusion (commissures) of the leaflets has been developed. Thus by preserving the integrity of the leaflets and restoring valvar action, the crippling effects of mitral stenosis are overcome without the production of mitral insufficiency.

From the Departments of Surgery and Medicine, Baylor University College of Medicine, and the Jefferson Davis, Methodist, and Veterans Administration Hospitals.

This study was aided by a grant from the Houston District Chapter, Texas Heart Association.

Patients in our series were selected for mitral valvotomy if there was evidence of mitral stenosis in relatively pure form, although moderate degrees of mitral insufficiency did not preclude operation. Details of clinical evaluation of patients before operation are reported elsewhere.[6, 10] Cardiac catheterization was performed in the first 30 consecutive patients in this series,[5] but in the last 80 of the 110 patients treated by mitral valvotomy it has been done only in doubtful cases. These studies showed elevation of pulmonary arterial and pulmonary capillary pressures at rest and particularly with exercise. In most cases cardiac output during rest and exercise was below normal and in general reflected the degree of functional incapacity. As determined by the formula of Gorlin and Gorlin,[13] the cross-sectional area of the normal mitral valve is 4 to 6 sq. cm., but in our patients the calculated valve area was less than 1.5 sq. cm. Moreover, there was a relatively close correlation between the calculated valve size and the size estimated by palpation at operation.

Radiographic studies of patients for commissurotomy have been of definite value. So-called mitralization of the cardiac contour includes right ventricular and left atrial enlargement and dilatation of pulmonary arteries (fig. 1). In the absence of significant associated valvar lesions, there is no enlargement of the left ventricle. Characteristically the left atrium in mitral stenosis presents as a chamber of moderate diameter which indents the esophagus over a relatively short distance in contrast to the tremendous saclike dilatation of the left atrium which may accompany mitral insufficiency. On the other hand 2 of our patients with pronounced stenosis and mild insufficiency of the mitral valve had extreme left atrial enlargement, and both patients obtained satisfactory functional results following valvotomy. In our opinion the most reliable single diagnostic feature in selection of patients for operation is the presence of the typical rumbling diastolic murmur of mitral stenosis.

Patients were prepared for operation by digitalization, salt restricted diets, and mercurial diuretics. One hour before operation, quinidine sulfate (3 to 6 grains) was administered orally. For the most part cardiac arrhythmias other than extrasystoles were not serious

during operation, and only occasionally was quinidine lactate given parenterally or intravenously during anesthesia. Intravenous or topical administration of procaine hydrochloride and procaine amide was not employed in this series of cases.

The operative technique used in these patients has been described in detail elsewhere[9]; therefore only a brief description will be given here. The patient lies supine on the operating table with the left shoulder slightly elevated and the left arm suspended from an overhead frame. A curved anterior submammary incision is made on the left, and the chest is entered through the fourth intercostal space after the fourth costal cartilage is divided. After insertion of a self retaining retractor, the left lung is partially collapsed, and the pericardium is entered anterior and parallel to the phrenic nerve and vessels. The incision in the pericardium provides adequate exposure of the pulmonary artery and left auricular appendage. Direct pressure determinations are made in the pulmonary artery, left atrium, and aorta. A purse-string suture of 0 black silk is placed about the base of the atrium and is used to control hemorrhage if necessary. A non-crushing clamp is placed across the base of the appendage, and near its apex an incision is made sufficiently large to accommodate snugly one's index finger. In patients suspected of having atrial thrombosis, the auricular clamp is released briefly to allow a gush of blood to wash out any loosely attached thrombi. Then as the auricular clamp is removed slowly, the index finger is inserted into the cardiac chamber.

Exploration of the atrium reveals whether or not mural thrombi are present, the elasticity and suppleness of the leaflets, the presence of calcification of the valve, and the degree of mitral regurgitation. Digital pressure and finger dissection at the commissures usually will produce the desired split, but occasionally a special valvotome may be employed to commence the valvar incision. The finger is introduced into the mitral orifice for a period not exceeding four or five heart beats in order not to impede blood flow for a significant period. After commissurotomy is accomplished, the finger is withdrawn into the atrium where a regurgitant jet of blood may be palpable during systole. Usually a carefully performed valvotomy produces no mitral insufficiency. As the finger is withdrawn from the heart, the auricular clamp is reapplied simultaneously with little or no blood loss. The auricular appendage is then amputated close to its base after the purse-string suture has been removed. The auricular opening is sutured with a double row of interrupted silk sutures, and pressures are again measured in the pulmonary artery, left atrium, and aorta for comparison with the prevalvotomy determinations. The pericardium is sutured loosely to allow drainage of pericardial fluid into the pleural cavity. An intercostal catheter is inserted into the pleural cavity for underwater drainage, and the incision is closed in layers. Ordinarily the amount of blood lost does not necessitate a blood transfusion.

After operation digitalization and salt restriction are maintained. Hemorrhagic shock rarely occurs. In all

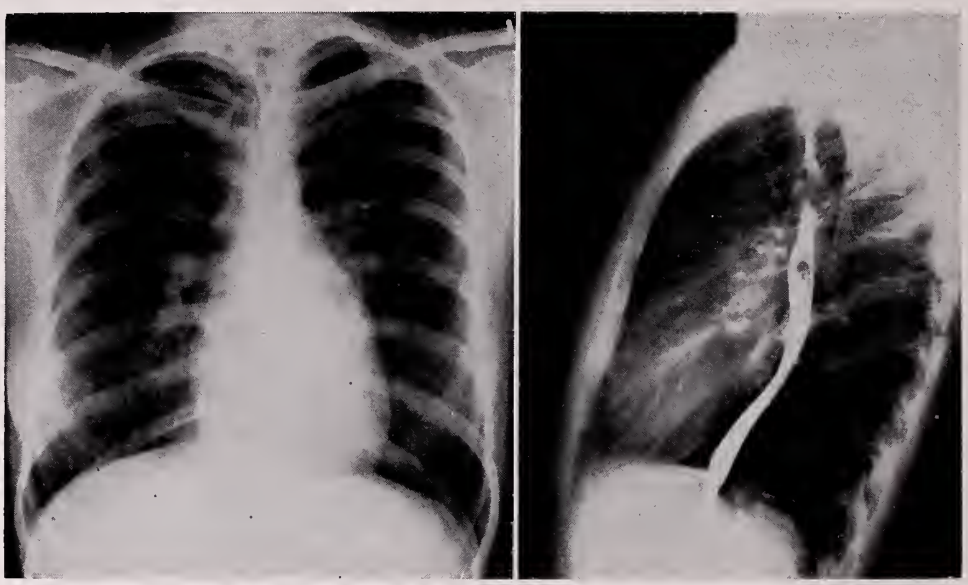

FIG. 1. Roentgenograms of the chest of a 26 year old housewife (functional class 3) demonstrating the typical mitralized contour of the cardiac silhouette. In the posterior-anterior view (*left*) the enlarged pulmonary arterial segment and left auricular appendage produce the prominence of the left cardiac border. In the lateral projection (*right*) indentation of the esophagus posteriorly by the distended left auricle is well demonstrated. The right ventricle is moderately hypertrophied, and the left ventricle is of relatively normal size. Mitral valvotomy in this case produced an excellent result.

patients with a sinus rhythm before operation quinidine sulfate (3 grains every four hours) is administered postoperatively to prevent the development of auricular fibrillation and is maintained for a period of four to six weeks. In 18 patients with sinus rhythm before operation fibrillation has occurred postoperatively, and in all but 1 sinus rhythm was restored by the oral administration of quinidine in larger doses. In our opinion it is desirable to maintain a sinus rhythm whenever possible. In some patients with auricular fibrillation before operation an attempt is made to convert the rhythm to sinus after operation, but conversion of the rhythm is not necessary to produce adequate functional improvement. Anticoagulants may be used in conjunction with quinidine in such cases. The usual period of postoperative hospitalization is eight days.

Aortic Stenosis

Aortic stenosis presents a more complex problem to the cardiologist and surgeon because of physiologic and pathologic features peculiar to lesions of the aortic valve. Patients may remain surprisingly well with a loud aortic murmur and marked left ventricular hypertrophy until decompensation occurs, but once this takes place there ensues an almost intractable condition which is extremely difficult to combat. The impaired function of the aortic valve interferes with coronary circulation and largely accounts for the inability of the failing left ventricle to recover its function. Thus patients should be operated upon for this condition before they have reached this precarious phase of the disease.

Aortic stenosis may be either of congenital or acquired origin. In congenital aortic stenosis the obstruction either may be in the valve itself or may occur in the subaortic zone as a fibromuscular membrane. If the stenosis is extreme, the patient may be subject to fainting attacks and even sudden death, but in most instances the congenital lesion is well tolerated. Acquired lesions of the aortic valve producing stenosis are usually the result of rheumatic fever, but there may be superimposed atherosclerosis and calcific changes particularly in the fifth and sixth decades of life. Under these circumstances the valve ring becomes rigid and immobile. Valvotomy after such changes have occurred may produce only slight benefit to the patient.

In 1913 Tuffier[26] made the first successful attempt at operative correction of aortic stenosis by digitally invaginating the aortic wall and dilating the valve. Interest in the surgical approach to this problem was revived by the late Horace Smithy,[24, 25] who himself died in 1948 of aortic stenosis. Numerous techniques for aortic valvotomy have been proposed.[19-23] The most satisfactory method in our opinion is described by Bailey, Redondo Ramirez, and Larzelere,[19] in which procedure a special valvotome is passed through the wall of the left ventricle into the stenotic valve. The head of the valvotome is composed of three expanding parts which engage the fused commissures and when opened split the cusps apart. Although a moderate degree of aortic insufficiency may be produced if the valve leaflets are ruptured or torn, relief of aortic stenosis may be obtained with associated clinical improvement if the valve is sufficiently supple to allow it to open and close after valvotomy is accomplished.

CLINICAL RESULTS

This report deals with 110 patients undergoing mitral valvotomy and 5 patients undergoing aortic valvotomy between March, 1951, and November, 1953. Although aortic and mitral stenosis occurred in combination in several instances, simultaneous aortic and mitral valvotomy was attempted only once.

Mitral Stenosis

In the series of 110 patients operated upon for mitral stenosis, there have been 10 deaths occurring at varying intervals following operation. In the 100 survivors an attempt has been made to estimate the degree of improvement, based on relief of symptoms, functional improvement, and when possible, information obtained by cardiac catheterization. Results were considered good in 74 of the survivors, fair in 19 patients, and poor in 7. In the group of patients whose results were classified good, there were many with excellent and striking restoration of functional activity, and in these, cardiac murmurs were almost eliminated. In others, the functional improvement was exceptionally good, but there was less striking alteration of the cardiac murmurs.

Deaths.—The 10 patients who died in this series of 110 mitral valvotomies were severely incapacitated, class 4 patients, most of whom were in the advanced age group (table 1). Moreover, all of these patients had had fibrillation before operation and 2 had previously had peripheral embolism. Of prime importance in the fatal cases was the fact that thrombosis and embolism was the probable cause of death in 9 patients. Thrombosis of a calcified mitral leaflet was evident in 2 patients and produced progressive valvar occlusion. Peripheral embolism definitely contributed to the death of 3 patients, and cerebral embolism was presumed to have been present in 2 others. Massive pulmonary embolism caused death in 2 patients, thirty hours and six days respectively after operation, and was the presumptive cause of death in a third patient who died suddenly at home one month after

operation. One patient who before operation had severe mitral insufficiency and almost intractable decompensation died of pulmonary edema four days after exploration of the mitral valve.

Severity of Cardiac Condition.—Functional rating of patients is similar to the classification proposed by the New York Heart Association.

As shown in table 2, 40 per cent of the patients in this series were in class 4, and 93 per cent were in either class 3 or 4. Most of the patients were severely disabled, and many had been totally bedfast from three to eighteen months. The percentage of good to fair results was higher in class 3 than it was in class 4, although good results were obtained in about 60 per cent of the patients in class 4. This high percentage of good results in class 4 patients would appear to offset the fact that all deaths occurred in this group. Operation thus seems to be justified in these patients who are otherwise destined to chronic invalidism or premature death.

Age.—The ages of the patients varied over a wide range between 16 years and 58 years, with 69 patients being less than 40 years of age and 41 patients more than 40 years old.

In all patients less than 25 years of age the possibility of reactivation of the rheumatic process by operation deserves consideration. All of our younger patients therefore were observed carefully for varying periods before operation to detect symptoms of rheumatic activity. Four patients in the younger group following operation have had transient symptoms suggestive of a recrudescence of rheumatic fever. In general, however, the most satisfactory results were obtained in patients between 25 and 35 years. In patients more than 40 years of age good results were obtained in 22 (more than half), and there were 7 deaths. In patients less than 40 years of age good results were obtained in 57 (about four-fifths) and 3 patients died. Although the fatality rate in the older patients was higher than in the younger group, the percentage of good results in the patients above 40 years justifies operation. The oldest patient in this series was 58 years old, and an excellent result was obtained. Three other patients beyond 50 years of age have obtained good symptomatic relief from operation.

Previous Embolism.—Peripheral embolism occurred before operation in 16 patients, and in 7 of these there were multiple emboli. Ten patients had cerebral emboli producing neurologic sequelae such as hemiparesis and partial aphasia. In others the emboli lodged in the vessels of the extremities or viscera (spleen, kidney, intestine). Seven patients were suspected of having pulmonary infarctions before operation, but in 4 of these the evidence was equivocal. Twelve of the patients with previous peripheral emboli had fibrillation at the time of operation. In this series of 16 patients with peripheral emboli prior to operation, 3 showed evidence of embolization after operation, 2 of which were fatal. Thus among the 14 patients who survived operation only 1 subsequently developed this complication. It appears, therefore, that peripheral embolism in the presence of mitral stenosis is actually an indication for valvotomy and offers best protection against future embolization.

Auricular Fibrillation.—Before operation 54 patients had auricular fibrillation, and 56 patients had sinus rhythm. Good results were obtained in 32 patients with auricular fibrillation and in 42 patients with sinus rhythm. Fibrillation was present in all patients who died. These results indicate that although auricular fibrillation is not a contraindication to valvotomy, it apparently does increase the operative risk and slightly diminishes the possibility of obtaining a

TABLE 1.—*Analysis of 10 Deaths in Series of 110 Mitral Valvotomies.*

Case	Age (Yr.)	Sex	Functional Classification	Auricular Fibrillation	Operative Findings	Survival	Cause of Death
1	53	M	4	+	Mural thrombi; calcified valve	30 hr.	Aortic "saddle" embolus
2	51	M	4	+	Calcified valve	4 mo.	Thrombosis mitral valve, aortic "saddle" embolus
3	49	F	4	+	Mural thrombi; calcified valve	3 days	Cerebral embolus
4	31	F	4	+	Marked mitral insufficiency	4 days	Congestive failure
5	47	F	4	+ (Flutter)	Calcified valve	1 mo.	Possible pulmonary embolus
6	33	M	4	+	Mural thrombi; temporary carotid occlusion	16 hr.	Cerebral anoxia; cerebral embolus(?)
7	47	F	4	+	Mural thrombi; calcified valve	10 days	Cerebral infarct; pulmonary congestion
8	37	M	4	+	Mural thrombi; calcified valve	6 days	Massive pulmonary embolus
9	44	M	4	+	Mural thrombi; calcified valve	30 hr.	Massive pulmonary embolus
10	41	F	4	+ (Intermittent)	Marked calcification	10 days	Thrombosis mitral valve

TABLE 2.—*Functional Classification (New York Heart Association) in 110 Patients Undergoing Mitral Valvotomy.*

Class	No. Cases	%
1	0	0
2	8	7
3	58	53
4	44	40
Total	110	100

good functional result. On the other hand, the proportion of good results in the patients with fibrillation is sufficiently high to justify operation.

Of real importance in auricular fibrillation is the frequency of the presence of mural thrombosis in the auricle. In the 54 patients with fibrillation, mural thrombi were demonstrated in the left atrium or auricular appendage in 17 instances. In 4 of these embolism was discovered soon after operation. In 1 the embolus involved only pulmonary vessels, indicating that there may have been right atrial thrombosis as well as left. Measures taken at operation to reduce the danger of embolism have been employed in all patients with auricular fibrillation and mural thrombosis. In most cases the valve was approached through the left auricular appendage whether or not it was suspected of containing thrombi. Access to the valve was gained through the superior pulmonary vein in 2 cases where the appendage was contracted and fibrosed or calcified, preventing its use as a means of safe entry into the heart.

In 6 patients the left atrium was completely lined by thrombi in varying stages of organization, but valvotomy was performed in all. Death from cerebral embolism occurred in 1 of these patients, and the others recovered uneventfully. Although it seems desirable during intracardiac manipulation to have the anesthetist compress the carotid arteries to prevent cerebral embolization, this technique failed to prevent fatal embolism in 1 case. The technique suggested by Bailey[2] for temporary complete occlusion of the carotid circulation within the thorax has been employed in 9 patients but also may be unreliable and even dangerous. If intrathoracic occlusion of the carotid arteries is to be used under these circumstances, the period of occlusion should be less than two minutes and full oxygenation of the circulating blood must be assured before the vessels are clamped. Obviously, temporary carotid occlusion does not preclude the possibility of emboli lodging elsewhere in the arterial system. Anticoagulants have been employed after operation in some of the patients but not in a sufficient number to permit definite conclusions.

Valvar Calcification.—The more extensively calcified mitral valve may be demonstrated by fluoroscopy and roentgenography prior to operation, but from our experience this finding does not contraindicate exploration. Calcification of the mitral valve was discovered at operation in 53 patients (48 per cent) in this series. In some instances calcification was extensive and involved the valve leaflets as well as the commissures. In a few, exuberant calcification was palpated at the commissures, usually the anterolateral one, but surprisingly good results have been obtained in these patients. When a split is made through a calcified commissure, mild but not incapacitating mitral insufficiency may be produced. In no instance did embolization of a calcified fragment occur or did bacterial endocarditis supervene. Of the 53 patients in whom calcification of the valve was discovered at operation, good results were obtained in 31 patients, fair results in 10 patients, poor results in 4, and 8 patients died.

Associated Valvar Lesions.—Although a moderate to marked degree of mitral insufficiency was present in about 25 patients operated upon, concomitant lesions of other valves were infrequent. Three patients had a moderate degree of associated aortic stenosis, but in none was simultaneous mitral and aortic valvotomy done. One of these patients died ten days after operation of thrombosis of the valve and sudden occlusion of the mitral orifice. The other 2 patients obtained excellent functional results in spite of the persistent aortic stenosis, although subsequent aortic valvotomy may be required in 1 of these patients. Aortic insufficiency was not demonstrated in any patient. Increasing experience indicates that a Graham-Steele murmur of functional pulmonic insufficiency is a frequent finding in pure mitral stenosis (26 cases in our series) and mimics the murmur of aortic insufficiency. When pulmonary arterial pressure is reduced after commissurotomy, the Graham-Steele murmur disappears. Before operation none of the patients was suspected of having associated tricuspid or pulmonic valvar lesions.

In general, the finding of a grade 1 or 2 mitral systolic murmur with mild left ventricular enlargement does not preclude surgical treatment in patients in whom mitral stenosis is the predominant lesion. A carefully performed mitral valvotomy seldom increases the degree of mitral insufficiency. In 5 patients, however, it was thought that mitral regurgitation was increased by the valvotomy, but in these instances the relief of mitral stenosis produced gratifying functional improvement. Commissural dissection should be performed with extreme care so that valvar action is restored and the stenosis relieved without producing an incompetent valve. Mild mitral insufficiency frequently accompanies mitral stenosis, but even in these cases valvotomy may produce striking functional improvement.

Pregnancy and Mitral Stenosis.—Five patients in this series were pregnant at the time of valvotomy. The first was a 28 year old primigravida in the fourth month of pregnancy who was experiencing progressive disability and mild decompensation. Valvotomy produced an excellent functional result, and five months later she delivered uneventfully a 7 pound normal girl.[8] A second patient was a 24 year old primigravida in the third trimester of pregnancy. She

had experienced 2 attacks of severe pulmonary edema in spite of a rigid regimen to control cardiac symptoms. Operation was performed during the thirty-sixth week of pregnancy, and sixty-two hours later she delivered a 5 pound 10 ounce boy. Mother and son were discharged from the hospital five days after delivery in good condition. Three other patients have undergone valvotomy during pregnancy, and all subsequently have withstood delivery uneventfully.

This experience indicates that mitral valvotomy is not only feasible during pregnancy but should be attempted in those instances of class 3 and 4 cardiac patients if the anticipated risk of decompensation during delivery appears to be serious. If commissurotomy is to be done under such circumstances, the optimum time for operation is before the fifth month of pregnancy. Further experience is necessary before other specific recommendations can be made in regard to cardiac surgery during pregnancy.

During operation the pressures in the left auricle, pulmonary artery, and a systemic artery have been measured before and after valvotomy. An immediate fall in mean pulmonary artery pressure and also in the left atrial pressure of 15 or 20 mm. of mercury represents a good immediate response. In several patients whose mean pulmonary arterial pressure was exceedingly high (80 to 100 mm. of mercury), the pressure did not fall immediately after commissurotomy in spite of a significant drop in left atrial pressure. This indicates that in some patients with mitral stenosis the vascular changes in the pulmonary vessels may delay the restoration of normal pulmonary pressure after operation. These vascular changes have been described in detail previously by Parker and Weiss.[15] In most of our patients such histologic changes have been investigated by lung biopsy and will form the basis of a subsequent report.

Recurrence of mitral stenosis after valvotomy has not taken place in any of our patients and must be rare, probably because the rheumatic infection is quiescent in patients selected for operation.[7] Other factors, too, undoubtedly are responsible for this gratifying observation. Histologic studies of the amputated auricular appendages reveal endocardial thickening and subendocardial infiltration with round cells in most specimens, but Aschoff nodules were encountered in only a few specimens, and other histologic findings of acute rheumatic carditis have not been demonstrated.

Aortic Stenosis

In 5 patients aortic valvotomy has been performed by the transventricular route using the Donaldson-Bailey valvotome. Three patients have survived operation and are improved, and 2 have died (table 3). In the first patient, a 40 year old taxi driver, the aortic stenosis was considered to be postrheumatic and was markedly incapacitating. Direct radial pulse tracings made before and after valvotomy indicated considerable improvement in cardiac output as evidenced by the change in the contour of the systolic component. There also was a general increase in functional capacity following operation, and no aortic insufficiency was produced.

TABLE 3.—*Analysis of 5 Cases of Aortic Valvotomies.*

Case	Age (Yr.)	Sex	Etiology	Operation	Remarks
11	40	M	Rheumatic	2-6-53	Uneventful recovery; improved
12	6	M	Congenital	2-17-53	Uneventful recovery; improved
13	27	F	Rheumatic	3-10-53; combined aortic and mitral valvotomy	Died; cardiac arrest and fibrillation during chest incision
14	10	M	Congenital	3-19-53	Recovered and improved; moderate aortic insufficiency
15	46	F	Rheumatic; calcific	6-12-53	Died; ventricular fibrillation during insertion of valvulotome

The 2 deaths occurred during operation. The first of these was a 27 year old woman who had severe cardiac dysfunction (class 4) with combined aortic and mitral stenosis. For the previous two months she had been in moderate to severe intractable congestive failure and required almost continuous oxygen therapy. Operation was undertaken as a last resort. Cardiac arrest occurred during induction of anesthesia. Hasty aortic and mitral valvotomies were done, and both valves were found to be markedly stenosed. Subsequently feeble heart action was restored temporarily by cardiac massage, but effective cardiac action was not maintained, and the patient died. The other seriously ill patient, who was 46 years old and had aortic stenosis and congestive failure, developed ventricular fibrillation during insertion of the valvotome. Valvotomy with subsequent attempts at cardiac resuscitation was unsuccessful.

In patients with pronounced left ventricular hypertrophy, the myocardium appears to be very susceptible to ventricular fibrillation possibly because of the relative coronary insufficiency and myocardial ischemia. The manipulation required to insert the valvotome in such instances is likely to produce fibrillation in spite of the use of depressants such as quinidine or procaine amide. Thus it appears that valvotomy should be recommended to patients with acquired aortic stenosis before advanced stages of deterioration and myocardial decompensation occur. From our study of autopsy specimens it appears that

operation upon patients with advanced calcific stenosis is unsatisfactory. In 1 such specimen the valvulotome was badly damaged by attempting to fracture a densely calcified valve and withdrawal of the instrument through the ventricular wall would have injured seriously the myocardium, possibly to a fatal degree. After valvotomy upon a calcified, rigid valve, there is a tendency for it to spring back into its original shape without relief of stenosis.

Two patients with congenital aortic stenosis have been operated upon with gratifying results. The first patient was a 6 year old boy who had several episodes of syncope prior to operation. Valvotomy was well tolerated, and since surgery he has remained entirely well. The second patient with a congenital stenosis was a 10 year old boy with moderate cardiac enlargement and physical incapacity. Temporary cardiac arrest occurred during valvotomy, but after the instrument was withdrawn, cardiac massage restored heartbeat and recovery was uneventful. Since operation this patient has developed mild aortic insufficiency, but he is active and free of symptoms.

In patients with congenital aortic stenosis the obstruction may be located in the valve itself or in a subvalvar zone where a fibromuscular membrane may obstruct the aortic outflow tract. In the strictly valvar lesion aortic insufficiency of moderate degree may occur after valvotomy whereas in subaortic stenosis the valve ring may be guarded by a relatively normal valve. Rupture of the subvalvar membrane in this instance would not produce aortic regurgitation. Unfortunately, methods to make this distinction between valvar and subvalvar stenosis prior to operation have not been satisfactory, and it appears to be justifiable to perform a surgical dilatation of the valve ring in those patients with progressive severe symptoms of congenital aortic stenosis even though mild aortic regurgitation may be produced. Further experience with congenital aortic stenoses is necessary before specific recommendations may be given in the selection of such cases for operation.

SUMMARY

During the past five years surgical procedures have been developed for the relief of congenital and acquired stenosis of the mitral and aortic valves.

This report deals with 115 patients undergoing either mitral or aortic valvotomy between March, 1951, and November, 1953. In 110 valvotomies for mitral stenosis there have been 10 deaths giving a fatality rate of 9 per cent. Eight patients died during the first ten days after operation, and death occurred in 2 patients one and four months respectively following operation. Thrombosis and embolism accounted for death in 9 of the 10 patients who died following operation. Clinical results in 74 per cent of the survivors was good to excellent, and many were restored to normal activity with nearly complete disappearance of murmurs.

Although the risk of operation is somewhat increased in severely incapacitated patients with mitral stenosis, particularly in the advanced age group, valvotomy has produced striking improvement in the majority of such patients. Ages of patients ranged between 16 and 58 years, but good results were obtained more uniformly in patients 25 to 35 years of age. Other factors such as history of previous embolism, auricular fibrillation, valvar calcification, and associated valvar lesions deserve consideration in the evaluation of patients for valvotomy but should not contraindicate operation in the presence of mitral stenosis. Five pregnant patients with mitral stenosis have been operated upon successfully with subsequent normal delivery. The tendency for severe stenosis to recur after successful mitral valvotomy appears to be relatively insignificant.

Aortic stenosis is a more complex problem to the cardiologist and surgeon, but valvotomy may relieve symptoms of reduced cardiac output in properly selected cases. In 5 patients undergoing aortic valvotomy, the lesion was acquired in 3 and congenital in 2. Two critically ill patients with acquired stenosis did not survive operation, but I survived and was improved. Valvotomy produced gratifying relief of symptoms in 2 patients with congenital aortic stenosis. Patients with aortic stenosis should be considered for operation before the development of marked cardiac enlargement and accompanying coronary insufficiency.

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HEART DISEASE IN PREGNANCY

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HEART disease in pregnancy has assumed a more important position as the frequency of other causes of maternal mortality has been reduced. As a result, cardiovascular disease is responsible for about one-fourth of maternal deaths occurring in this country today. There are signs which suggest that this mortality is not irreducible.

The fundamental studies regarding the basic physiologic changes in the cardiovascular system during pregnancy are becoming more widely appreciated. This knowledge, together with the growing awareness of the need for cooperative, careful prenatal attention by the obstetrician and internist or cardiologist, has already brought the mortality down to such low figures as the 0.64 per cent recently reported by Gorenberg and Chesley.[9] Furthermore, recent advances in the treatment of mitral stenosis, coarctation of the aorta, patent ductus arteriosus, tetralogy of Fallot, and subacute bacterial endocarditis tend to make pregnancy a lesser hazard in certain patients, although it is true that new and often trying problems confront the physicians who attend these patients. For many years rheumatic heart disease has been responsible for from 90 to 95 per cent of the total of cardiac patients who become pregnant, with congenital heart disease accounting for 2 or 3 per cent and miscellaneous disorders constituting the remainder. These proportions undoubtedly will change as surgical management prolongs the life of patients with congenital cardiac defects and preventive measures of various types reduce the incidence of rheumatic heart disease.

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CARDIOVASCULAR LOAD OF PREGNANCY

The burden which pregnancy imposes upon the heart may be understood from table 1, which summarizes the changes occurring in the cardiovascular system. Although the causes of these alterations are not fully understood, they are probably related to endocrinologic modifications attending the pregnancy with accompanying retention of salt and water. The increased blood volume is primarily an increase in plasma volume. Furthermore, the studies recently reported by Berlin and his associates[3] using erythrocytes labeled with radioactive phosphorus (P^{32}) have shown a definite decrease in total red cell volume in the first trimester followed by a slow rise to a maximum in the ninth month. This is followed by a decrease prior to delivery and a further 300 cc. fall at delivery. The plasma volume begins to rise in the second month and also reaches a maximum at the ninth month. Again, a fall precedes delivery with an additional 700 cc. drop at delivery. Berlin and his coworkers reported an average increase of more than 1,300 cc. in the total blood volume during pregnancy.

TABLE 1.—*Changes in Circulatory Dynamics in Pregnancy.*

Increased total blood volume (1-1.3 L.)
Increased cardiac output (25-40%)
Increased cardiac work (50%)
Increased oxygen consumption (15-25%)
Accelerated circulation rate
Decreased arteriovenous oxygen difference

Burwell and his associates[6] developed the hypothesis that the placenta behaves much like an arteriovenous aneurysm and that the circulatory dynamics are altered accordingly. It is believed that this alteration may be one of the participating mechanisms, but the retention of salt and water is as important, or more so. This latter circumstance lends itself to alteration by medical means if the patient should develop congestive heart failure during the pregnancy.

The feature which seems of greatest practical importance in the cardiovascular changes accompanying pregnancy is that the load upon the heart reaches a peak at from thirty-two to thirty-six weeks. There is then a gradual drop in the last lunar month. A curve

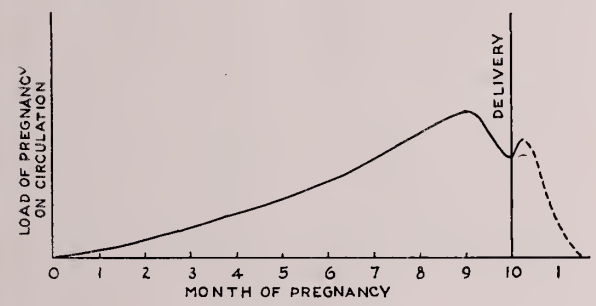

FIG. 1. A graph representing the postulated load of pregnancy upon the circulation. Note that the peak occurs at the ninth lunar month and a significant fall precedes delivery. A small second peak occurs in the early postpartum period. (Modified from Hamilton, B. E., and Thomson, K. J.: Heart in Pregnancy and Childbearing Age, Boston, Little, Brown and Co., 1941.)

representing this load has been developed by Hamilton and Thomson[10] (fig. 1). If this curve is kept in mind, it is of help in managing pregnant cardiac patients. For many years when congestive heart failure developed during pregnancy, there was an inclination to terminate the pregnancy, often by cesarean section, at exactly the point on this curve when the load is greatest to spare the patient what was thought to be the greater burden at full term. It is appreciated now that the load lessens markedly during the last month and that the patient is really in a more favorable state at full term.

When the load of pregnancy upon the circulation is understood, it becomes clear why many normal women develop certain manifestations which suggest heart disease. These include dyspnea, palpitation, pulmonic and apical systolic murmurs, apical third heart sounds, tachycardia, full pulses, and a seeming increase in the size of the heart. When patients have not been examined prior to pregnancy, it is necessary to evaluate these manifestations with some care in order to avoid an erroneous diagnosis of structural heart disease.

EVALUATION OF PATIENT

Several plans for evaluating particular patients in pregnancy have been proposed. Such systems of classification are of great usefulness since they permit the attending physicians to anticipate difficulties, particularly congestive heart failure, in certain classes of patients. In addition they are of help in advising patients, whether or not the burden of pregnancy should be undertaken. The New York Heart Association developed a classification applicable to patients with heart disease.[15] There are four classes of patients under this system according to their functional capacity. Class 1 consists of those persons with heart disease who have no limitation of physical activity. Class 2 is made up of those who have slight limitation of physical activity. Class 3 is for those patients who have marked limitation of physical activity, and class 4 consists of those patients who are unable to carry on any physical activity without discomfort. General experience has shown that patients in classes 1 and 2 usually tolerate pregnancy well. The risk of pregnancy, particularly the development of congestive heart failure, is much greater for patients in classes 3 and 4.

TABLE 2.—*Duration of Rheumatic State and Incidence of Heart Failure During Pregnancy.*

Duration of Rheumatic State (Yr.)	Pregnancies (No.)	Pregnancies with Failure (No.)	(%)
0-9	40	2	5
10-19	77	15	19.3
20-29	36	14	38.8
30+	6	5	83.3

Hamilton and Thomson[10] proposed classification of cardiac patients into unfavorable and favorable groups insofar as the hazard of pregnancy is concerned. The unfavorable category is made up of those who have (1) signs or history of heart failure, (2) a dangerous disorder of the heart beat such as auricular fibrillation, or (3) a complicating serious disease. Women with heart disease who do not have any of these criteria are considered favorable risks. The experience of Hamilton and Thomson with the first 750 cardiac patients delivered at the Boston Lying-In Hospital indicated a mortality rate of 3.5 per cent for the patients in the favorable class and 16.7 per cent for those in the unfavorable class.

It is generally believed that rheumatic fever is a disease which has a rather definite natural history consisting of four phases: (1) the initial attack characterized by arthralgia, carditis, chorea, and other rheumatic manifestations; (2) a subacute phase during which recrudescences are frequent; (3) an inactive phase, usually from puberty to the fourth or fifth decade, during which functional capacity is usually good; and (4) a final phase characterized by pro-

gressive reduction in functional capacity with ultimate congestive heart failure and death. The development of auricular fibrillation often signals the onset of the fourth phase.

Bunim and Rubricius[5] have recommended that by establishing the position of the patient in the natural course of rheumatic heart disease, the possibility of congestive failure can be prognosticated and the risk of pregnancy may be estimated. The risk of pregnancy, particularly the possibility of congestive failure, is much greater when the patient has entered the fourth phase of rheumatic disease. In 1950, Correll and I[7] reported observations made in 52 women with rheumatic heart disease who had four or more pregnancies. It may be seen from table 2 that congestive failure occurred in only 5 per cent of those pregnancies which occurred within nine years of the onset of rheumatic fever, whereas failure developed in 83 per cent of the pregnancies which occurred thirty or more years after the onset of rheumatic fever.

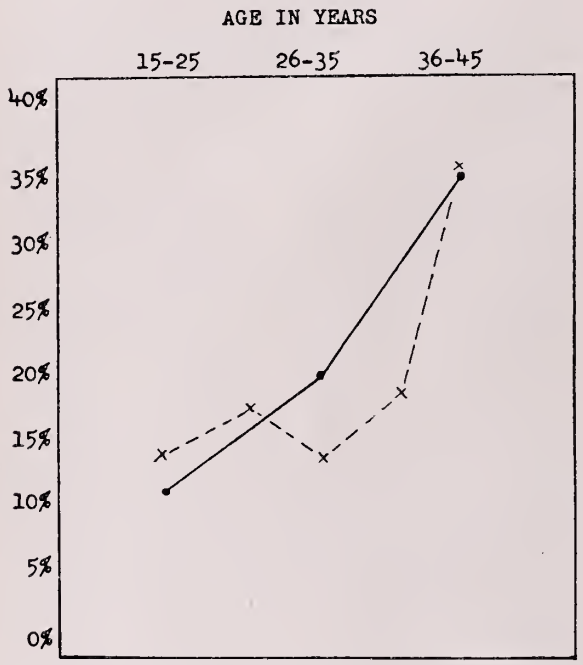

FIG. 2. A graph showing the incidence of congestive heart failure during pregnancy in patients with heart disease, which indicates the increasing frequency of this complication as the patient grows older. Solid line represents studies of Correll and Rosenbaum.[7] Dotted line indicates observation of Hamilton and Thomson.[10] (After Correll, H. L., and Rosenbaum, F. F.: Multiple Pregnancies in Patients with Rheumatic or Congenital Heart Disease, Am. Heart J. 39:283-297 [Feb.] 1950.)

It is of value to survey a single patient from many points of view when the risk of pregnancy is being estimated. In addition to classifications such as those described, specific features may be evaluated. The age of the patient is probably more important than any other single factor. Hamilton and Thomson observed a sharp increase in the incidence of heart failure in pregnancy at age 35 years, the frequency of this complication doubling in the older patients. Bunim and Rubricius[5] have confirmed this, and our observations (Correll and Rosenbaum[7]) in the special group of patients mentioned earlier support this belief (fig. 2).

A feeling in some quarters that the outlook is more serious if the size of the heart exceeds the predicted normal by 10 per cent exists; however, there is some difference of opinion on this point.[4, 5] I recently have followed the progress of a woman, aged 33 years, with aortic stenosis and insufficiency and mitral insufficiency through her third pregnancy. The heart was at least 60 per cent larger than the predicted normal and electrocardiograms showed evidence of pronounced left ventricular hypertrophy. Nevertheless, the pregnancy was uneventful and delivery uncomplicated. The first attack of rheumatic fever had occurred twenty-four years earlier. Striking exceptions to rules, such as this, are uncommon.

There is also no complete agreement concerning the prognostic significance of the type of valvular involvement.[5, 10] One of the greatest hazards is acute pulmonary edema which may occur without warning and prove rapidly fatal in women with mitral stenosis. Bramwell[4] and Jones[11] both have called attention to this condition and emphasized that it is apt to occur when normal sinus rhythm is present, probably as the result of abrupt left auricular failure.

Auricular fibrillation increases the death rate by as much as four times.[4] In one large series of cardiac patients with unfavorable prognosis, who had auricular fibrillation either established or transient, the maternal death rate was 33⅓ per cent.[10] However, Bramwell recently has expressed the opinion that auricular fibrillation is not a bar to pregnancy if observation and adequate treatment are possible. It is my own belief that this disorder of rhythm is both an unfavorable sign and an index of the final phase of the natural history of rheumatic disease. Pregnancy should be undertaken or continued in the face of this arrhythmia only with a full appreciation by all concerned of the risk involved.

There is a growing body of evidence that parity per se is not a vitally important factor in prognosis in these patients.[9, 10, 11] Our study (Correll and Rosenbaum[7]) was initiated as an attempt to determine the relationship of parity to prognosis. We observed 10 patients who had had ten or more pregnancies carried to term. No clear correlation could be worked out between the incidence of heart failure and increasing parity (table 3). It must be borne in mind that with each succeeding pregnancy the patient is older and the rheumatic state of greater duration, factors which

TABLE 3.—*Correlation of Increasing Parity with Incidence of Heart Failure.*

Para	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Total patients	53	53	53	53	39	31	27	22	13	10	4	2	1	1	1	1
No. with failure	6	5	3	6	5	4	5	3	1	2	1	0	0	0	0	0
Per cent with failure	11.3	9.4	5.7	11.3	12.8	13.0	18.5	13.6	7.7	20	25	0	0	0	0	0

After Correll, H. L., and Rosenbaum, F. F.: Multiple Pregnancies in Patients with Rheumatic or Congenital Heart Disease, Am. Heart J. 39:283-297 (Feb.) 1950.

already have been shown to affect appreciably the course of pregnancy.

If the patient has had previous pregnancies, a detailed description of their course is helpful. If heart failure has occurred in a previous pregnancy, there is a 50 to 75 per cent chance of its recurrence in succeeding pregnancies.[7, 8] In some series this recurrence rate has been as high as 89 per cent.[19] Not only does congestive failure recur but there is evidence to suggest that it appears earlier and is of more severe degree with each successive pregnancy. It is believed by many observers that patients with acute rheumatic fever present an unusually high risk, and if the diagnosis can be made unequivocally early in pregnancy, termination is indicated.[13] In evaluating any patient's status it is well to estimate the functional capacity on the basis of what the patient was able to do in her ordinary routine of living prior to the pregnancy.[4] It is well to keep in mind, however, that the functional capacity may change from time to time during the pregnancy.

MANAGEMENT OF PREGNANCY

The most important principle to keep in mind in the management of these patients is that they must be seen often and watched carefully. It is my own practice on each visit to review the symptoms, asking particularly about unusual dyspnea, cough, hemoptysis, palpitation, sudden gain in weight, or unexpected edema of the ankles. Furthermore, there should be a careful examination, including measurement of the blood pressure and vital capacity; and search for basillar rales; changes in the cardiac sounds, murmurs, or rhythm; and enlargement of the liver. The appearance of basillar rales and a gradually diminishing vital capacity may foretell congestive failure before the patient is aware of any change in symptoms. Patients with heart disease should be advised to limit weight gain to 20 pounds, to restrict the sodium intake moderately throughout pregnancy, to do that amount of housework and physical activity which can be performed with ease and comfort and without undue fatigue or dyspnea, and to take daily rest periods. If any infection occurs, the patient should take to her bed at once and appropriate treatment should be started. Respiratory infections are particularly prone to precipitate congestive heart failure in these patients.

If congestive heart failure appears, the patient should be hospitalized and treated in the usual way. It is probably wise to keep such patients in the hospital throughout the remainder of pregnancy. This is often difficult because of the economic burden imposed, and patients resist such confinement because they feel so well when the heart failure is relieved. The following case illustrates this point.

CASE 1.—L. Z., aged 34 years, was seen initially April 25, 1947, during the fifth month of her third pregnancy. The previous pregnancies eight and five years earlier were associated with considerable dyspnea during the last trimester. Features of mitral stenosis were present (fig. 3).

Hemoptysis and severe dyspnea appeared abruptly during

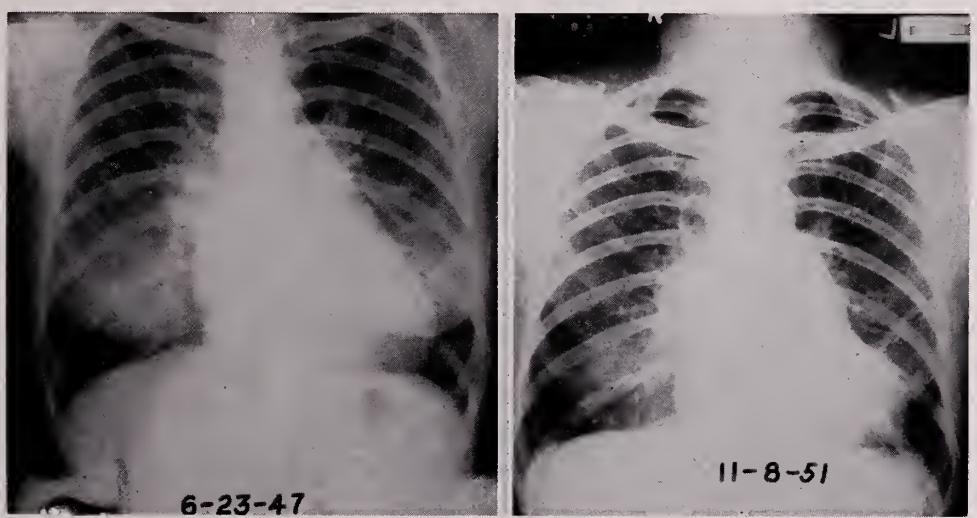

FIG. 3. Case 1. Woman, aged 34 years, with rheumatic mitral stenosis. *Left.* Roentgen study of the heart during the seventh month of the third pregnancy. The cardiac silhouette has typical mitral configuration. Delivery was complicated by nearly fatal acute pulmonary edema. *Right.* Roentgen study of the heart four months after successful mitral valvulotomy shows some decrease in cardiac size.

the seventh month, and the patient was admitted to the Milwaukee Hospital. Prompt improvement followed application of the usual measures. The patient left the hospital at her own insistence three weeks after admission. There was some increase in peripheral edema thereafter but the lungs remained clear.

Six weeks after discharge she was readmitted for induction of labor. Shortly after rupture of the membranes with subsequent rapid progress, the patient developed overwhelming acute pulmonary edema so severe that she appeared moribund. Delivery was so rapid and the patient's condition so poor that the spinal anesthesia which was planned was not used. Atropine, aminophyllin, venous tourniquets, and oxygen administered under positive pressure did not alter her condition. Improvement followed venesection with withdrawal of 500 cc. of blood.

The patient subsequently recovered and went on to develop severe, chronic congestive failure. A mitral valvulotomy was performed by Dr. Dwight Harken July 5, 1951, and the patient currently is in satisfactory condition.

If this patient had been kept in the hospital from the time of first admission until the delivery, it is probable that acute pulmonary edema would have been avoided. This case illustrates the suddenness with which the complication may arise in pure mitral stenosis and the value of phlebotomy as well. I have seen a similar case in an elderly primipara with mitral stenosis and auricular fibrillation who undertook a pregnancy despite the advice of many physicians to the contrary. Phlebotomy was again life saving. If it is remembered that the total blood volume is increased by more than one liter during pregnancy, the load upon an embarrassed circulation may be appreciated and the relief afforded by venesection understood. It is a measure which too often is not considered or felt to be outmoded.

It is perhaps well to point out that because of this increase in the total blood volume, the parenteral administration of fluids or blood must be undertaken with great caution and a full understanding of the hazard. Acute pulmonary edema of alarming degree has been observed when such measures have been used to overcome dehydration or anemia in pregnant women with mitral stenosis.[17]

It is often gratifying to observe how well some patients will tolerate the load of pregnancy when at first appraisal the risk would seem prohibitive. This point is illustrated by the following case.

CASE 2.—J. R., aged 21 years, was first seen January 3, 1949, during the third month of her first pregnancy. A murmur had been first detected when she was six months of age; a deformity of the spine had appeared at the age of 10 years. There was an extremely severe right dorsal, left lumbar kyphoscoliosis, and the cardiac findings were characteristic of an interventricular septal defect (fig. 4).

The patient was seen at two week intervals throughout pregnancy. The vital capacity, which was 1,000 cc. on first determination, never fell below 850 to 900 cc. A few, transient rales, moderate dyspnea, and fatigue appeared during the last trimester, but these changes were never severe enough to cause concern. A normal infant was delivered by mid-forceps July 20, 1949, and the postpartum period was uneventful.

In this instance the risk of continuation of the pregnancy was discussed at length with the patient and her husband. She was cooperative in following the recommendations given her by the obstetrician and me. Such cooperation by all concerned is imperative, if such high risk patients are to be carried through pregnancy successfully.

Patients with congenital heart disease present certain special problems. Girls with tetralogy of Fallot reach the childbearing age frequently, yet pregnancy can be a great burden for them. The development of surgical procedures for the amelioration of this condition has lessened this burden. Successful outcomes

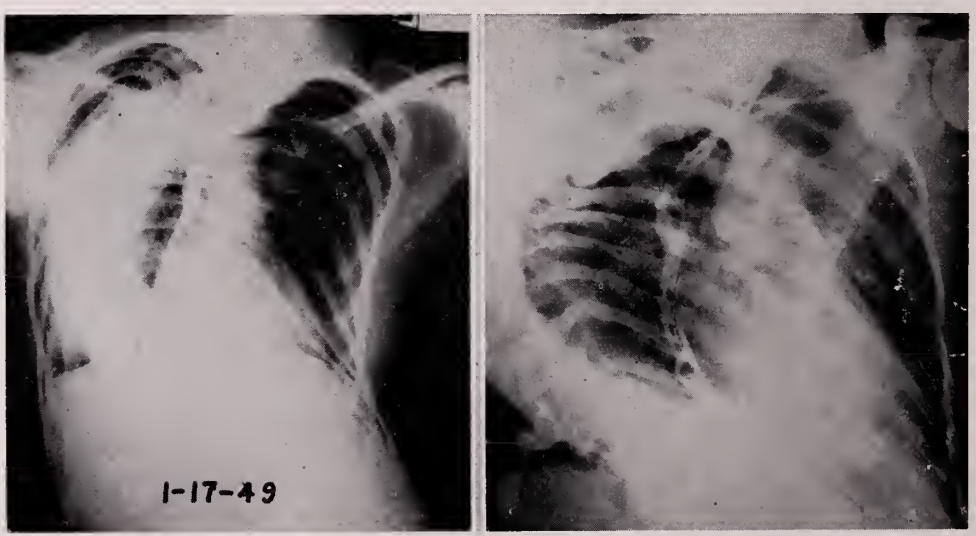

FIG. 4. Case 2. Woman, aged 21 years, with interventricular septal defect and severe kyphoscoliosis. Roentgen studies of the heart and thorax during the third month of the first pregnancy. *Left.* Antero-posterior view. *Right.* Right anterior oblique view. Gross distortion of the spine is easily seen. An uncomplicated pregnancy concluded with a normal fetus delivered at full term.

FIG. 5. Case 3. Woman, aged 24 years, with tetralogy of Fallot. Electrocardiograms recorded during the fourth month of a first pregnancy show classic changes of pronounced right ventricular hypertrophy.

of pregnancy after the Blalock procedure have been recorded by Russell and his associates[18] and by Olim and Turner.[16] The following case illustrates a successful pregnancy in this disorder without any such operative procedure.

CASE 3.—M. P., aged 24 years, was first seen June 18, 1952, during the fourth month of her first pregnancy. Cyanotic heart disease had been recognized since infancy. Although unable to participate in sports of any kind, the patient had been able to attend grammar school and to carry out light household duties thereafter. The clinical features were characteristic of tetralogy of Fallot and electrocardiograms suggested pronounced right ventricular hypertrophy (fig. 5 and 6).

The entire pregnancy was uneventful. Cyanosis of moderate degree was present throughout, but it did not increase in degree. The vital capacity never changed appreciably from the 2,600 cc. recorded on the initial examination. A normal infant was delivered vaginally at full term with no complications.

Some concern was felt about the infant in this case, since Olim and Turner[16] reported anencephaly in 2 fetuses of a mother with tetralogy of Fallot only a short time after my patient was seen initially. In this report attention was called to the possibility that the low oxygen tension in the mother's blood may affect the cephalic phase of development adversely, drawing a parallel with the experimental production of anomalies by maternal insult in the form of anoxic anoxia. Fortunately, my patient was delivered of a normal infant. In a series of more than 10 patients with congenital heart disease, followed through pregnancy in

FIG. 6. Case 3. Roentgenographic study of the heart shows cardiac configuration of surprisingly normal contour even though the patient was distinctly cyanotic and had electrocardiographic evidence of right ventricular hypertrophy. A normal fetus was born at full term after uncomplicated pregnancy.

the past six years, only a single abnormal fetus was born of an elderly primipara with a patent ductus arteriosus but no evidence of cyanosis.

A new problem in this field is the management of patients with mitral stenosis who have successful valvulotomy and become pregnant thereafter. Massey[13] indicates that at least a score of such patients have come to his attention. He also mentions a successful commissurotomy performed by Rumel during pregnancy. This procedure also has been accomplished by Baker, Brock, and Campbell[1] and by Logan and Turner.[12] Such a case is described briefly through the courtesy of Dr. Donald M. Willson.

CASE 4.—A. P., aged 32 years at the time of delivery, had had rheumatic fever at 17 years of age. The mitral stenosis which resulted limited her activities severely. Congestive heart failure and auricular fibrillation developed in 1950. In November, 1950, the patient had an embolus to the right popliteal artery (fig. 7). A mitral commissurotomy performed by Dr. Charles Bailey in January, 1951, was followed by a striking improvement in function so that the patient undertook all normal activities. The auricular fibrillation present prior to operation persisted unchanged. The patient became pregnant one year after the operation and delivered a normal infant after an entirely uneventful pregnancy.

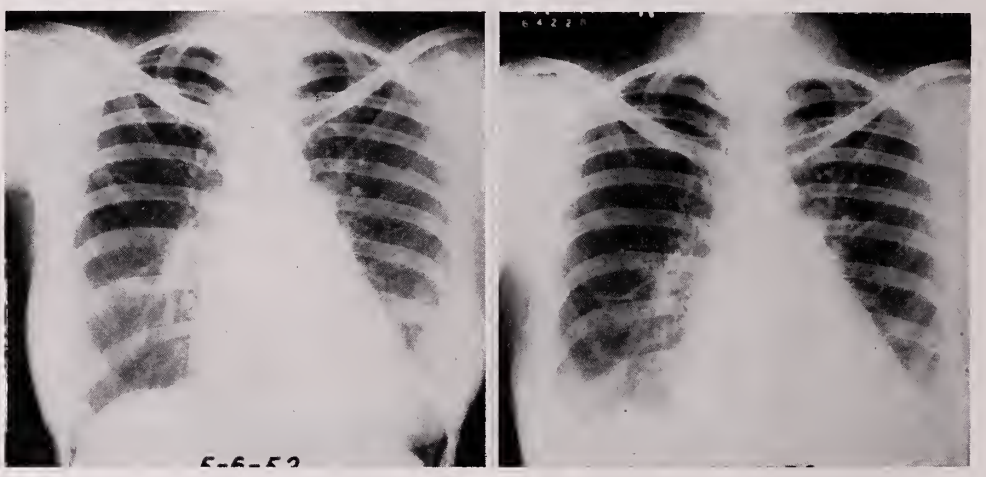

FIG. 7. Case 4. Woman, aged 32 years, with mitral stenosis and successful mitral commissurotomy performed in January, 1951. *Left.* Roentgenographic study of the heart during pregnancy, which began slightly more than one year after commissurotomy. *Right.* Roentgenographic study of the heart at full term shows mitral configuration and apparent slight increase in the size of the heart as compared with the earlier roentgenogram. A normal fetus was born at full term after an uncomplicared pregnancy.

More and more of these patients will present themselves in the future. The criteria for the risk of pregnancy must be altered in these women because the structural valvular disorder has been altered. Evaluation must be based upon the postoperative functional capacity. It is probably wise that such patients wait at least one year after operation for full benefit to develop and to permit a proper evaluation by the physician before pregnancy is undertaken.

In 1951, McRoberts[14] reported several cases in which the dorsal recumbent position during pregnancy produced discomfort and circulatory collapse. The following case seems related to this situation and is reported as an illustration of the type of problem which often causes the obstetrician some concern.

CASE 5.—E. D., aged 22 years, was seen first March 9, 1949, during the eighth month of her first pregnancy. One month earlier when placed in the dorsal recumbent position in the office of her obstetrician she had become faint and dyspneic, and tachycardia had appeared. The symptoms cleared promptly when she sat up.

The sensations recurred one month later under the same circumstances. On three separate occasions during March, 1949, the heart rate was observed to increase from levels of 75 to 88 per minute on first assuming the dorsal recumbent position to 152 to 164 per minute within three to seven minutes (fig. 8). The rate returned abruptly to normal levels when the patient turned to the left lateral position. However, at the time of labor the phenomenon was less pronounced and delivery was carried out in the usual way.

The patient is now in the course of a second pregnancy. During the eighth month of this pregnancy, the heart rate rose from 84 to 114 per minute while she lay flat on the examining table.

The explanation for such cases is obscure. McRoberts has suggested that obstruction of venous return from the lower extremities results from pressure by the pregnant uterus with the patient in the supine position. The resultant fall in right auricular pressure then results in a decreased cardiac output. If this hypothesis is true, it should be possible to reproduce the symptoms by application of venous tourniquets to the thighs even with the patient on her side. I have not had the opportunity to make this observation.

MANAGEMENT OF LABOR

The actual management of labor in patients with heart disease need not be dealt with in detail except

to point out a few important principles. With the exception of coarctation of the aorta, cesarean section should be performed in patients with heart disease solely for obstetric indications. The choice of the anesthetist is more important than the choice of anesthesia, although the agent should be one which permits a fairly high concentration of oxygen and which is not prone to excite cardiac arrhythmias. I have a personal preference for ether anesthesia in these patients.

The second stage of labor should be shortened judiciously. Some years ago Barker[2] suggested the application of venous tourniquets to all four extremities after delivery of the placenta. I have adopted this practice with the thought that contraction of the uterus forces blood into the general circulation abrupt-

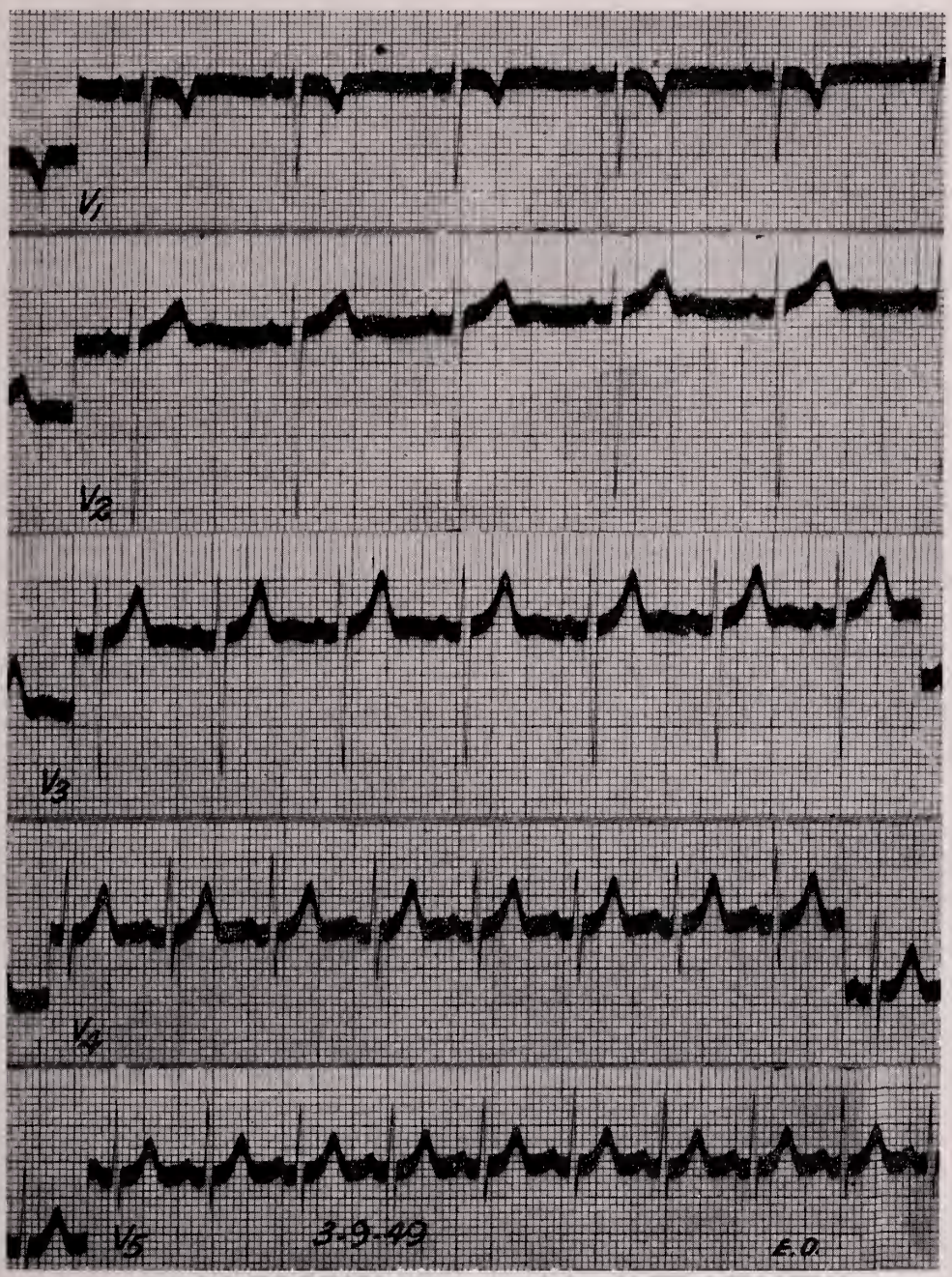

FIG. 8. Case 5. Woman, aged 22 years. Electrocardiographic observations were made during the eighth month of a first pregnancy. Marked sinus tachycardia was observed repeatedly when the patient assumed the dorsal recumbent position. Records shown were taken in rapid succession with the patient lying on her back. Lead V_1 shows a ventricular rate of 66 per minute. Subsequent records show progressive increase in the heart rate to 116 per minute in lead V_5. At times the rate rose to 164 when the patient assumed this position.

ly, and by exclusion of a large volume of blood in the extremities for one or two hours patients may be carried through a potentially dangerous, immediate postpartum period.

Prophylaxis with antibiotic agents against the possibility of subacute bacterial endocarditis has been my practice, and in my modest series of patients this complication has not occurred. Penicillin usually is given for five to seven days after delivery.

Most observers are agreed that early ambulation has no place in the treatment of cardiac patients.[8, 13] It must be remembered that there is a rebound in the load of pregnancy following delivery (fig. 1), and the postpartum period is also a hazard to these patients.

Fetal mortality in mothers with heart disease tends to be high. Although only slightly higher than in normal mothers in uncomplicated pregnancies, the rate may be as high as 30 per cent when congestive failure occurs.

CONTRAINDICATIONS TO PREGNANCY

The contraindications to pregnancy are those features which aggravate the risk of pregnancy far beyond the average. They include a past or present history of congestive failure, acute rheumatic fever, failure appearing in the first trimester, and most instances of auricular fibrillation. Economic, religious, and social factors must always be taken into account. If a pregnancy is terminated, this should be accomplished before the fifth month because a hysterotomy after that date may prove more hazardous and complicated than delivery at term.

SUMMARY

The current understanding of the physiologic load of pregnancy has made more intelligent the physician's approach to the cardiac patient who becomes pregnant. New advances in the treatment of heart disease have brought new problems in this special field because patients who could not previously withstand the load of pregnancy are now being made able to do so. The close cooperation of the obstetrician and the internist or cardiologist has become even more important in the proper management of these cases.

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ABSTRACT OF DISCUSSION

DR. E. A. CHANDLER, Houston: Dr. Rosenbaum has outlined the latest methods of management of heart disease in pregnancy, and it behooves all of us to use his teachings.

More than fifteen years ago, when I first began seriously to study heart disease in pregnancy, less was known than today and there was little agreement as to the proper management of these cases. Now there is a better understanding and knowledge of heart disease, and more definite agreement on conduct of these patients through the various stages of pregnancy and delivery. Treatment of rheumatic heart disease has improved, more knowledge has been gained about the physiologic changes during pregnancy, and much valuable cardiovascular surgery has been developed. All of these factors have been of great benefit.

Most of the mortality of heart disease in pregnancy has been caused by lack of cooperation (patients' fault), and lack of ability to evaluate and predict the outcome of each case and lack of proper attention to patients during labor and the immediate postpartum period (doctors' fault). In order to improve mortality rates physicians must continue to educate the public and themselves and to practice eternal vigilance in the conduct of pregnancy and labor.

ESSAY CONTEST ON CHEST DISEASE

The American College of Chest Physicians will present three awards for the best original contribution, prepared by any student in an accredited medical school, on any phase of the diagnosis and treatment of chest disease. Each winner will be given a certificate of merit, and the first place winner will also receive a cash award of $250 at the twentieth annual meeting of the college in San Francisco June 17-20.

Deadline for the manuscript to be submitted to the executive director of the college, 112 East Chestnut Street, Chicago 11, is March 15.

TOBACCO ADDICTION
A Suggestion as to Its Remedy

CHARLES T. BROWN, Lt. Col., MC, USA, Fort Sam Houston, Texas

MARK TWAIN once remarked: "It is easy to give up tobacco; I have quit a thousand times." The humor in his statement cannot be denied; however, it seriously reflects the experience of the older smoker who has spent a good part of a lifetime in the consumption of more than one-half million cigarettes. Such a person is in a good position to elaborate on literally hundreds of attempts on his part to abandon the poison threatening his very existence. Similar unsuccessful attempts by millions of other tobacco users since the time of Raleigh would indicate once more that the substance under discussion is not to be dealt with lightly. The user of tobacco who wishes to refute the addicting qualities of this drug has only honestly to examine his own experience.

TOBACCO: A NARCOTIC

Tobacco is a narcotic capable of producing tolerance, dependency, and withdrawal phenomena in those persons accustomed to its use. Thus, it fulfills the requirements for the definition of an addicting substance. The skeptic who is unwilling to accept this fact will find solace in the words of Sollmann,[2] who writes of the toxic effects of the active principle of tobacco, the alkaloid nicotine:

> Nicotine is one of the most fatal and rapid of poisons; the vapors arising from a glass rod moistened with it and brought near the beak of a small bird causes it to drop dead at once, and 2 drops placed on the gums of a dog may give a similar result.... It acts with a swiftness equalled only by hydrocyanic acid.

Aside from its addicting properties, there appears to be ample evidence that there is a relationship between tobacco and physical disease. Carcinoma of the lung, coronary and peripheral vascular disease, nutritional and nervous disorders, peptic ulcer—all are the vade mecum of nicotine, and their unnatural alliance cannot be denied or ignored.

It is a strange commentary on the public at large, and especially on the medical profession as a class, that despite repeated and pointed warnings in both lay and professional literature of the deleterious and even fatal implications of tobacco addiction, use of the drug continues in rising proportion. This has been the history of other narcotics. The extensive use of opium and its derivatives began in this country just prior to the Civil War and continued to spread unabated until its curtailment by the enactment of the Harrison Narcotic Act in 1915. Another narcotic, barbituric acid, first synthesized by Fischer in 1903, after half a century became known as a dangerous substance with addicting properties and other lethal potentialities. Cannabis, popularly known as marihuana, was not classed as a narcotic until the passage of the Marihuana Tax Act in 1938. Similar legislation and restrictions finally were applied to meperidine and other synthetics and later to mescaline and peyote. Another narcotic, alcohol, needs no comment here.

Certainly, tobacco and heroin should not be placed in the same company; however, under certain conditions a .22 rifle has been known to possess all the lethal potentialities of a .50 caliber machine gun. The man dead of carcinoma of the lung after years of heavy cigarette smoking and his brother whose death is the result of heroin deprival may well be from a standpoint of toxicology in *status quo*. The essential differences in the causative agents of their demise can be argued and delineated from a standpoint of pharmacology by professors in the classroom; nevertheless, the fact remains that the agents of their deaths could well be the addicting drugs of their respective choice. And as Metchnikoff said: "Man does not die; he poisons himself."

The question of motivation is paramount in the determination of any form of behavior. The person who desires to achieve worth-while goals must be prepared to make certain sacrifices ranging from minimal to heroic, depending upon the nature and magnitude of his undertaking. The renunciation of tobacco for some is a simple task; for others the task is of Herculean proportion. Unfortunately, the work to be done often is rendered no less easy by news of a heart disease or a suspicious lung lesion that portends catastrophe. The scheme that follows is not for the strong who wear their chains lightly; rather, it is for the miserable slave whose shackles bruise and grow heavier with the passing of the years.

SUGGESTED REMEDY

Some 200 years ago, a venerable apothecary of London whose name has been lost in obscurity, becoming alarmed over the increasing prevalence of "snuff taking" and its deleterious consequences, offered a remedy for those afflicted with what he considered to be an unwholesome pastime. It is the purpose of this

From the Department of Neuropsychiatry, Medical Field Service School, Brooke Army Medical Center.

paper to present the proposed remedy as a simple and effective approach to the abandonment of tobacco. The plan is unique in that it paradoxically allows the tobacco addict to continue the use of the drug while in the process of its complete renunciation. The plan of treatment is as follows:

The patient proceeds upon a planned schedule with the determination to adhere faithfully to its simple provisions. The principle involved is the progressive reduction of the tobacco intake by one hour each day. The subject, for example, arises at 6 a. m. and will thus embark upon his reduction at that hour for the first day. He starts smoking at 6 a. m. and may smoke all that he chooses until midnight, or thereabouts, when he normally retires for the night. The next morning, or the second day of the treatment plan, he moves his smoking time up one hour to 7 a. m. Again, he may smoke all that he desires until midnight. On the third day he moves his smoking activities up until 8 a. m., and so on successively to the end that smoking is delayed by one hour each day until the subject reaches midnight of the final day. He is now aware of the fact that during the eighteen day period he has progressively diminished his smoking time by one hour each day and finds that on the last day he has only one hour, from 11 p. m. until midnight, to indulge in smoking. Again, he may smoke all he wishes during this final hour. At its conclusion, he retires to bed having completed the reduction treatment.

COMMENT

Obviously, the treatment as outlined in this presentation is no more than a gradual reduction procedure with the goal of detoxification common to all drug withdrawal plans. However, this plan is more than that and upon this hinges the secret of its success. In the case of tobacco, as with other narcotics, there are both psychologic and physiologic factors in addiction.

In consideration of one of the more important psychologic components of the problem, it is a well known fact that a major obstacle in the withdrawal of any narcotic is the patient's frightening prospect of an existence without support of the drug. In other conventional forms of narcotic drug withdrawals such a prospect exists throughout the treatment. However, in the plan proposed the patient is assured positively from the first day that he not only will be allowed to smoke, but will further be permitted to smoke as much as he chooses. He is required only to delay for a relatively short, though increasing, time each day his initial indulgence in tobacco. The positive assurance of unlimited smoking privileges is sufficient to sustain him through the progressively increasing period of daily abstinence.

As to the physiologic component of tobacco withdrawal, standard references on pharmacology give a detailed account of the altered physiology of each organic system incident to the ingestion of tobacco. Obviously, as the subject limits and decreases his daily intake of the narcotic and his exposure to the drug is lessened progressively each day, there will be a gradual restoration of normal bodily functions. Along with this gradual restoration of bodily health there is uniformly an abatement of the abstinence symptoms, both psychologic and physiologic, to the end that the patient has achieved a psychic and somatic tranquillity heretofore unknown in a tobacco laden atmosphere.

The question now arises as to the possibility of relapse. Experience shows the possibility of such an eventuality, for relapse in drug addictions is the rule rather than the exception. According to Otto Fenichel,[1] addicts are persons who have a disposition to react to the effects of drugs in a specific way, namely, in such a way that they try to use these effects to satisfy the archaic oral longing which is sexual longing, a need for security, and a need for the maintenance of self-esteem simultaneously. Thus, the origin and the nature of the addiction are not determined by the chemical effect of the drug, but by the psychologic structure of the patient. So the premorbid personality of the subject is the decisive factor, both as to the initial exposure to tobacco and as to the continuing use of the drug. It may be postulated that so long as tobacco fulfills some inner need or gratification to the subject or satisfies again the archaic oral longing, he will be perpetually in danger of relapse. However, one or more relapses should not be so discouraging to the patient as to persuade him that his situation is hopeless. One, or even a succession of relapses, does not necessarily mitigate against ultimate and complete success with its reward of permanent and irrevocable renunciation.

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SURGEONS TO HOLD SECTIONAL MEETINGS

The medical profession at large is invited to attend any of six sectional meetings to be held by the American College of Surgeons during the first six months of 1954. Panels, symposiums, papers, and motion pictures will be presented at each session, which will concentrate on problems encountered in day-to-day practice. The meetings are scheduled as follows: February 1-3, Charlotte, N. C.; February 25-26, Reno, Nev.; March 1-4, Omaha, Neb.; March 15-17, French Lick Springs, Ind.; March 31-April 2, Montreal, Quebec, Canada; May 17-19, London, England.

Details may be obtained from Dr. H. Prather Saunders, associate director of the American College of Surgeons, 40 East Erie Street, Chicago 11.

CASE REPORTS

ENDOCARDIAL SCLEROSIS

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ENDOCARDIAL sclerosis, by definition, is a fibrous thickening of the endocardium. Sclerosis of the valvular endocardium is viewed with suspicion, and when discovered, it is routinely studied microscopically by pathologists. Sclerosis of the mural endocardium, however, has received scant attention, except as a striking feature of "fibroelastosis," a uniformly fatal entity occurring in infants. This is understandable as endocardial sclerosis is often an incidental finding in diseased hearts. White plaques of endocardial thickening are frequently seen overlying healed myocardial infarcts. In coronary sclerosis without infarction, arterial hypertension, valvular heart disease, congenital anomalies of the heart and coronary circulation, chronic lung disease producing pulmonary hypertension, and isolated myocarditis, more diffuse thickening is sometimes seen. Sclerosis of the mural endocardium, however, may occur in the absence of other demonstrable heart disease and be the only abnormal anatomic finding other than cardiac hypertrophy in certain patients dying of congestive heart failure.

These patients are usually young adults who develop advanced congestive heart failure within a few weeks; their previous history is asymptomatic. Clinically, these patients exhibit cardiomegaly and gallop rhythm, but show none of the stigmas usually associated with common forms of heart disease. The blood pressure is often low; retinal vessels are normal. No significant murmurs are found. The temperature, white blood cell counts, and sedimentation rates are normal. Tremors, eye signs, thyroid enlargement, and quadriceps weakness, which might indicate hyperthyroidism, are not present. There are no signs of myxedema. Roentgenograms show cardiac contours of generalized dilatation without suggestion of hypertensive, valvular, or congenital heart disease. They resemble hearts made abnormal by beriberi, but there is no response to therapy with thiamine chloride. Sooner or later embolic phenomena occur in most cases, leading to a suspicion of subacute bacterial endocarditis. Incident to infarction, fever, leukocytosis, and an elevation of the sedimentation rate strengthen this suspicion. But repeated blood cultures are negative. A poor response to digitalis is mentioned in almost all cases reported. Mercurial diuretics, cation-exchange resins, and low salt diets may help temporarily, but the course of the disease is progressively downhill. Death usually occurs within a few months to a year.

Two cases of endocardial sclerosis are presented in this report. The clinical and pathologic features of the condition are discussed.

Read before the Section on Internal Medicine, Texas Medical Association, Annual Session, Houston, April 28, 1953.

CASE REPORTS

CASE 1.—A 41 year old meat department supervisor was admitted to the hospital September 16, 1952. He complained of shortness of breath of three weeks' duration.

In 1945, early in the course of surgery for an inguinal hernia, the patient's heart ceased to beat for a short time and the incision was closed. The operation was completed successfully ten days later. His past history was otherwise negative.

The patient first noted dyspnea when he lifted a meat basket that weighed approximately 25 pounds. The following day, walking a distance of only 50 feet made him breathless. One week prior to hospitalization he had been confined to bed; on several occasions he had been forced to sit upright to breathe comfortably. On the day of admission he coughed up bright red blood.

Physical examination revealed a dyspneic, well nourished white male about 40 years of age, in bed with the head elevated approximately 45 degrees. The patient's temperature was normal, the pulse rate was 140 per minute, and respirations 30 per minute; blood pressure was 106/70. Rales were present at both lung bases. A diastolic gallop was present at the apex, but there were no murmurs. The liver edge was palpable at the umbilicus, and there was extreme tenderness in the right upper quadrant of the abdomen. There was no peripheral edema.

An electrocardiogram revealed sinus tachycardia and a left ventricular strain pattern.

A roentgenogram of the chest showed an enlarged heart and evidence of pulmonary congestion.

The patient was given digitalis, oxygen, a mercurial diuretic, and morphine sulfate, and was moderately improved within twelve hours. The pulse rate had slowed to 90, but in another twenty-four hours it had become rapid again; it was rarely below 120 per minute the remaining three months of his life despite full digitalization. Follow-up roentgenograms revealed a large pulmonary infarct to be the source of his hemoptysis. Anticoagulant therapy was instituted.

The course remained largely afebrile, and white blood cell counts and sedimentation rates were normal. Slight elevations of temperature followed embolic episodes; there were many of these. An attack of flank pain associated with microscopic hematuria, after anticoagulants had been discontinued, was interpreted as being due to renal infarction. It was thought a short period of aphasia was the result of cerebral em-

bolization. On at least four occasions it was possible to make a positive diagnosis of recent pulmonary infarction.

Repeated blood cultures were negative. As one of the several studies of peripheral blood was thought to be positive for "L. E. cells," cortisone was used in daily doses of 200 to 400 mg. for eight days without benefit. During the last month of the patient's illness, changing systolic murmurs appeared and splinter hemorrhages were noted beneath the nails. These findings suggested subacute bacterial endocarditis. Thus, penicillin, and later Terramycin were used, without benefit. Death occurred suddenly three and one-half months from the onset of his illness.

At autopsy, fluid was present in all serous cavities in moderate amounts. The lungs contained multiple infarcts which showed various degrees of organization. Antemortem clots of various sizes were present in many branches of the pulmonary arteries. The heart was greatly dilated and weighed 500 Gm. White plaques of endocardial thickening were present in the apices of both ventricles. Within the cavity of the left ventricle an ovoid-shaped organized thrombus, measuring 8 by 4 by 3 cm. was firmly attached near the apex.

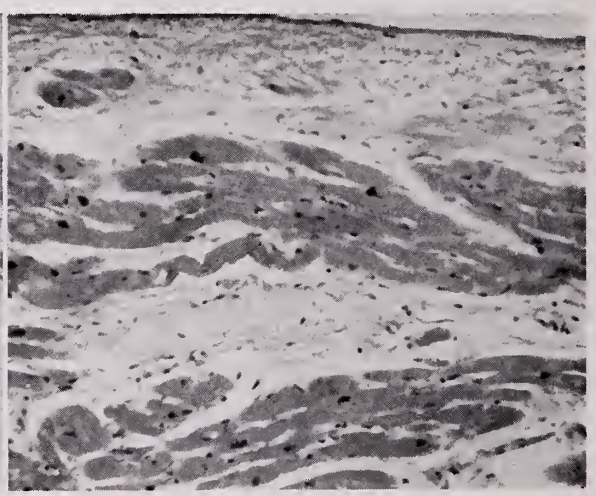

FIG. 1. Left. Photomicrograph showing thickened endocardium overlying the papillary muscle.

Right. Photomicrograph showing the extension of fibrosis into the subendocardial myocardium.

Smaller organized thrombi were attached at the apex of the right ventricle and in the right auricular appendage. Grossly, the valves and coronary vessels appeared normal. Both kidneys contained recent and healed infarcts.

Microscopically, the thickened endocardium and focal areas of fibrosis in the subjacent myocardium were striking. Mild scattered round cell infiltration was present. The coronary vessels showed minimum eccentric intimal thickening.

CASE 2 (Courtesy of Col. T. S. Mattingly, U.S.A.).—A 38 year old white man was admitted to the hospital June 14, 1949, with a chief complaint of shortness of breath and swelling of the ankles of three weeks' duration.

In 1945, because of pain in the region of the umbilicus, an appendectomy was attempted, but when the abdomen was opened, heart and respirations ceased. The patient was revived and the abdomen closed; the appendix was not removed at this time. In 1948, he was admitted to the hospital twice because of abdominal pain. In one instance a perforated duodenal ulcer was suspected, but a cardiologist was called when a fast heart rate was noted. Supraventricular tachycardia was confirmed by electrocardiogram, and an acutely distended liver subsided after treatment.

Following the last-mentioned episode, which occurred in November, 1948, the patient remained asymptomatic until three weeks before his admission in June, 1949. For one week he had suffered attacks of nocturnal dyspnea.

Physical examination revealed a well developed white man with dusky cyanosis of lips and extremities. The temperature was normal; the pulse rate was 116 per minute and the rhythm was regular. The point of maximal impulse was in the anterior axillary line in the sixth interspace. There was 3 plus edema of the lower legs.

A complete blood count and sedimentation rate were normal.

Roentgenograms of the chest revealed an enlarged heart without characteristic contour.

An electrocardiogram showed sinus tachycardia, left axis deviation, and abnormal P waves.

The patient was placed in an oxygen tent as he was cyanotic, and was rapidly digitalized. On the morning of the third day the pulse rate was recorded by the nurse as 82 per minute. Shortly thereafter he suddenly became cyanotic and expired.

Autopsy revealed 1,500 cc. of clear fluid in the right pleural cavity and 500 cc. in the left pleural cavity. The heart weighed 675 Gm. Both ventricles were dilated. The endocardium was moderately to markedly thickened, and organized thrombi were firmly attached to the apex of the left ventricle. The valves were normal. The coronary arteries were not unusual. Other findings included passive congestion of liver and lungs, and a recent infarct of the spleen.

Microscopic examination revealed endocardial sclerosis, focal fibrosis of subjacent myocardium, and scattered round cell infiltration.

DISCUSSION

Thickening of the endocardium received scant attention until the report of Bedford and Konstam[1] in 1946. They described cardiac dilatation, fibrous thickening of the endocardium, and focal fibrosis in the subjacent myocardium as the only significant finding in 40 young West African soldiers dying of congestive heart failure. Two years later, Davies[3] reported similar findings in East African natives and called the condition endocardial fibrosis. Ian Gray[4] in London in

1951, reporting the condition in Europeans, pointed out that whereas cases in Africa might be due to some obscure infestation or infection, the same gross pathologic picture had been described in the medical literature under a variety of titles. These included "cardiac hypertrophy of unknown etiology," "chronic fibroplastic myocarditis," "thromboendocarditis," and others. He referred specifically to cases reported by Levy and Rousselot,[6] Reisinger and Blumenthal,[10] Löffler,[7] and Ware and Chapman.[11] Recently similar cases have been reported by MacMahan, McNicol, Benenson, and Winship,[9] and one from the records of Massachusetts General Hospital.[8]

In cases of endocardial sclerosis, gross specimens show hearts that are noticeably dilated. Actual hypertrophy not so apparent upon inspection is evidenced by weights of 500 and 600 Gm. Sclerosis of the endocardium may occur in white plaques of irregular shape, or it may be diffuse. It is usually most evident near the apices of the ventricles. The entire parietal endocardium may be involved. Organized mural thrombi occur most frequently near the apices of the ventricles, where they extend into the bays between papillary muscles to attach themselves firmly; they may become so large they diminish ventricular filling. Other thrombi may be found in the auricles or their appendages. Cut surfaces of ventricular walls may or may not show subendocardial areas of focal fibrosis. The heart valves, coronary vessels, and pericardium appear normal.

Microscopically, the endocardium is many times its usual one-cell thickness. The subjacent myocardium may show focal areas of fibrosis, or these areas may be elsewhere in the myocardium. They do not have a significant relationship to blood vessels, and they do not occur in all cases. There may be some increase in interstitial stroma. In some areas individual myocardial fibers may be separated, some may be hypertrophied, and some seemingly have undergone pressure atrophy. This pathologic picture has been given the name "serous myocarditis." Small vessels in the subendocardium may contain thrombi. A scattering of round cells may be observed, but careful search fails to reveal focal cellular infiltration as seen in isolated myocarditis.

There are various theories concerning the etiology of endocardial sclerosis: (1) that it results from a dietary deficiency, (2) that it is residual of isolated myocarditis, or (3) that it is a primary chronic parietal endocarditis. Bedford and Konstam, in their original report, suspected a dietary deficiency but found that their patients did not respond to large doses of thiamine chloride. Ian Gray thought that this report excluded a vitamin deficiency as an etiologic factor since heart failure due to thiamine deficiency usually responds promptly to treatment; furthermore, it is the only vitamin deficiency known to produce heart failure. He pointed out that Chagas' disease, or South American trypanosomiasis, produces sclerosis of the endocardium, which supports the opinion that other infections or infestations might likewise produce it. Dammin[2] has reported fibrous thickening of the endocardium, focal fibrosis of myocardium, and active focal myocarditis in the same specimen. One explanation for the cause of endocardial thickening in association with focal myocarditis is that focal myocarditis interferes with blood supply. Finally, the hypothesis that endocardial sclerosis is a primary condition affecting the endocardium does not explain focal fibrosis and other changes in the myocardium. Although Gross[5] explained focal fibrosis as being caused by occlusion of thebesian, arterioluminal, and arteriosinusoidal channels, Wiggers has not found these to be functional in the presence of normal hemodynamics.

SUMMARY

Sclerosis of the mural endocardium may be the only abnormal anatomic finding, other than cardiac hypertrophy, in certain young adults dying of congestive heart failure.

Two such cases are presented.

Clinical features, pathology, and theories as to the etiology of the condition are discussed.

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ABSTRACT OF DISCUSSION

DR. GEORGE R. HERRMANN, Galveston: I have seen the hearts of 3 infants with endocardial fibroelastosis, 2 of which were reported by Dr. C. Ralph Letteer of San Antonio in the March, 1953, *Annals of Internal Medicine*. These cases

were recognized from the clinical data by Dr. Louis Manhoff. The other juvenile was not recognized in Galveston but went to postmortem with the diagnosis of congestive heart failure and cardiac enlargement of unknown origin.

I saw 1 adult case in an officer at Brooke Army Medical Center in San Antonio. The officer had returned from Korea and was doing special work at Fort Leavenworth when symptoms of heart failure suddenly began and progressed rapidly. He was transferred to Fort Sam Houston for care, diagnosis, and treatment. He had many of the symptoms which Dr. Howell has outlined, and most of the suggested erroneous diagnoses were made. I thought that he had a hypoplastic aorta, but particularly a hypoplastic coronary artery system. Col. R. B. Johnson agreed, but Col. Carl J. Lind, the pathologist, returned the diagnosis of endocardial fibroelastosis; however, he has not yet made his final report.

Dr. Howell has covered adequately this unusual and probably frequently overlooked condition; I would only add coronary hypoplasia among the theories as to the etiology of endocardial fibroelastosis. We probably make the common error of misdiagnosing some of these cases in which no cause has been apparent as chronic and diffuse coronary artery heart disease, which seems to explain the picture. On several occasions in clinical pictures of this type I have found evidence of a narrow great arch and made the diagnosis of hypoplastic aorta and coronary artery system. I was made aware of this syndrome of hypoplasia of the aorta by one of my oldest students, G. Werley, who died in El Paso recently. He sent me a patient with the diagnosis of hypoplastic aorta twenty years ago. The diagnosis was confirmed by Mavis Kelsey, then a member of the Department of Pathology at the University of Texas Medical Branch, who made a careful study of the case. He also studied the caliber of the aortas and recorded that the hypoplastic aorta and hypoplastic coronary arteries may have given off at right angles extremely hypoplastic muscular branches. The gradient of blood pressure drops off sharply in such arterial systems. This results in decreased blood flow in the transmural branches that run off at right angles from the epicardium almost to the endocardium. This could easily account for the endocardial ischemia and injury and later fibrosis.

The electrocardiograms are suggestively characteristic, I believe, in most of the cases (as I pointed out to Dr. Letteer in his first case and noted in Dr. Howell's first case before digitalization), a depression of the ST segments and negative T waves in leads I, II, III, V_4, V_5, and V_6 indicating an injury and ischemia in the subendocardial tissue. I have always insisted upon a description of the RST changes rather than using the term ventricular strain, which term should be abandoned. Certainly in these instances the blood pressure is low and one cannot visualize physical strain. It is much more logical to visualize a subendocardial ischemia and injury from coronary insufficiency or even digitalization.

Subendocardial fibroelastosis may not be far removed from sclerodermatous heart disease. Dr. Howell has dealt with the collagen disease etiology as a possibility. I have seen the hearts of patients with Chagas' disease at the Oswaldo Cruz Institute in Rio de Janiero and noted that the myocardial process is much more diffuse. Triatoms infected with Trypanosoma cruzi are found in Texas; we should have Chagas' disease myocarditis in Texas, but we have not recognized it.

ACUTE HEMOLYTIC ANEMIA

Report of 3 Cases in One Family

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FAMILIAL hemolytic anemia, also known as spherocytic anemia, chronic hemolytic jaundice, or acholuric jaundice, is a disease characterized by chronic or recurring anemia associated with hemolytic crises, increase in fragility of the erythrocytes, a tendency for the red cells to be spherical and microcytic, high reticulocyte count, increased excretion of urobilin in the urine, splenomegaly, and usually icterus. Doan said that "true hemolytic icterus is always the manifestation of an inherited constitutional defect." However, there is also a so-called acquired type, which most often manifests itself later in life than the congenital form. The acquired form is usually the more severe.

Hemolytic anemia seldom becomes apparent in infancy, but is usually detected before adolescence. Pallor and slight jaundice may be the first signs, together with a mild anemia. Usually the spleen is enlarged. First indication of the disease may be a crisis.

Hemolytic crises may be mild or they may be fatal. A crisis may be precipitated by trivial illness, emotional stress, or fatigue. Crises occur at varying intervals, with fever, abdominal pain, pallor, jaundice, and weakness. During a crisis there is excessive destruction of red blood cells, as shown by a lower red cell count, rising icteric index, and increased urobilin in the stools and urine. The urine is highly colored. The stools appear normal in color and consistency, but contain much urobilin. There is always a high reticulocyte count, perhaps to 95 per cent. Fragility of red blood cells to hypotonic sodium chloride solution is noticeably increased, as a rule. The white cell count is not characteristic but most frequently shows a leukocytosis, with increase of polymorphonuclear leukocytes. It has been shown that hepatic function is diminished during a crisis, a form of hepatitis being present. Cholecystitis is commonly found associated with the anemia, and cholelithiasis is frequent, even in the very young.

Splenectomy is curative. It usually relieves all symptoms; however, the increased fragility of red blood cells may persist long after the operation. It is best

not to perform the operation during an acute crisis, but when the crisis is unduly prolonged, surgery may be indicated. Transfusions may be harmful during a crisis but are often necessary as a preoperative measure when the blood count is extremely low.

This report concerns a family in which hemolytic anemia has appeared in three successive generations. I have performed splenectomy on three members of the family. One grandfather is said to have died of anemia, without benefit of surgery. His daughter (case 2) was relieved by splenectomy. Two of her sisters have had splenectomy, and 2 of her 3 daughters also have undergone splenectomy (cases 1 and 3). The grandfather had 3 sons, brothers of the patient in case 2. The second of these brothers has a son, aged 6 years, who is soon to have surgery for anemia, and another son, aged 1, who has anemia.

CASE REPORTS

CASE 1.—R. M. B., aged 12 years, entered Providence Hospital on June 20, 1950. Her mother said that the child had always had trouble from "spleen disease." She had been chubby until the age of 7. For the past five years she had been sick most of the time. Attacks of abdominal pain had occurred at intervals. One doctor had given a poor prognosis because of heart disease. The patient had been under treatment in Mexico, where several blood transfusions had been given. Approximately four days before she entered the hospital, jaundice had been noticed. At about the same time, she began to complain of abdominal pain and to vomit.

Examination revealed a thin, acutely ill Mexican girl. She was deeply jaundiced and dehydrated, with temperature of 100 F., pulse of 120 per minute, and respiration of 22 per minute. All mucous membranes, sclerae, and skin showed deep jaundice. The skin was excessively dry. A loud to-and-fro murmur was heard at the apex of the heart. Blood pressure was 120/72. The spleen was markedly enlarged, extending to the level of the umbilicus, and was firm. There was generalized abdominal tenderness of moderate degree. Blood count on June 20 showed red blood cells 2,700,000 per cubic millimeter, hemoglobin 7.25 Gm. per 100 cc. (50 per cent), white blood cells 7,700 with polymorphonuclear leukocytes 79 per cent, stabs 4 per cent, lymphocytes 20 per cent, and large monocytes 1 per cent. A fragility test showed hemolysis beginning at .50 per cent sodium chloride and complete at .35 (control: beginning at .40 per cent, complete at .34). The conclusion was increased fragility of erythrocytes. The hematocrit level was 26 cc. per 100 cc. of blood. The sedimentation rate was 35 mm. per hour. Kahn and Eagle tests were negative. The urine was cherry red, slightly turbid, acid, with specific gravity of 1.015, no albumin or sugar, 24 to 32 pus cells per high power field, a few squamous epithelial cells, and much bile. On June 23, coagulation time was 5 minutes, bleeding time 1.75 minutes, and icteric index 114. A cephalin flocculation test was negative.

The diagnosis was familial hemolytic jaundice, with splenomegaly. A consulting pediatrician diagnosed rheumatic mitral valve disease without decompensation. On June 21, 300 cc. of citrated blood was given as a transfusion; on June 23, another 300 cc. Following the second transfusion there was a mild reaction, with urticaria and some edema of the eyelids.

By June 24 the blood count had improved: red blood cells 3,680,000, hemoglobin 10.5 Gm. (72.4 per cent), white blood cells 5,550, polymorphonuclear leukocytes 55 per cent, stabs 2 per cent, lymphocytes 34 per cent, large monocytes 1 per cent, and eosinophils 4 per cent. Prothrombin was 100 per cent of normal.

On June 26, splenectomy was done, through a left transverse incision. The spleen weighed 610 Gm. and measured 26 cm. in the greatest diameter. There were no abnormal adhesions about the spleen. Palpation of the gallbladder and bile ducts detected no stones. During the operation, a transfusion of 500 cc. of citrated blood was given. Convalescence was uneventful. Temperature, which had receded to normal before operation, rose to 101 F. for two days postoperatively, then remained normal. Preoperatively, this patient received vitamin K with caroid and bile salts. Postoperatively, vitamin C and protein hydrolysate were administered. On June 28 another transfusion of 300 cc. of citrated blood was given. The blood count on June 30 was red blood cells 4,900,000, hemoglobin 13.7 Gm. (94.8 per cent), and white blood cells 8,150. The wound healed by first intention. Jaundice cleared up. The patient left the hospital July 4, the eighth postoperative day.

Repeated blood counts over a period of sixteen months showed the red cell count and hemoglobin within normal limits. A recent report from Mexico tells that the patient is having serious heart trouble.

CASE 2.—Mrs. J. B., aged 31, mother of the patient in case 1, was admitted to Providence Hospital January 30, 1951, for a blood transfusion. In July, 1947, I had performed a laparotomy on this woman for ruptured tubal pregnancy. Her blood count had remained low. She had been delivered of a normal child in June, 1948 (case 3). The patient gave a history of having been jaundiced at times. A cholecystogram had revealed no calculi, though the gallbladder did not fill. It was noted in the history that 2 of the patient's sisters had undergone splenectomy.

On the patient's admission to the hospital the blood count was red blood cells 3,300,000, hemoglobin 10 Gm. (62.5 per cent), white blood cells 9,500, polymorphonuclear leukocytes 67 per cent, lymphocytes 30 per cent, and large monocytes 3 per cent. Marked anisocytosis and slight poikilocytosis of red blood cells were observed. A transfusion of 500 cc. of citrated blood was given, and the patient went home the same day. Subsequent blood counts showed progressive anemia: February 6—red blood cells 3,100,000, hemoglobin 55 per cent; February 21—red blood cells 2,640,000, hemoglobin 55 per cent.

On March 6 the patient was readmitted to Providence Hospital with a diagnosis of familial anemia. She was not acutely ill, but felt tired and weak and complained of dizziness. The spleen was palpable, moderately enlarged, and tender. The blood count March 6 showed red blood cells 3,200,000, hemoglobin 10 Gm. (62.5 per cent), white blood cells 7,000, polymorphonuclear leukocytes 52 per cent, lymphocytes 37 per cent, monocytes 4 per cent, and eosinophils 7 per cent. Kahn and Eagle tests were negative. A fragility test was inconclusive. A transfusion of 500 cc. of citrated blood was given on the day of admission. Next day, March 7, splenectomy was performed through a left transverse incision. During the operation, transfusion of 1,000 cc. of blood was given. The spleen was approximately twice normal size, weighing 778 Gm. It measured 28 by 18 cm. There were some adhesions between spleen and diaphragm. A small accessory spleen approximately 5 cm. in diameter was found in the gastrosplenic mesentery. It was removed. Palpation revealed calculi in the gallbladder, which was large

and bound with adhesions. No stones could be detected in the common duct.

Convalescence was uneventful, the patient complaining only of some pain in the left anterior cervical region (from diaphragmatic irritation). Her temperature never rose above 100.8 F. She left the hospital on March 13, six days postoperatively. The wound healed by first intention.

Subsequent blood counts showed some anemia persisting: March 19—red blood cells 3,830,000, hemoglobin 65 per cent, white blood cells 11,400; September 6—red blood cells 3,430,000, hemoglobin 78 per cent, white blood cells 8,500. However, the patient gained weight and felt well. On May 3, 1952, she was delivered of an apparently normal boy. The record shows that at that time the red blood cell count was 5,200,000, with hemoglobin of 17.5 Gm. (103 per cent), and white blood cell count of 10,900. A differential count showed polymorphonuclear leukocytes 79 per cent, stabs 8 per cent, lymphocytes 16 per cent, monocytes 3 per cent, and eosinophils 2 per cent. Urinalysis was normal, and an Eagle test negative.

This patient has refused operation for gallstones, which are apparently asymptomatic.

CASE 3.—P. B., aged 4 years, is the daughter of the patient in case 2 and the sister of the patient in case 1. She was admitted to Providence Memorial Hospital March 8, 1953, acutely ill, with abdominal pain, vomiting, chills, and fever. The mother said that the illness began suddenly March 6 with vomiting. The temperature rose abruptly to 105 F. The patient complained of abdominal pain and vomited frequently. There was a slight diarrhea. The mother noticed that the urine was brick red. Only previous illness had been attacks of tonsillitis, which always responded promptly to an injection of penicillin. The mother had noticed that the child's urine was brick red on one previous occasion, at the age of 3 years.

Examination on admission revealed a very sick child, flushed, with hot, dry skin, pulse of 140, respiratory rate of 22. The temperature spiked to 105 or 106 F. daily, fell to normal or subnormal every day (as low as 95.6 F. one day). Chills were frequent. Stools were frequent, dark, and malodorous. The abdomen was slightly distended, somewhat tympanitic. It presented slight generalized tenderness, not localized. Auscultation suggested increased peristalsis. The liver extended 2 fingerbreadths below the right costal margin. The spleen could not be palpated.

Since the diagnosis was obscure, a large amount of laboratory work was done: A blood count on March 8 showed red blood cells 3,200,000, hemoglobin 9 Gm. (53.9 per cent), white blood cells 8,900, polymorphonuclear leukocytes 72 per cent, segmented cells 68 per cent, lymphocytes 27 per cent, and monocytes 1 per cent. Marked anisocytosis was found. Two normoblasts were present among 100 cells. On March 9 a fragility test showed hemolysis beginning at .48 per cent sodium chloride and complete at .34 per cent sodium chloride. A Coombs' test was negative. March 10 the blood count was red blood cells 3,400,000 (following a transfusion of 300 cc. of blood March 9), hemoglobin 11.0 Gm. (64.7 per cent), white blood cells 9,050, polymorphonuclear leukocytes 77 per cent, segmented cells 57 per cent, lymphocytes 22 per cent, and monocytes 1 per cent. Smears showed no malaria parasites.

March 11, agglutination tests were negative for typhoid, paratyphoid, Brucella abortus, Brucella melitensis, and Proteus X19. March 12 the serum albumin-globulin ratio was reported as 1.7:1.0. On the same day stool examination revealed no parasites or ova, and no blood. Later a stool culture was negative. Blood chlorides were 105.4 milliequivalents per liter with sodium chloride 154.8 milliequivalents and potassium chloride 3.8 milliequivalents. Blood culture was negative March 13 and again April 9.

The fever did not respond to antibiotics or other therapy. Supportive treatment was given, and advisability of surgery during the crisis was debated. The diagnosis of hemolytic anemia was established.

March 16 the blood count was slightly improved: red blood cells 3,500,000, hemoglobin 10 Gm. (58.8 per cent), white blood cells 6,200, polymorphonuclear leukocytes 53 per cent, segmented cells 50 per cent, lymphocytes 42 per cent, and monocytes 3 per cent.

On March 18, for no accountable reason, the temperature fell to normal, and it remained down. The patient felt well, was up and about the ward, and ate well.

On March 24, under ether anesthesia, splenectomy was done through a left transverse incision. Before the abdominal incision was made, a polyethylene tube was inserted into a vein of the right arm. This facilitated giving fluids for several days. The spleen was found to be approximately twice normal size, somewhat lobulated at its lower border. Before the splenic pedicle was clamped, Adrenalin Chloride was given hypodermically, causing contraction of the spleen. Only a few adhesions were present, about the lower pole of the spleen and about the diaphragm. As soon as the splenic pedicle had been clamped, blood transfusion was started. The pathologist reported dilated and empty sinusoids in the spleen, the picture of hemolytic anemia. The spleen weighed 79.5 Gm.

Postoperative convalescence was smooth. On the first postoperative day, temperature rose to 102.4 F. Then it quickly receded to normal, remaining normal after the third day. The patient was sent home one week after operation, on March 31. The wound had healed by this time. The patient gained weight and has remained well since. On May 28, 1953, the red blood cell count was 4,520,000, hemoglobin 15 Gm. (88.2 per cent), and white blood cell count 4,000 with polymorphonuclear leukocytes 62 per cent, stabs 2 per cent, lymphocytes 30 per cent, and eosinophils 8 per cent. The hematologist also observed occasional nucleated erythrocytes and cells showing Howell-Jolly bodies.

SUMMARY

Familial hemolytic anemia is congenital in most cases, may appear in children or adults, and has characteristic blood findings. Crises may be severe. Operation should be deferred until a remission occurs, if possible. Splenectomy cures these patients.

Three cases are presented, all in the same family, all cured by splenectomy. Family history is reviewed, with evidence of the disease in 8 members of one family.

REFERENCES

A bibliographic list may be obtained from the author.

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A legal obstacle that originally stood in the way of the civil defense program of sending help from one state to another involved professional licenses and certificates of technical skill. Many states do not recognize the rights of doctors, engineers, and similar professional people from other states to practice within their borders. Interstate compacts have now been entered into which allow all holders of "certificates of professional skill" to function in neighboring states in time of emergency.

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, San Antonio, May 3-5, 1954. Dr. George Turner, El Paso, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, San Francisco, June 21-25, 1954. Dr. Edward J. McCormick, Toledo, Ohio, Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, Houston, Feb. 1-3, 1954. Dr. Ben Z. Rappaport, Chicago, Pres.; Dr. Alan G. Cazort, 1425 West 7th St., Little Rock, Secy.

American Academy of Dermatology and Syphilology. Dr. Michael H. Ebert, Chicago, Pres.; Dr. John E. Rauschkolb, 25 Prospect Ave., N. W., Cleveland 15, Secy.

American Academy of General Practice, Cleveland, March 22-25, 1954. Dr. U. R. Bryner, Salt Lake City, Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Dr. William F. Mengert, Dallas, Pres.; Dr. C. Paul Hodgkinson, Detroit, Secy.

American Academy of Ohthalmology and Otolaryngology. Dr. Frederick C. Cordes, San Francisco. Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Montreal, Canada, May 3-5, 1954. Dr. Emile F. Holman, San Francisco, Pres.; Dr. Paul C. Samson, 2938 McClure St., Oakland 9, Calif., Secy.

American Association of Genito-Urinary Surgeons, Shawnee-on Delaware, Pa., May 26-28, 1954. Dr. Vincent J. O'Conor, Chicago, Pres.; Dr. Norris J. Heckel, 122 S. Michigan Ave., Chicago 3, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 9-11, 1954. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Miami Beach, April 5-10, 1954. Dr. M. Murray Peshkin, New York, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, San Francisco, June 17-20, 1954. Dr. Alvis E. Greer, Houston, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Chicago, April 5-9, 1954. Dr. Leroy H. Sloan, Chicago, Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 5, 1954. Dr. John D. Camp, Los Angeles, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-18, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress of Physical Medicine and Rehabilitation, Washington, D. C., Sept. 6-11, 1954. Dr. William B. Snow, New York, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, White Sulphur Springs, W. Va., April 13-17, 1954. Dr. Louis A. Brunsting, Rochester, Minn., Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, San Francisco, June 18-19, 1954. Dr. J. M. Ruffin, Durham, N. C., Pres.; Dr. H. Marvin Pollard, 1313 E. Ann St., Ann Arbor, Mich., Secy.

American Gynecological Society, Hot Springs, Va., May 20-22, 1954. Dr. Richard W. TeLinde, Baltimore, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, Chicago, April 1-4, 1954. Dr. Robert L. King, Seattle, Pres.; Dr. William H. Bunn, 44 E. 23d St., New York 10, Secy.

American Hospital Association. Dr. Edwin L. Crosby, Chicago, Pres.; Mr. George P. Bugbee, 18 E. Division St., Chicago, Executive Secy.

American Laryngological, Rhinological, and Otological Society, Boston, May 25-27, 1954. Dr. LeRoy A. Schall, Boston, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Atlantic City, N. J., June 14-16, 1954. Dr. Roland P. Mackay, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, Glacier Park, Mont., June 16-18, 1954. Dr. William L. Benedict, Rochester, Minn., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, Bretton Woods, N. H., June 6-9, 1954. Dr. A. R. Shands, Jr., Wilmington, Del., Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Buck Hill Falls, Pa., May 3-5, 1954. Dr. Rustin McIntosh, New York, Pres.; Dr. Aims McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, Los Angeles, June 2-5, 1954. Dr. Wendell Green, Toledo, Ohio, Pres.; Dr. Stuart T. Ross, 131 Fulton Ave., Hempstead, N. Y., Secy.

American Psychiatric Association, St. Louis, May 3-7, 1954. Dr. Kenneth E. Appel, Philadelphia, Pres.; Dr. R. Finley Gayle, 6300 Three Chopt Rd., Richmond 21, Va., Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Wilton L. Halverson, San Francisco, Pres.; Dr. R. W. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Washington, D. C., Sept. 6, 1954. Dr. John R. Schencken, Omaha, Pres.; Dr. Clyde G. Culbertson, Indiana University School of Medicine, Indianapolis, Secy.

American Surgical Association, Cleveland, April, 1954. Dr. Howard C. Naffziger, San Francisco, Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison St., Chicago 3, Secy.

American Urological Association, New York, May 31-June 3, 1954. Dr. J. A. Campbell Colston, Baltimore, Md., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Jackson, Miss., April 1-3, 1954. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1954. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Atlantic City, N. J., May 17-21, 1954. Mr. Mark H. Harrington, Denver, Pres.; Mr. Kemp D. Battle, 1790 Broadway, New York 19, Secy.

Radiological Society of North America. Dr. Ira H. Lockwood, Kansas City, Mo., Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association. Dr. I. A. Bigger, Richmond, Va., Pres.; Dr. John C. Burch, 2112 West End Ave., Nashville 5, Tenn., Secy.

Southwest Allergy Forum, New Orleans, May 9-11, 1954. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference. Secy., 209 Medical Arts Bldg., Fort Worth.

Southwestern Medical Association, El Paso, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Oklahoma City, Sept. 27-29, 1954. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen, Oklahoma City 3, Secy.

Tri-State Medical Assembly, Fall, 1954. Dr. Joe D. Nichols, Atlanta, Pres.; Dr. Broox C. Garrett, 940 Margaret Pl., Shreveport, La., Secy.

United States-Mexico Border Public Health Association, Albuquerque, N. M., April, 1954. Mr. Richard F. Poston, Dallas, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice, Galveston, Sept. 9-11, 1954. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris, 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association, San Antonio, May 2-3, 1954. Dr. George L. Gallaher, Harlingen, Pres.; Dr. J. S. Minnett, 2512 Welborn, Dallas, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Waco, Feb. 19-20, 1954. Dr. D. D. Wall, San Angelo, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, San Antonio, May 2, 1954. Dr. Henry H. Hoskins, San Antonio, Pres.; Dr. Walter C. Brown, 1733 S. Brownlee Blvd., Corpus Christi, Secy.

Texas Club of Internists. Dr. Joseph F. McVeigh, Fort Worth, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, San Antonio, May 2, 1954. Dr. Maurice Barnes, Waco, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, San Antonio, May 2, 1954. Dr. Raymond L. Gregory, Galveston, Pres.; Dr. Edmond K. Doak, 501 Hermann Professional Bldg., Houston, Secy.

Texas Division, American Cancer Society, Austin, Jan. 14-15, 1954. Mr. Travis Wallace, Dallas, Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Heart Association, San Antonio, May 3, 1954. Dr. Joseph McVeigh, Fort Worth, Pres.; Miss Roberta Miller, 412 Fidelity Union Life Bldg., 1511 Bryan St., Dallas, Executive Secy.

Texas Hospital Association, Houston, May 18-20, 1954. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, San Antonio, May 2, 1954. Dr. James Blair, San Antonio, Pres.; Dr. John L. Otto, John Sealy Hospital, Galveston, Secy.

Texas Orthopedic Association, San Antonio, May 3, 1954. Dr. Edward T. Smith, Houston, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, October, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Public Health Association, Galveston, Feb. 14-17, 1954. Dr. Roy G. Reed, La Marque, Pres.; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Executive Secy.

Texas Radiological Society, Dallas, Jan. 29-30, 1954. Dr. J. E. Miller, Dallas, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, San Antonio, May 3, 1954. Dr. William E. Crump, Wichita Falls, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred H. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Waco, March 4-6, 1954. Mrs. Frank Schoonover, Fort Worth, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 21, Executive Secy.

Texas Society of Anesthesiologists, San Antonio, May 2, 1954. Dr. James B. Robinett, Jr., Houston, Pres.; Dr. C. R. Allen, John Sealy Hospital, Galveston, Secy.

Texas Society of Gastroenterologists and Proctologists, San Antonio, May 3, 1954. Dr. Cecil O. Patterson, Dallas, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology. Dr. Dan Brannin, Dallas, Pres.; Dr. Lyle Hooker, 627 Esperson Bldg., Houston, Secy.

Texas Society of Pathologists, Galveston, Jan. 31, 1954. Dr. A. O. Severance, San Antonio, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society, Waco, April 5-6, 1954. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Dallas, April 9-10, 1954. Dr. R. G. McCorkle, San Antonio, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Fort Worth, Feb. 22, 1954. Dr. J. Reese Blundell, Houston, Pres.; Dr. Dolphus E. Compere, 1415 Pennsylvania Ave., Fort Worth, Secy.

DISTRICT

First District Society, Pecos, Feb. 12, 1954. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society, Sweetwater, April 15, 1954. Dr. T. D. Young, Sweetwater, Pres.; Dr. Francis Hood, Sweetwater, Secy.

Third District Society, Amarillo, April 13, 1954. Dr. Robert A. Neblett, Canyon, Pres.; Dr. James T. Hall, 1626 Fifteenth St., Lubbock, Secy.

Fourth District Society, San Angelo, Fall, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July, 1954. Dr. Y. C. Smith, Sr., Corpus Christi, Pres.; Dr. Robert J. Sigler, 1126 Third Street, Corpus Christi, Secy.

Seventh District Society, Austin, Feb. 18, 1954. Dr. Benjamin Clary Bates, Austin, Pres.; Dr. William McLean, 4618 Burnet Road, Austin, Secy.

Eighth District Society. Dr. Howard Z. Fretz, Wharton, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society, Brenham, March 25, 1954. Dr. George D. Bruce, Baytown, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. Edmund D. Jones, Beaumont, Pres.; Dr. O. W. Harris, Jr., Liberty, Secy.

Eleventh District Society, Crockett, Spring, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society, Waco, Jan. 12, 1954. Dr. Howard Dudgeon, Jr., Waco, Pres.; Dr. Walter B. King, Jr., Waco, Secy.

Thirteenth District Society, Fort Worth, 1954. Dr. William E. Crump, Wichita Falls, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society, Denton, 1954. Dr. J. W. Atchison, Gainesville, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Longview, April 20, 1954. Dr. L. E. Rutledge, Daingerfield, Pres.; Dr. George Tate, Longview, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 15-18, 1954. Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco, April 7, 1954. Dr. Walter B. King, 2320 Columbus Ave., Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 26-28, 1954. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 8-11, 1954. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference. Dr. C. H. Wilson, Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, July 19-21, 1954. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls, March 31, 1954. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, June 21-23, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

American Academy of Allergy

Texas physicians are invited to attend the annual meeting of the American Academy of Allergy to be held in Houston on February 1, 2, and 3. No charge will be made for registration, although those who wish to attend the postgraduate courses in clinical allergy, advanced subjects (seminar), and allergenic molds and pollens, scheduled for January 29-31, will pay $40, $15, and $35 respectively.

Specialists from throughout the United States and representatives from several foreign countries will present papers, and scientific and commercial exhibits will be displayed. A program for visiting ladies also is planned.

The Committee on Local Arrangements includes Drs. Homer E. Prince, chairman; Ralph Bowen, DeWitt H. Hotchkiss, Jr., Richard L. Etter, Jack M. Rose, and Warren F. Kahle. The Hostess Committee is headed by Mrs. Homer E. Prince, chairman.

Hotel reservations should be made with the Shamrock Hotel, Houston, and registration for the postgraduate courses with the American Academy of Allergy, 208 E. Wisconsin Avenue, Milwaukee 2. No advance registration is necessary for attending the meeting.

LEGISLATIVE PREVIEW

As the second session of the Eighty-Third Congress gets under way, the Washington office of the American Medical Association has outlined some of the pending legislation of interest to the medical profession.

Social Security.—Awaiting action is the administration's plan to extend social security coverage to more than 10,000,000 additional persons, including physicians. The American Medical Association, as well as other groups of the self-employed, has opposed this type of legislation consistently. Instead, the AMA recommends the passage of a measure to allow self-employed persons to defer income tax payments on a portion of their incomes, placed in restricted pension funds and obtainable in the form of benefits only in case of disability or at the specified retirement age. Such provisions were included in bills first introduced as Reed-Keogh bills and now identified as Jenkins-Keogh because of the sponsors.

Other possible amendments to the social security law involve total and permanent disability payments and waiver of old age and survivor insurance premiums for the disabled so that their final pensions will not be reduced because of periods when they had little or no income. In each of these, medical determinations would be required, threatening an expansion of the federal medical program, placing the physicians in an unreasonable role, or calling for compulsory rehabilitation. The AMA is not opposed to the objective of the proposals but suggests that pension rates be based on the ten best earning years instead of that premiums be waived, thus obviating the need for medical determinations.

It is expected that Congress again will be asked to pass legislation providing free hospitalization under the old age and survivors insurance laws for all persons past the age of 65 years and covered by the insurance.

Military Personnel and Veterans.—In line with the recent action of the Veterans Administration in amending its forms to require more financial information from veterans applying for hospitalization of nonservice connected disabilities, who must state that they cannot afford private care, Congress may want further clarification of the government's obligations to veterans. It is thought that special effort will be made to expand medical benefits to veterans by such methods as increasing the periods in which certain diseases may be presumed to be of service origin. The position of the American Medical Association with respect to medical care of veterans has been declared as (1) for the best possible care by the Veterans Administration of all veterans with service connected conditions, (2) for Veterans Administration care of long-term tuberculous and neurologic patients if the veterans cannot pay for it themselves and until local and state facilities are adequate, and (3) against Veterans Administration care of all other cases of nonservice connected conditions, these being the responsibility of the veteran, his family, or his community.

Efforts to implement the Moulton Commission's recommendations for broadening the medical care program for military dependents has been promised by the Defense Department. The commission favors caring for as many dependents as possible at military installations, with others receiving private care primarily at the expense of the federal government. The American Medical Association in December proposed that in the United States military personnel and facilities be used for dependents only if private facilities are inadequate.

Another measure which the Defense Department is recommending would provide government scholarships for medical, dental, and nursing study with the recipients obligated for government service at the rate of one year for every year of the scholarship. The AMA House of Delegates referred to the Board of Trustees the problem of whether or not such legislation should be endorsed.

Health Insurance.—Bills probably will be offered to provide government subsidy of private health insurance plans.

Bricker Amendment.—Holding over from the previous session is the Bricker resolution to check the treaty-making powers of the President. The AMA has endorsed such a measure.

Relationship of Governments. — Two commissions appointed last year, one headed by Clarence Manion and the other by former President Herbert Hoover, are studying the relationships between the federal government on one hand and state and local governments on the other and also the operations of the executive branch of the federal government. The Manion Commission is supposed to have a report ready by March but may ask for more time; the Hoover Commission has until next year to report.

HEALTH INSURANCE INCREASE

Accident and health coverage in the United States increased to a new record high level in 1952, according to the Health Insurance Council's annual survey released in September, 1953.

In Texas, 3,800,000 persons were protected against the expense of hospitalization at the end of 1952, 3,697,000 against surgical expenses, and 1,743,000 against medical expense.

More than $2 billions cash benefits were received in 1952 in the nation, with about half this amount to cover the cost of hospitalization. The total number of persons with hospitalization insurance increased 7 per cent over 1951. There was a 12 per cent increase in the number of persons protected against the cost of operations under surgical expense coverage, and the number of those protected against doctors' bills under medical expense coverage shows an increase of 29 per cent over 1951.

The council stated that at the close of 1952 more than 38 million persons were protected against the loss of income due to disability, and nearly 700,000 had major medical expense coverage, the newest form of voluntary health protection designed to help meet the costs of very serious illness.

Organizations covered in the council report include insurance companies, Blue Cross, Blue Shield, and various other independent plans sponsored by business and industry, employee benefit associations, and private group clinics.

COX RESIGNS AS STATE HEALTH OFFICER

Dr. George W. Cox, State Health Officer of Texas for the past seventeen years, offered his resignation, effective March 1, when the State Board of Health met in Austin on December 14. The board accepted his resignation with the request that he remain in office until a successor can be selected and pointed out that during his term the services of the State Department of Health have been extended to "every county and municipality in Texas with a degree of efficiency equal to the best public health services in the nation."

AMERICAN GERIATRICS SOCIETY

The American Geriatrics Society will meet June 17-19 in San Francisco, immediately preceding the meeting of the American Medical Association. Physicians and other scientists interested in geriatrics may attend. Hotel reservations should be made through the San Francisco Convention and Visitors Bureau, 200 Civic Auditorium, San Francisco 2. Additional information may be obtained from the chairman of local arrangements, Dr. Laurance W. Kinsell, Highland Alameda County Hospital, 2701 Fourteenth Avenue, Oakland 6.

BLOOD BANKS FORM CLEARING HOUSE

The Texas Association of Blood Banks, meeting December 4 and 5 in Fort Worth, agreed to establish a clearing house for the exchange of blood between banks in the state. The clearing house will maintain an inventory of the types and quantity of blood available in participating banks, initiate the exchange of blood, record transactions and arrange for cancellation of indebtedness between banks, collect and pay processing fees, and maintain itself by a proration among member banks.

More than 100 delegates were present for the meeting, which included papers, panel and round-table discussions, a luncheon and a banquet, and a business meeting. Out-of-state participants in the program were Dr. John Upton, chairman of the California Blood Bank Commission, San Francisco; Mrs. Charles Hemphill, managing director of the Irwin Memorial Blood Bank, San Francisco; Dr. Sam Gibson, associate director of the blood program of the American National Red Cross, Washington; and Dr. Joseph A. Hertell, assistant national director of the American National Red Cross, Washington.

Dr. C. T. Ashworth, Fort Worth, was named president for the coming year; Dr. Jarrett Williams, Abilene, president-elect; Dr. O. J. Wollenman, Jr., Fort Worth, vice-president; Miss L. Jean Stubbins, M. T., Galveston, treasurer; and Miss Marjorie Saunders, Dallas, secretary. The 1954 meeting will be held December 3 and 4 in Abilene.

TEXAS RHEUMATISM ASSOCIATION

The Texas Rheumatism Association held its sixth annual meeting December 4 in Houston with Dr. Edward W. Boland, president-elect of the American Rheumatism Association, as special guest. Dr. J. C. Crager, Beaumont, president, presided; Dr. Jesse W. Hofer, Houston, was program chairman.

Dr. Alfred H. Harris, Dallas, was elected president; Dr. Howard C. Coggeshall, Dallas, first vice-president; Dr. Frank F. Parrish, Houston, second vice-president; and Dr. Charles H. Cornwell, Marlin, secretary-treasurer. Drs. C. C. Smith, Waco, and W. W. Moorman, Fort Worth, are new members of the board of governors.

The following program was presented:

Roentgenological Findings of Rheumatoid Arthritis and Rheumatoid Spondylitis—Dr. Vincent P. Collins, Houston.

Rheumatic Manifestations of Endocrine Diseases—Dr. E. L. Crain, Houston.

Mechanism of Action and Clinical Use of Probenecid in Gout—Dr. Ralph V. Ford, Houston.

Unusual Bone Tumors—Dr. John R. Thomas, Houston.

Conditions Producing Pain in Shoulder Girdle—Dr. Frank F. Parrish, Houston.

Neurological Disorders Simulating Rheumatic Diseases—Dr. Moses Ashkenazy, Houston.

Orthopedic Principles in Management of Rheumatoid Arthritis—Dr. Bedford F. Boylston, Houston.

Physical Medicine in Treatment of Rheumatoid Arthritis—Dr. Lewis A. Leavitt, Houston.

Present Status of Steroid Therapy in Rheumatoid Arthritis—Dr. Boland.

Dr. Boland also led informal discussions of the papers and an open question period. All other speakers are on the staff of Baylor University College of Medicine. Approximately eighty-five Texas physicians attended.

Reciprocity Applications Coming Due

Reciprocity applications must be complete thirty days prior to the time for examinations for licensure by the Texas State Board of Medical Examiners, Dr. M. H. Crabb, secretary, has reminded. The next examination session will be held June 21-23 at the Texas Hotel in Fort Worth.

Texans Enter College of Surgeons

Sixty-three Texas doctors of medicine became fellows in the American College of Surgeons at its 1953 convocation in October. The names released by the college are as follows:

Mack F. Bowyer, Abilene; William R. Klingensmith, Jr. and Walter C. Watkins, Amarillo; Percy R. Fayle and Robert O. Whitson, Baytown; Lamar C. Bevil, Kenneth T. Miller, and Charles L. Pentecost, Beaumont; Houston J. Zinn, Big Spring; George Dudley Moore, Jr. and Charles R. Nester, Canyon; Jack F. Fox, Childress; Sam R. Burnett, J. Harold Cheek, Vanda A. Davidson, Jr., Foster Fuqua, W. N. Fuqua, Jr., Arthur P. Gottlich, Henry G. Montgomery, Philip D. Newell, Donald L. Paulson, Robert R. Shaw, and Nathan Tobolowsky, Dallas; Haskell D. Hatfield and Morton H. Leonard, El Paso; J. Robert Harris, Rex J. Howard, and Hub E. Isaacks, Fort Worth.

Also Clifford C. Snyder, Galveston; George W. Duncan, Harlingen; Moses Ashkenazy, Frederick H. Aves, Bedford F. Boylston, Oscar Creech, Jr., Loren W. Haus, Boyd W. Haynes, Jr., George Robert Kolodny, Milbourne K. Leggett, Jack H. Mayfield, John W. Overstreet, George E. Rohrer, Bryan V. Williams, and Edward Carson Williams, Houston; J. Collier Rucker, Jacksonville; James H. Johnson, Jr., Longview; Robert T. Canon and Archie Lee Hewitt, Lubbock; Milton J. Loring and J. S. Roden, Midland; John B. Case, Graham M. Coffman, Phillip L. Day, Paul L. Gorsuch, James E. Pridgen, William W. Sawtelle, and Edwin M. Sykes, Jr., San Antonio; Hanes H. Brindley, Elihu I. Klein, and John F. McKenney, Jr., Temple; H. Gates Brelsford and Madison J. Lee, Jr., Tyler; Thomas R. Hunter, Jr., Wellington; and Charles H. Wilson, Wichita Falls.

Neuropsychiatric Session in Little Rock

Interested professional personnel have been invited to attend the sixth annual neuropsychiatric meeting to be held at the Veterans Administration Hospital, North Little Rock, February 25 and 26. There will be no charge for registration.

Guest lecturers who will participate include Drs. Kenneth E. Appel, president, American Psychiatric Association, Philadelphia; Franz Alexander, director, Chicago Institute for Psychoanalysis, Chicago; Francis J. Braceland, psychiatrist-in-chief, Institute of Living, Hartford, Conn.; Richard L. Jenkins, chief, Research Section, Psychiatry and Neurology Service, Department of Medicine and Surgery, Veterans Administration, Washington; William Malamud, professor of psychiatry, Boston University School of Medicine, Boston; Jules H. Masserman, neuropsychiatrist, Chicago; Henry G. Schwartz, professor of neurological surgery, Washington University, St. Louis; Harvey J. Tompkins, director, Psychiatry and Neurology Service, Department of Medicine and Surgery, Veterans Administration, Washington; Gregory Zilboorg, psychoanalyst, New York.

In addition to scientific sessions, there will be exhibits prepared by hospital staff members and a dinner the evening of February 25 at which Dr. Appel will be the principal speaker.

Additional information may be obtained from Dr. Ewin S. Chappell, director of professional education at the hospital.

EL PASO HAS NEW MEDICAL CENTER

A new El Paso medical center has nine professional buildings containing thirty-five suites and offices for doctors and dentists. A tenth building will house a prescription pharmacy and a restaurant.

The center is centrally located near the hospitals and will have ample parking facilities.

New Orleans Graduate Medical Assembly

The New Orleans Graduate Medical Assembly will hold its seventeenth annual meeting March 8-11, to be followed by a postclinical tour to Hawaii from Los Angeles by airplane and ship, March 14-April 6. Eighteen guest speakers will participate in the scientific program. Also on the agenda are symposiums, clinicopathologic conferences, round-table luncheons, three-dimensional surgical motion pictures, medical motion pictures, and technical exhibits.

The speakers will be Drs. Perry P. Volpitto, Augusta, Ga.; Earl D. Osborne, Buffalo; Julian M. Ruffin, Durham, N. C.; Allan C. Barnes, Cleveland; Walter C. Alvarez, St. Paul; William D. Stroud, Philadelphia; Lawrence C. Kolb, Rochester, Minn.; Nicholson J. Eastman, Baltimore; A. D. Ruedemann, Detroit; Oscar L. Miller, Charlotte, N. C.; Francis L. Lederer, Chicago; Emmerich von Hamm, Columbus, Ohio; Philip M. Stimson, New York; Brian Blades, Washington, D. C.; Samuel F. Marshall, Boston; Orvar Swenson, Boston; Charles D. Creevy, Minneapolis; and one other to be announced.

Registration fee of $20 is all-inclusive. Information concerning the assembly meeting or the tour is available from the secretary, Dr. Maurice E. St. Martin, 1430 Tulane Avenue, Room 103, New Orleans 12.

HYPERTENSION MORTALITY

Several tentative conclusions concerning mortality from essential hypertension have been reached as the result of a ten-year follow-up study of 646 persons suffering from the affliction by Drs. Robert S. Palmer and Hugo Meunch, Boston. Mortality was found to be greatest among young people, decreasing rapidly with age, and definitely lower in women, according to the doctors' report in the September 5 issue of *The Journal of the American Medical Association*. At the time the report was prepared, 453 patients were alive. The conclusions follow:

1. Relative risk is highest in the young and decreases rapidly with age.

2. Mortality in women is definitely lower (except in the more severe types) and increase of severity is slower. In the higher ages with the milder forms of hypertension, the mortality of women is approximately that of the general population.

3. The average age increases from those with very mild hypertension to those with more severe types. Each of the more severe types must be to some extent a later development of the previous one.

4. Duration of the disease, apart from advancing age, does not seem to have any effect on mortality, except in the most severe type in which short duration is associated with higher mortality at youngest ages.

5. With each increasing degree of hypertension, patients die at a faster rate than that expected of the general public. In general, this increase in mortality tends to diminish with time under observation or higher ages.

Treatment of the patients observed by the physicians was chiefly dietary according to conventional indications; ordinary rules of good hygiene and simple psychotherapy were varied and adapted to the particular patient.

Chest Disease Course Set for New Orleans

Postgraduate courses in diseases of the chest are being sponsored by the American College of Chest Physicians in New Orleans, February 15-19, and in Philadelphia, March 15-19. Tuition for each course is $75. Additional details may be obtained from the Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11.

OKLAHOMA ACADEMY OF GENERAL PRACTICE

The Oklahoma Academy of General Practice will meet in Tulsa February 15-17 to hear the following speakers: Dr. William F. Guerriero, Dallas; Dr. Horace L. Hodes, New York; Dr. Manuel E. Lichtenstein, Chicago; Dr. Perrin H. Long, Brooklyn; Dr. Carlo Scuderi, Chicago; Dr. Harry Wilkins, Oklahoma City; and other outstanding speakers presented by Lederle Laboratories in conjunction with the convention. There is no registration fee, and Texas physicians will be welcome.

A public forum on children's diseases will be held February 16, and a banquet, breakfast, and entertainment also are scheduled. A luncheon and style show will be held for wives.

Further information may be obtained from the president, Dr. Marshall O. Hart, 1228 South Boulder, Tulsa 5.

Aspirin in Respiratory Disorders

In patients suffering from such acute respiratory infections as influenza, bronchitis, and the common cold, aspirin produces normal temperatures more speedily than Terramycin and Erythromycin, according to an article in the September 26 *Journal of the American Medical Association*. The findings of a team of United States Air Force doctors show that aspirin brought the patients' temperature down to normal in an average of thirty hours as compared with forty-one hours for Terramycin and forty-two hours for Erythromycin. The evidence indicates that the antibiotic drugs had no influence on the course of these diseases nor was the use of these drugs necessary since no secondary bacterial infections developed in any of the patients tested.

"The patients who were given aspirin usually felt better sooner than those who were receiving either terramycin or erythromycin," the article states. The patients in the study were 150 airmen with respiratory diseases, the majority believed to be of the influenza-like type. A 600 mg. dose of aspirin was administered to a group of 54 patients with follow-up doses for each group at six-hour intervals. With the exception of some tiredness and a dry cough, such symptoms as headache, general muscular aches, and sore throats disappeared once the fever in all patients returned to normal.

Since no specific cure for common virus infections is now available, the doctors state, "any measure that will limit or minimize the duration of the illness is important."

The study was conducted by Capt. Philip N. Jones, Major Roy S. Bigham, Jr., and Lt. Phil R. Manning, from the Chanute Air Force Base in Illinois.

Medical Aid Needed in Asia

The barest necessities of hospital and medical equipment are needed in the nearly 300 hospitals in India and surrounding Southeast Asian countries, and a joint program of CARE and the World Health Organization, approved by the American Medical Association and its Auxiliary, is attempting to fill this need. About $1,750,000 is needed to take care of the minimum requirements of bed linen, surgical instruments, sterilizers, and laboratory apparatus, according to a survey by WHO.

Purchasing, shipping, and delivering has been put in the hands of CARE, a nonprofit, cooperative agency composed of twenty-seven major American welfare agencies which for the past seven years has channelled American aid in the form of 15,000,000 food, textile, and "self-help" tool packages, books, and other equipment totalling more than $150,000,000 to needy people and institutions in more than thirty overseas countries.

Donations to the project may be forwarded to CARE, 660 First Avenue, New York 16.

PERSONALS

Dr. Lawrence M. Shefts, San Antonio, lectured and performed surgery for a postgraduate course in chest surgery at the medical school of the University of Nuevo Leon, Monterrey, Mexico, in October.

Dr. G. V. Brindley, Temple, has been elected chairman of the Medical and Scientific Committee of the American Cancer Society. Dr. Brindley is chairman of the executive committee of the Texas division and a member of the national board of directors.

Dr. Oren H. Chandler, Ballinger, has been named president of the board of trustees of Howard Payne College, Brownwood. Dr. Chandler has been a trustee for twelve years and vice-president the past two years.

Dr. W. Earl Reed, San Juan, is president of the Pharr Kiwanis Club.

Dr. Perry R. Jeter, Childress, was named Lion of the Month for September by the local Lions Club.

Dr. J. R. McGee, New Boston, first General Practitioner of the Year in Texas, and *Dr. J. H. McCracken,* Mineral Wells, past president of the Texas Medical Association, were among the physicians in practice fifty years or more who were honored by the University of Tennessee, Memphis, this fall. Certificates of honor were presented to them in recognition of their service.

Dr. John Q. Rounsaville, Dallas, has been named medical director of the National Bankers Life Insurance Company.

The father of *Dr. Warren G. Knox,* Fort Worth, died November 23 at Roby.

Mrs. Felix Peebles, mother of *Dr. Felix Peebles, Jr.* of Lufkin, died in Jefferson October 21.

Dr. and Mrs. John R. Thomas, Corpus Christi, were honored at a reception given by their children October 24 in Corpus Christi in observance of their golden wedding anniversary.

Dr. Albert Wilson Harrison and Miss Florence Adelaide Gask were married October 31 in Daytona Beach, Fla. They reside in Galveston.

Dr. and Mrs. O. T. Kirksey, Galveston, and *Dr. and Mrs. Bernard Rosen,* Corsicana, are recent parents of sons; *Dr. and Mrs. R. V. Jones,* Houston, are parents of a daughter.

Dr. and Mrs. W. Compere Basom, El Paso, are parents of a boy, Robert Compere, born December 5.

Hospital Construction Progress

The Texas State Department of Health recently issued its annual plan for construction of hospitals and public health centers, which in reality is a report of progress made since funds from the Hill-Burton hospital survey and construction act adopted by the United States Congress became available in 1947 and a summary of anticipated activity making use of those funds in the future.

The report shows that 133 projects have been approved, of which 86 have been completed, 21 are under construction, 8 are not yet under contract, and 18 have been withdrawn. The 115 projects completed or now scheduled for construction include 89 general hospitals, 4 hospitals for chronically ill patients, 6 tuberculosis hospitals, 2 hospitals for nervous and mental diseases, 6 public health centers, 3 nurses' homes, 4 equipment projects, and 1 expansion of the state laboratory. The hospitals provide for an additional 8,988 beds.

For the future, the areas of greatest need and specific ameliorative projects are defined in the report. Possible sponsoring agencies for these projects will be encouraged to apply for assistance, but the proposed overall plan will be modified as necessary.

Operating under the general direction of the State Board of Health, the hospital survey and construction division of the State Department of Health also has a state advisory council of twelve members. Four vacancies on the council now exist; Drs. R. W. Kimbro, Cleburne; Joe D. Nichols, Atlanta; and James T. Lee, Wichita Falls, are among the members.

CARDIOVASCULAR COURSE IN HOUSTON

A combination of hospital ward rounds, conferences, and demonstrations and of evening lectures will be used in the cardiology course to be held February 15-19 in Houston. The course is sponsored jointly by the University of Texas Postgraduate School of Medicine and Baylor University College of Medicine in association with the Houston Heart Association, Texas Medical Association, Texas State Department of Health, Houston Society of Internal Medicine, and Houston Academy of General Practice.

Visiting lecturers will include Dr. Robert H. Bayley, professor of medicine, University of Oklahoma, Oklahoma City; Dr. Arthur Grollman, professor of experimental medicine, Southwestern Medical School of the University of Texas, Dallas; Dr. George Herrmann, professor of medicine, University of Texas Medical Branch, Galveston; Dr. Donald Seldin, professor of medicine, Southwestern Medical School, Dallas; and Dr. Henry M. Winans, emeritus professor of medicine, Southwestern Medical School, Dallas. Fifteen local faculty members will participate, and the staffs of Hermann, Jefferson Davis, M. D. Anderson, Memorial, Methodist, St. Joseph's, and Veterans Administration Hospitals will cooperate.

Newer diagnostic procedures; cardiac surgery and anesthesia; treatment of heart failure, shock, and hypertension; special problems of etiology and therapy; and other subjects of current interest are scheduled for consideration. The course will provide twenty-five hours of formal credit by the American Academy of General Practice.

The registration fee of $25 may be sent to the University of Texas Postgraduate School of Medicine, 1400 Outer Belt Drive, Houston 25, from which additional information also may be obtained.

Wichita Falls Tumor Conference

The third annual State Tumor Conference sponsored by the Wichita County Medical Society Tumor Clinic, the American Cancer Society, and the State Department of Health will be held March 13 in the main auditorium of Midwestern University in Wichita Falls. This clinic, which is approved for credit in formal postgraduate training, is open to physicians without payment of a registration fee.

The program follows:

Address of Welcome—Dr. James T. Lee, Wichita Falls, President of Wichita County Medical Society.
Diagnosis and Treatment of Cancer of Thyroid—Dr. Shields Warren, Boston, New England Deaconess Hospital.
Early Diagnosis and Treatment of Caocer of Stomach—Dr. Alton Ochsner, New Orleans, Tulane University School of Medicine.
Caocer in General Practice—Dr. Jesshill Love, Louisville, St. Joseph Infirmary.
Radioisotopes in Treatment of Tumors—Dr. Warren.
Early Diagnosis of Cancer of Lung—Dr. Ochsner.
Treament of Maligoaot Disease—Dr. Love.

Dr. Bailey R. Collins, director of the clinic, will preside over the morning session; Dr. David H. Allen over the afternoon session. Luncheon at the Midwestern University Cafeteria and morning and afternoon recesses are on the schedule, and the day will be ended with a question and answer period.

INTERNATIONAL MEDICAL MEETINGS

Announcements have been made of several international meetings of medical interest:

Congress of Pan American Association of Ophthalmology, Brazilian Congress of Ophthalmology, and *International Congress of Oto-Neuro-Ophthalmology,* June 17-21, Sao Paulo, Brazil. Interested physicians are invited to participate in these three events for a registration fee of $10, which also will cover a number of social events planned in connection with Sao Paulo's four hundredth anniversary. Dr. Daniel B. Kirby, 780 Park Avenue, New York, United States representative on the council of the Pan American Association, can give further details.

International Cancer Congress, July 23-29, Sao Paulo, Brazil. Interested physicians may attend this sixth congress sponsored by the International Union Against Cancer, at which fundamental research, clinical studies, and control of cancer will be considered. Travel by ship and plane and special South American tours are being arranged for visitors from the United States, and financial assistance to cover part of the travel costs is available to a limited number. Further details may be obtained from the Chairman, National Committee on the International Union Against Cancer, National Research Council, 2101 Constitution Avenue, N. W., Washington 25, D. C.

International Congress of Internal Medicine, September 15-18, Stockholm, Sweden. The International Society of Internal Medicine, representing forty nations, will sponsor a program including symposiums on hypertension and collagen diseases and a variety of other papers. Visits to hospitals and scientific institutions are on the agenda. Professor Nanna Svartz, Caroline Medical Institute, Stockholm, is chairman of the planning committee and president of the society.

International Congress on Diseases of the Chest, October 4-8, Barcelona, Spain. All aspects of chest diseases, including cardiorespiratory function and inhalation therapy, will be covered in this world congress. The program will include papers, motion pictures, and scientific and technical exhibits. Murray Kornfeld, executive director of the American College of Chest Physicians, the sponsoring agency, has additional information and may be addressed at 112 East Chestnut, Chicago 11.

MISSISSIPPI VALLEY ESSAY CONTEST

A $100 cash prize, a gold medal, and a certificate are being offered for the best unpublished essay on any subject of general medical interest (including medical economics and education) and of practical value to the general practitioner by the Mississippi Valley Medical Society. Resident citizens of the United States who are members of the American Medical Association may compete. Manuscripts up to 5,000 words must be submitted by May 1. Further information is available from Dr. Harold Swanberg, Secretary, Mississippi Valley Medical Society, 209-224 W.C.U. Building, Quincy, Ill.

UNIVERSITY OF TEXAS MEDICAL BRANCH

December visitors at the University of Texas Medical Branch, Galveston, included David E. Green, Ph. D., director of the Enzyme Institute, University of Wisconsin, Madison; Burton L. Baker, Ph. D., University of Michigan, Ann Arbor; and William C. Rose, Ph. D., professor of biochemistry and nutrition, University of Illinois, Urbana.

Dr. Harriet Felton, professor of pediatrics at the Medical Branch, presented an exhibit on her work to develop a new vaccine for whooping cough at the recent meeting of the American Academy of Pediatrics at Miami.

PRIVATE CLINICS AND HOSPITALS OF TEXAS

Dr. W. R. Swanson, Taylor, assumed duties as president of the Private Clinics and Hospitals Association of Texas at the group's annual meeting December 4-6 in Austin. Other officers are Drs. Neil Buie, Marlin, president-elect; R. D. Holt, Meridian, vice-president; John Dupree, Levelland, secretary-treasurer; and William Blair, Wharton, editor-in-chief.

The program included round-table discussions of problems of privately owned clinics and hospitals in such areas as nursing care, insurance, food, and laboratory service. Leaders of the discussions were Drs. Harvey Renger, Hallettsville; J. P. Anderson, Brady; Van D. Goodall, Clifton; Dupree; Buie; Gilbert Casey, Jacksonville; and Kline S. Dewees, Wills Point. Dr. Joe Nichols, Atlanta; William R. Hunt, Waco; and Bill Burton, El Paso, spoke at the luncheons, and Dr. S. D. Coleman, Navasota, gave the president's address.

SOUTHWESTERN MEDICAL SCHOOL

Dr. William F. Mengert, head of the Department of Obstetrics and Gynecology at Southwestern Medical School of the University of Texas, Dallas, became president of the American Academy of Obstetrics and Gynecology at its meeting in Cincinnati on December 14.

Dr. Hans Selye, director of the Institute of Experimental Medicine and Surgery at the University of Montreal, delivered the Phi Delta Epsilon lecture at Southwestern Medical School of the University of Texas, Dallas, on October 24, using as his subject "The General Adaptation Syndrome."

S. Edward Sulkin, Ph. D., professor of bacteriology at Southwestern Medical School of the University of Texas, Dallas, joined researchers from five countries at the International Symposium on Dynamics of Virus Infections October 21-23 in Detroit.

SOUTHWESTERN MEDICAL ASSOCIATION

Dr. Willard W. Schuessler, El Paso, was installed as president of the Southwestern Medical Association at its thirty-fifth annual meeting October 29-31 in Tucson, Ariz. Other officers elected by the 260 physicians present from Arizona, New Mexico, West Texas, and Northern Mexico follow: Dr. Joseph Bank, Phoenix, president-elect; Dr. N. K. Thomas, Tucson, first vice-president; Dr. John H. Dettweiler, Albuquerque, second vice-president; Dr. Leslie Daviet, Las Cruces, N. M., third vice-president; and Dr. Celso C. Stapp, El Paso, secretary-treasurer.

On the scientific program were Drs. Merl J. Carson, Glendale, Calif.; Donovan C. Browne, New Orleans; Edmund B. Spaeth, Philadelphia; William Paul Thompson, Los Angeles; and Henry K. Ransom, Ann Arbor, Mich.

Baylor Hospital Celebrates Half Century

Baylor Hospital in Dallas on October 16 celebrated fifty years of being chartered by the State of Texas as a hospital. Observance of the occasion included a five-day series of tours for visitors, a banquet with United States Senator Price Daniel as chief speaker, coffees honoring Baylor Nurses' Alumnae and the Baylor Woman's Auxiliary, and dinners for employees and for the medical staff.

Harris County General Practitioners Elect

The Harris County Academy of General Practice has announced the election of officers for 1954 as follows: Dr. Donald M. Gready, president; Dr. William F. Cole, president-elect; Dr. Milton Littell, vice-president; Dr. Ben Walpole, secretary; Dr. Homer A. Taylor, treasurer; Dr. A. C. Madsen, director.

LIBRARY SECTION

GLAUCOMA

To avoid the easy error of assuming we are racing along abreast of an always fast and sure current of medical progress, a deliberate backward look can be sobering. Consider that there exists a twenty-three century old description of glaucoma, that it was some four centuries after this description before any difference between glaucoma and cataract was hinted by Rufus, and that another six hundred years elapsed before a written account by Paulus Aegineta of actual symptomatic differences was made. Aegineta, incidentally, remarked, "Glaucoma is in every case incurable," an opinion repeated as late as 1858 by Desmarres. Consider that the entire Greek-Roman period and the Dark Ages provided little more than recognition of the disease, failing adequately to separate it from cataract, and that this state of affairs continued approximately the same until the appearance of a book by Brisseau in 1709. Consider the remarkable fact that although a condition of firmness or hardness of the glaucomatous eye was recognized in 1622 by Barrister, more than a hundred years passed before general appreciation of the requirement of increased intraocular pressure followed the description of the association by Platner in 1745 and again particularly by Bowman in 1858. Indeed, remember that it was some twenty-two centuries after the Hippocratic description before one appeared by Weller in 1826 which was substantially correct and useful even by today's standards.

The stream of medicine quickened in the nineteenth century, and ophthalmology was no exception. Largely because of von Helmholz's ophthalmoscope, there developed almost automatically a voluminous literature about glaucoma and other subjects. Small, slowing eddies appeared, as evidenced by the misconception about the optic disk in glaucoma; Jaeger and even von Graefe believed it bulged forward rather than being cupped. That giant of ophthalmology, von Graefe, whose incalculably valuable operation (iridectomy) was announced when he was but 22 years of age, required some time before he was completely convinced that hardness of the eyeball was the cause of blindness, since he required proof of concavity of the nerve head. Iridectomy initially seemed phenomenally successful and was almost the sole surgical attack for the subsequent fifty years, although its mode of action was by no means understood for most of that period, even by the originator. Von Graefe felt that every practitioner should be able to diagnose glaucoma, still a desideratum as evidenced by the motion picture film, "Glaucoma: What the General Practitioner Should Know," now available at the Texas Medical Association Memorial Library.

Consider that miotics were introduced as late as 1877 and that the palpating finger estimation of intraocular pressure or tension was only replaced following the announcement of Schiøtz's tonometer in the period 1905-1910. And recall that it is really of only late years that we at last seem able to be categorical about some of the types of glaucoma. In any case, it is the recollection of what has gone before—and the time it took—that will cause a natural hesitancy when it comes to predicting which of more recent observations shall prove lastingly helpful or astonishingly neglected. Yet, there would seem no way any physician can reasonably fail to heed modern words such as these of Kirby:

"Patients, unguided and unhelped, or treated by persons not trained in the detection, recognition and modern treatment of glaucoma, are inevitably destined for blindness. With early recognition, proper treatment and supervision, the condition is serious but the prospects for recovery are usually excellent and useful vision can be maintained. A knowledge of the early symptoms of glaucoma is essential so that timely, remedial measures may be taken while they are still of great value."

Now Texas physicians easily can obtain the previously mentioned film about glaucoma produced by the National Society for the Prevention of Blindness, Inc. From it, we may all be assisted in "early recognition, proper treatment and supervision," thus to keep abreast of the current of medicine, whatever its present speed of movement.

—SAM N. KEY, JR., M. D., Austin.

BOOKS RECEIVED IN DECEMBER

Adler, Francis Heed: *Physiology of the Eye, Clinical Applications,* ed. 2, St. Louis, C. V. Mosby, 1953.

Association for Research in Nervous and Mental Diseases: *Patterns of Organization in the Central Nervous System,* Baltimore, Williams and Wilkins, 1952.

Association for Research in Nervous and Mental Disease: *Psychiatric Treatment,* Baltimore, Williams and Wilkins, 1953.

Bakwin, Harry, and Bakwin, Ruth Morris: *Clinical Management of Behavior Disorders in Children,* Philadelphia, W. B. Saunders, 1953.

Barsky, Arthur Joseph: *Principles and Practice of Plastic Surgery,* Baltimore, Williams and Wilkins, 1950.

Bisch, Louis E.: *Cure Your Nerves Yourself,* New York, Wilfred Funk, 1953.

Brailsforth, James F.: *Radiology of Bones and Joints,* ed. 5, Baltimore, Williams and Wilkins, 1953.

Brams, William A.: *Managing Your Coronary,* Philadelphia, J. B. Lippincott, 1953.

Clinical ACTH Conference Proceedings, Second, Philadelphia, Blakiston, 1950.

Conference on Drug Addiction Among Adolescents, New York, Blakiston, 1953.

Dickinson, Robert Latou: *Human Sex Anatomy,* ed. 2, Baltimore, Williams and Wilkins, 1949.

Engle, Earl T.: *Menstruation and Its Disorders, Proceedings of the Conference,* Springfield, Ill., Charles C Thomas, 1950.

Glaister, John: *Medical Jurisprudence and Toxicology,* Edinburgh, E. & S. Livingstone, 1953.

Gordon, I.; Turner, R.; and Price, T. W.: *Medical Jurisprudence,* Edinburgh, E. & S. Livingstone, 1953.

Haymaker, Webb, and Woodhall, Barnes: *Peripheral Nerve Injuries,* ed. 2, Philadelphia, W. B. Saunders, 1953.

Klendshoj, Niels C.: *Fundamentals of Biochemistry in Clinical Medicine, Springfield, Ill.,* Charles C Thomas, 1953.

Koch, Frederick C., and Hanke, Martin E.: *Practical Methods in Biochemistry,* ed. 6, Baltimore, Williams and Wilkins, 1953.

Mackie, T. J., and McCartney, J. E.: *Handbook of Practical Bacteriology,* ed. 9, Edinburgh, E. & S. Livingstone, 1953.

Means, J. H.: *The Thyroid and Its Diseases,* ed. 2, Philadelphia, J. B. Lippincott, 1948.

Moore, Daniel C.: *Regional Block,* Springfield, Ill., Charles C Thomas, 1953.

Noble, Frank W.: *Electrical Methods of Blood-Pressure Recording,* Springfield, Ill., Charles C Thomas, 1953.

Noyes, Arthur P.: *Modern Clinical Psychiatry,* ed. 4, Philadelphia, W. B. Saunders, 1953.

Parsons, Langdon, and Ulfelder, Howard: *An Atlas of Pelvic Operations,* Philadelphia, W. B. Saunders, 1953.

Puestow, Charles B.: *Surgery of the Biliary Tract, Pancreas and Spleen,* Chicago, Year Book Publishers, 1953.

Russ, Joseph D.: *Resuscitation of the New Born,* Springfield, Ill., Charles C Thomas, 1953.

Scott, Wendell G.: *Planning Guide for Radiologic Installations,* Chicago, Year Book Publishers, 1953.

Seed, Lindon, and Fields, Theodore: *Treatment of Toxic Goiter with Radioactive Iodine,* Springfield, Ill., Charles C Thomas, 1953.

Simons, R. D. G. Ph.: *Handbook of Tropical Dermatology,* Amsterdam, Elsevier, 1952.

Smul, Josef S.: *Respiratory Diseases and Allergy,* New York, Medical Library Company, 1953.

Spurling, R. Glen: *Lesions of the Lumbar Intervertebral Disc,* Springfield, Ill., Charles C Thomas, 1953.

Weil, Alfred J., and Saphra, Ivan: *Salmonellae and Shigellae,* Springfield, Ill., Charles C Thomas, 1953.

Weisberg, Harry F.: *Water, Electrolyte and Acid-Base Balance,* Baltimore, Williams and Wilkins, 1953.

Wolstenholme, G. E. W.: *Ciba Foundation Symposium, Visceral Circulation,* Boston, Little, Brown and Co., 1953.

Zimmerman, Leo M., and Anson, Barry J.: *Anatomy and Surgery of Hernia.* Baltimore, Williams and Wilkins, 1953.

CONTRIBUTIONS TO LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library of the following recent gifts:

Dr. T. J. Archer, Austin, 95 journals.

Dr. Robert Franken, Austin, 2 journals.

Dr. P. I. Nixon, San Antonio, "Medical Ethics," 1803, by Thomas Percival.

Dr. Morris Polsky, Austin, 130 journals.

Dr. Henry Renfert, Austin, 1 book.

Dr. Earl L. Yeakel, Jr., Austin, 10 journals.

Unusual Gift to Library

Dr. E. E. Lowrey, Gatesville, has given the Library an anatomic model of the skull. The model has a hinged jaw, and the calvarium is cut and may be removed. Made of hard, rigid ivory plastic, the realistic skull has all vascular and neural openings present, and the bone structure and sutures are reproduced.

MOTION PICTURES FOR LOAN

Drug Addiction

16 mm., sound, 21 minutes. (Purchased by Texas Medical Association Memorial Library.)

This is a dramatic and straightforward story of the hazards of narcotic drugs. It depicts with stark realism all phases of this problem, particularly as it affects teenagers. The film explains the derivation of heroin, marijuana, and cocaine and employs animated drawings to describe their physiologic effects. The connection between drug addiction and crime is noted, and the highlights of a typical case are dramatized.

Surgical Treatment for Carcinoma of Lower End of Esophagus

16 mm., silent, color, 42 minutes. (Courtesy of Dr. Philip Thorek, Chicago.)

This film presents a case in which carcinoma of the cardiac end of the stomach extends into the esophagus. A transthoracic partial esophagogastrectomy is performed with an end-to-side esophagogastrostomy. Roentgen-ray studies and the patient's postoperative course are included.

Hemicolectomy for Carcinoma of Right Side of Colon

16 mm., silent, color, 22 minutes. (Courtesy of Dr. Philip Thorek, Chicago.)

Surgical treatment for adenocarcinoma of the ascending colon is presented in the film. Following mobilization of the ascending colon in the proper avascular cleavage plane, the last 6 inches of ileum, cecum, ascending colon, hepatic flexure, and proximal half of the transverse colon are removed. An aseptic end-to-end ileo transverse colostomy is performed. Preoperative and postoperative roentgenograms and the patient one year postoperatively are shown.

Treatment of Varicose Veins

16 mm., silent, color, 30 minutes. (Courtesy of G. D. Searle and Company.)

This film includes a discussion of the venous anatomy of the leg, demonstrates by animation the various types of varicosities, and shows the treatment of each type. A test to determine the adequacy of collateral circulation is demonstrated. This is an excellent film for general practitioners and surgeons.

What Is Cancer?

16 mm., sound, color, 30 minutes. (Courtesy of Texas Cancer Coordinating Council, Austin.)

Designed especially for nurses and nursing trainees, this film is helpful in explaining the problem of cancer from a nurse's standpoint. This film is excellent for nurses and hospital groups. Physicians concerned with nursing education programs will find this a valuable adjunct to their lectures.

BOOK NOTICES

[1]Introduction to Physiological Optics

ARMIN VON TSCHERMAK-SEYSENEGG, *University of Munich, Regensburg Extension. Translation sponsored by the American Committee on Optics and Visual Physiology of the Section on Ophthalmology, American Medical Association; American Ophthalmological Society; and American Academy of Ophthalmology and Otolaryngology. Translated by* PAUL BOEDER, PH. D., *Instructor in Ophthalmology, Harvard Medical School, 298 pages. $10.50. Springfield, Ill., Charles C Thomas, 1952.*

The student who looks for information on physiology of vision finds relatively scanty information in the English ophthalmic and physiologic literature. Hence this monograph is an effort to arouse primarily an interest of larger ophthalmologic groups in physiologic optics and to invite them to practical evaluation. It is a masterly survey of the physiology of vision, especially in the physiology of binocular vision and ocular motility.

The book is divided into six chapters, the first dealing with the optic image, its significance and formulation. The second deals with an introduction to the light sense, photometric and physiologic factors. This stresses that according to the method of exact subjectivism, the treatment of the light-color sense must not begin with the physical discussion of the light stimulus but with the analysis of the physiologic effect. This basic conception opposes the older objectivistic conception which asserted direct perception through the sensory tools or at least a simple causal connection between stimulus and effect.

Following this is an introduction to color sense, giving a

[1]*J. W. Pickens, M. D., Cleburne.*

general description of the character of color sensations, relationship of wave length, intensity, and composition of light stimuli, and the qualities of color sensation.

The latter part of this monograph discusses binocular space sense and the physiology of ocular movements, giving special attention to retinal correspondence and to the laws governing the movements of the eye.

The author of the book concludes that "In spite of the unavoidable incompleteness of the presentation and in spite of the perhaps somewhat strongly subjective coloring,... the harmony of the resulting picture should not be overlooked."

[2]Office Psychiatry

LOUIS G. MOENCH, M. D., *Assistant Clinical Professor of Medicine and of Psychiatry, University of Utah School of Medicine. 310 pages. $6. Chicago, Year Book Publishers, 1952.*

This is an exceptionally fine book in that it accomplishes well the author's desire of acquainting the general practitioner, the nonpsychiatric specialist, and the medical student with the more valued contributions of psychiatry to the practice of medicine.

The book is comprehensive in scope but leaves out all of the argumentative and controversial afflictions of psychiatry. At times oversimplification might seem to defeat the author's purpose, but on the whole probably it will stimulate the readers to investigation of the references in his bibliography.

I was impressed particularly with the introductory chapters and the chapter entitled "The Interview."

Throughout the text there are numerous caricatural illustrations that cleverly emphasize important interpersonal situations and possibly some pet peeves of the author.

A combination of excellent writing technique with adequate understanding of the prospective readers definitely increases the value of this contribution.

[3]Contact Dermatitis

GEORGE L. WALDBOTT, M. D., F.A.C.P., *Senior Physician, Harper Hospital; Chief of Division of Allergy, Grace Hospital; Chief of Allergy Clinic, Children's Hospital of Michigan, Detroit. Edited by* ARTHUR C. CURTIS, M. D., *Chairman, Department of Dermatology and Syphilology, University of Michigan, Ann Arbor. A Monograph in the Bannerston Division of American Lectures in Dermatology. 218 pages. $8.75. Springfield, Ill., Charles C Thomas, Publisher, 1953.*

The interrelated fields of allergy and dermatology are correlated in this work on a dermatologic subject by an allergist. It is a striking departure from the usual "cut and dried" style of the ordinary textbook, and it makes good reading.

The book covers incidence, mechanism, pathology, and diagnosis in an abbreviated form, and these chapters present no unusual features. One still must be familiar with clinical dermatology to diagnose contact dermatitis. The real value of the book appears in the chapters devoted to determination of the causes and "the pattern." The author has devised a method of marking the exposed surfaces of skin in such a way as to denote the contact areas and to group the patterns according to the causes, as, for instance, the "reaching into" pattern, the "finger grasp" pattern, and the "large ball" or "small ball" patterns. By referring to the pattern of a dermatitis, the detective job of the clinician is greatly aided, and clues are ascertained by which deductions may be made, the appropriate tests performed, and the guilty antigen may be indicated.

In a section on "Special Situations," plants, pollen, cosmetics, soap, wearing apparel, industrial irritants, drugs, and the like are discussed as sources of dermatitis. The author rightly evaluates the psychosomatic aspect of skin diseases, notably disposing of "nervousness" as the cause for every otherwise unexplainable condition.

Therapy of allergic dermatoses is well covered, and the point of avoidance of further aggravation by ill chosen medicaments is well taken.

The appendices, tables, and bibliography are good. The author has indulged in worthy consultations, and his editor, a dermatologist of note, was well chosen. There is a glossary inserted for the benefit of "non-medical readers." Undoubtedly, this book will be read by many such readers, but whether or not the glossary will enable them to place the proper interpretation upon the subject matter is, to this observer, highly problematical.

[4]Gifford's Textbook of Ophthalmology

FRANCIS HEED ADLER, M. D., *Professor of Ophthalmology, University of Pennsylvania Medical School; Consulting Surgeon, Wills Eye Hospital, Philadelphia. Fifth edition. $7.50. Philadelphia, W. B. Saunders Company, 1953.*

This work is designed primarily for the instruction of undergraduates in medicine and for physicians not specializing in the practice of ophthalmology.

Each of the twenty-two chapters contains a thorough discussion of the subject to which it pertains. The anatomy and physiology of the various parts and structures are given. Aside from an occasional mention, surgical techniques are entirely eliminated. Treatment of the various ocular diseases and injuries (other than surgical) is presented quite extensively. Hypertensive diseases and diabetes are presented in more than average detail.

The entire contents of this edition are presented in a clear, concise but comprehensive manner, with superfluous details and verbiage eliminated.

This is a textbook that should be of ultimate value to the undergraduate student of medicine, to practitioners, and most particularly to those engaged in general practice. It will be a valuable adjunct to every medical library.

[5]Hypersplenism—A Clinical Evaluation

CYRUS C. STURGIS, M. D., *Chairman of the Department of Internal Medicine and Director of the Thomas Henry Simpson Memorial Institute for Medical Research, University of Michigan. A Monograph in American Lectures in Medicine. 97 pages. $3.25. Springfield, Ill., Charles C Thomas, 1953.*

This monograph is the William Beaumont Lecture delivered to the Wayne County (Michigan) Medical Society in January, 1952. The entire problem of hypersplenism is presented with a review of the literature in a concise and unbiased manner. The subject is defined and a summary of the current ideas concerning the functions and circulation of the spleen is included. The possible mechanisms of the hypersplenic state are discussed, following which the author classifies and discusses the types of hypersplenism specifically as regards etiology, pathology, signs and symptoms, laboratory findings, diagnosis, and treatment. Occasional case histories with the charted laboratory findings serve to enhance the value of the text. The bibliography and index are adequate. All in all, this monograph is a satisfactory compendium of the general problem as it is understood today. It can be recommended to medical students, general practitioners, and internists.

[2]*F. T. Harrington, M. D., Dallas.*
[3]*Evan B. Hume, M. D., Brownsville.*
[4]*Frederic H. Thorne, M. D., Kerrville.*
[5]*G. N. Irvine, Jr., M. D., San Angelo.*

Clinical Diagnosis by Laboratory Methods

JAMES CAMPBELL TODD, Ph. B., M. D., *Late Professor of Clinical Pathology, University of Colorado School of Medicine, Denver;* ARTHUR HAWLEY SANFORD, M. D., *Emeritus Professor of Clinical Pathology, The Mayo Foundation, University of Minnesota, Minneapolis; Emeritus Member, Division of Clinical Laboratories, The Mayo Clinic, Rochester; Director of Laboratories, Rochester State Hospital; and* BENJAMIN B. WELLS, M. D., Ph. D., *Professor of Medicine, Department of Medicine, School of Medicine, University of Arkansas, Little Rock. Twelfth edition. 998 pages. $8.50. Philadelphia, W. B. Saunders Company, 1953.*

The new edition of a standard textbook in medicine has been brought up to date, with the section on hematology being rewritten and many new additions to the chapter on serology being made. Each test is explained step by step and many tests are so simplified that they can be performed in the office without any special equipment. Every possible result of each test has been considered, and the significance of each in the clinical picture is given.

The index outline of laboratory findings arranged in alphabetical order adds to the value of this well known reference tool.

[6]Physiological and Therapeutic Effects of Corticotropin (ACTH) and Cortisone

DWIGHT J. INGLE, Ph. D., *Senior Research Scientist (Physiologist), The Upjohn Company, Kalamazoo, Mich.; and* BURTON L. BAKER, Ph. D., *Professor of Anatomy, University of Michigan Medical School, Ann Arbor. A Monograph in American Lectures in Metabolism. 172 pages. $5.50. Springfield, Ill., Charles C Thomas, 1953.*

This monograph is an effort on the part of two research scientists to compile all the known information about the adrenal cortical hormones in a readable form for the average physician. The first seventy-five pages deal with the nature of the various hormones and with their effects on normal and abnormal tissue. They show step by step how work regarding these hormones is carried out on experimental animals, on persons with Addison's disease, and in various other disease processes. Diseases in which the hormones have been used are discussed. Beneficial results, where obtained, are described and weighed against the undesirable side effects in an effort to determine their actual value.

This book is not written with a viewpoint of being used in day to day practice but rather to give the reader a good general idea about the whole field in a few pages. An extensive bibliography covering thirty-one pages is found at the end of the book. I found it a very interesting book to read, but I doubt its value in the average physician's library.

[7]Hormonal and Neurogenic Cardiovascular Disorders

WILHELM RAAB, M. D., F.A.C.P., F.A.C.C., F.C.C.P., *Professor of Experimental Medicine and Head of Cardiovascular Research Unit, University of Vermont, Burlington. 722 pages. $15. Baltimore, Williams and Wilkins Company, 1953.*

The author's purpose is "to convince cardiologists and other physicians that neuroendocrine and endocrine influences play a fundamental and decisive part in the origin and therapeutic amenability of many cardiovascular disorders." In this he has admirably succeeded.

The book is divided into three main sections: experimental cardiovascular effects of hormones and neurohormones, cardiovascular features in endocrine and neuroendocrine syndromes, and endocrine and neuroendocrine factors in cardiovascular syndromes.

There are helpful summaries of individual chapters. Each section has a synopsis. The book concludes with a general summary and more than 3,000 references to the literature.

The reviewer noted only one error; in Read's formula on page 129 "the pulse rate" should be corrected to "the pulse pressure."

This book is heartily recommended to those interested in the fields of endocrinology and cardiovascular diseases.

[8]Amebiasis: Pathology, Diagnosis and Chemotherapy

HAMILTON H. ANDERSON, M. D., *Professor and Chairman, Pharmacology and Experimental Therapeutics;* WARREN L. BOSTICK, M. D., *Associate Professor of Pathology, Department of Pathology; and* HERBERT G. JOHNSTONE, Ph. D., *Professor of Parasitology, Parasitology and Mycology Section of the Department of Medicine, School of Medicine, University of California Medical Center, San Francisco. 431 pages. $11.50. Springfield, Ill., Charles C Thomas, 1953.*

This book is one of the best that has been brought out in regard to amebiasis. It covers the subject thoroughly, is well planned, and goes into adequate detail. Controversial points are well handled and discussed, and these are presented in an unbiased manner.

The authors make every attempt to do away with the commonly accepted symptom of dysentery as one of the most looked-for symptoms in amebiasis. It has been shown repeatedly that dysentery itself is not infrequently absent in amebiasis, and this fact alone is well worth bringing before the profession as a whole.

The book is divided into convenient chapters, each of which goes thoroughly into its particular aspect of amebiasis, and at the end of each chapter is an extensive bibliography. For the general practitioner, the chapters dealing with symptomatology and clinical manifestations and with laboratory diagnosis of amebiasis are especially well presented.

[9]Clinical Cardiology

Edited by FRANKLIN C. MASSEY, A. B., M. D., *Assistant Professor of Medicine, Hahnemann Medical College, Philadelphia. 1,060 pages. $13.50. Baltimore, Williams and Wilkins Company, 1953.*

This book contains several excellent chapters, but as a whole it does not compare favorably with other available textbooks of cardiology. Written by thirty-three collaborators, it lacks that warm, almost personal relationship that should be obtained between author and reader. In addition, while the editor admits in his preface that multiple authorship often involves poor continuity and perspective, he has not always offset these defects by choosing contributors of invariably high standards of scholarship and experience.

The chapter on surgery of the heart is especially commendable. Also authoritative and readable are the sections on fundamentals (as opposed to clinical aspects) of coronary circulation, endocarditis, and roentgenology. Electrocardiography is reliably presented but too compressed and the illustrations too few. Schemm's discussion of congestive failure is stimulating, though his understandable enthusiasm for his own ideas has led him to slight other useful therapeutic measures. Illustrations in the book range from strikingly beautiful to inartistic, and many of the bibliographies are incomplete.

Misleading errors of fact are numerous. That intensity alone will distinguish functional from organic murmurs is

[6]*W. S. Rhode, M. D., Colorado City.*
[7]*H. L. Wolf, M. D., Amarillo.*
[8]*O. B. Gober, M. D., Temple.*
[9]*Royall M. Calder, M. D., San Antonio.*

debatable and that organic cardiac lesions never alter the first pulmonic sound is patently erroneous. Few clinicians would agree that it is "nonsense" to administer quinidine for the prevention of possibly fatal arrhythmias complicating myocardial infarction or that it is impossible to master the art of percussing the heart. Likewise, believing that uncomplicated neurocirculatory asthenia is often characterized by fever might well lull an immature clinician into overlooking a remedial infection.

Muscle metabolism is ignored and dosages and pharmacology of drugs (even digitalis) often are treated in a sketchy fashion. Ouabain, digitalis glucosides, and many other drugs of established usefulness are not mentioned.

Striving for elegance of style has resulted frequently in declamations rather than simple, informative exposition and in the misuse of big words when little ones would have served. Occasional neologisms, unacceptable abbreviations, mistakes in simple grammar, and innumerable misspelled words bespeak indifferent editing.

This reviewer has read every page of this text, is not a competing author, and is disappointed that the unquestionably good features of this book do not outweigh the bad.

[10]Hypnosis in Modern Medicine

Edited by JEROME M. SCHNECK, M. D., *Clinical Associate in Psychiatry, College of Medicine, State University of New York; Founder and President, Society for Clinical and Experimental Hypnosis. 323 pages. $7.50. Springfield, Ill., Charles C Thomas, 1953.*

This book is composed of eleven separate chapters, each written by a different investigator and each having an extensive bibliography appended to it. Through this type of organization the author has attempted to bring under one cover the experience and knowledge of certain selected authorities who are proficient in their respective areas of interest within the broader field of hypnosis in its relationship to medicine. The book offers interesting information on the history of hypnosis and its use in various of the specialties of medicine, surgery, and dentistry.

There is an especially interesting chapter on the physiologic aspects of hypnosis.

This publication can be read with ease and offers an opportunity for every physician to become more informed on a subject which is both controversial and somewhat neglected in the medical preparation of the average physician.

[10]*Anthony P. Rousos, M. D., Austin.*

[11]Physical Examination of the Surgical Patient

J. ENGLEBERT DUNPHY, M. D., F.A.C.S., *Associate Clinical Professor of Surgery, Harvard Medical School; Surgeon, Peter Bent Brigham Hospital, and* THOMAS W. BOTSFORD, M. D., F.A.C.S., *Clinical Associate in Surgery, Harvard Medical School; Senior Associate in Surgery, Peter Bent Brigham Hospital. 326 pages. $7.50. Philadelphia, W. B. Saunders Company, 1953.*

This book will prove to be a needed adjunct in the teaching of physical diagnosis since for some time emphasis has been placed upon the examination of the chest. Most surgical conditions are covered in the text, and practicing physicians will find it helpful in differentiating surgical lesions. Descriptions of the techniques and procedures to be mastered in surgical diagnosis are detailed and well illustrated. In every section the approach to the examination is presented in such a way as to make the doctor-patient relationship more pleasant and the examination easier.

Each system of the body is considered separately, and there is a special chapter on the examination of the abdomen in infants and children. The last six chapters will be of interest to all physicians in general practice since methods are presented for rapid diagnosis following trauma.

Doctor in the House

RICHARD GORDON. *186 pages. $2.75. New York, Harcourt, Brace and Company, 1953.*

"Doctor in the House" is a fantastic story of an English medical school. It is beyond comprehension for anyone to read the story and see such frivolous young men in medical schools today, regardless of the country.

This book is well written and easy to read, yet the impression one receives of the English medical student is certainly not complimentary, and a person can be happy the student will not be his doctor some day.

[11]*Robert M. Tenery, M. D., Waxahachie.*

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION

Clinical Session Attended by 7,716

There were 7,716 persons including 2,730 physicians registered for the seventh annual clinical session of the American Medical Association in St. Louis, December 1-4. In addition to a full scientific program, the meeting included sessions of the House of Delegates in which policy action was taken in a number of areas.

The House adopted a modification of the Principles of Medical Ethics which clarifies the relationship of physicians to all form of public information media and referred to the Board of Trustees a resolution calling for the appointment of a special committee to study the publicity problems which result from unethical practices by a small minority of physicians.

Opposition to compulsory coverage of physicians under federal old age and survivors insurance was voiced again, whereas passage of the Jenkins-Keogh bills to permit a voluntary pension program for the self-employed, of the Bricker amendment to restrict treaty-making powers, and of measures to reduce or remove the limitation on the deduction of medical and dental expenses for income tax purposes was approved. The House voiced strong opposition to extension of the doctor draft beyond the present expiration date of June 30, 1955. A resolution endorsing the principle of federally subsidized scholarships for prospective military personnel was referred to the Trustees.

The Council on Medical Service was requested to proceed at once with special study of problems relating to catastrophic coverage and coverage for retired persons in voluntary health insurance plans. The House again affirmed itself as considering pathology, radiology, anesthesiology, and psychiatry as medical services and condemned insurance contracts which classify any such medical service as hospital service. The Joint Commission on Accreditation of Hospitals was requested to publicize its regulations and interpretations on accreditation.

The House referred to the Judicial Council a resolution from Iowa calling for approval of a joint billing procedure when services are rendered by two or more physicians.

Note was made that the American Medical Association has given a fourth grant of $500,000 to the American Medical Education Foundation. The foundation reported a total income for 1953 of $1,174,000 with the number of contributors more than double that for 1952.

One of the speakers before the House of Delegates was Dr. Chester Keefer of Boston, special assistant to the Secretary of Health, Education, and Welfare in Washington.

Dr. Joseph I. Greenwell, New Haven, Ky., was named General Practitioner of the Year.

NEW AMA TELEVISION FILMS

The American Medical Association's Television Film Library now has available four new television shows to be used exclusively by local medical societies. The films will not be aired on any national television network but have been designed to be presented on public service time locally.

The films are "Operation Herbert," which deals with medical care costs; "A Citizen Participates," which shows a citizen's campaign to get a doctor for the town; "What to Do," which is a series of six five-minute shows demonstrating the use of a thermometer, the application of artificial respiration, the stocking of a medicine chest, and emergency treatment of colds, abdominal pains, and headaches; and "Your Doctor," which describes medical training facilities and focuses on the career of a general practitioner in a rural community.

Prints of these films may be obtained by county societies by writing to the AMA's Television Film Library, 535 North Dearborn Street, Chicago 10.

Education and Licensure Congress Set

The annual Congress on Medical Education and Licensure conducted by the Council on Medical Education and Hospitals of the American Medical Association and the Federation of State Medical Boards of the United States will be held February 8 and 9 in Chicago. An open meeting of the Advisory Board for Medical Specialties will be held the preceding day.

Blasingame Resigns Legislative Job

Dr. F. J. L. Blasingame, Wharton, who has been serving as chairman of the Legislative Committee of the American Medical Association, has resigned from that position because of pressure of other commitments. Dr. Blasingame is a member of the AMA Board of Trustees.

Industrial Health Conference at Louisville

The fourteenth annual Congress on Industrial Health sponsored by the Council on Industrial Health of the American Medical Association will convene February 23-25 at Louisville. The role of industry in the maintenance of the health of the nation, health programs for executives, screening examinations, employment welfare of the handicapped, problems of the small plant operator, preparation for emergencies by plant and community, and the relationship of American medicine with labor and management will be considered.

Rural Health Conference in Dallas

The ninth National Conference on Rural Health sponsored by the Council on Rural Health of the American Medical Association will be held at the Baker Hotel, Dallas, March 4-6. Additional details of this conference will appear in the February JOURNAL.

TEXAS MEDICAL ASSOCIATION

MORE TELEPHONE BROADCASTS

Two telephone broadcasts under the sponsorship of the Council on Medical Education and Hospitals of the Texas Medical Association and available to county medical societies or other interested professional groups have been announced for February 16 and March 9. Both broadcasts will originate at the headquarters building of the Texas Medical Association in Austin.

The February program will be presented by members of the faculty of the University of Texas Medical Branch, Galveston, with Dr. George R. Herrmann as moderator. Dr. Herrmann also will present a discussion on "Recent Advances in Cardiovascular Diseases." Other topics and speakers include "Recent Advances in Endocrinology and Metabolism" by Dr. Raymond L. Gregory; "Recent Advances in Hematology" by Dr. William C. Levin; and "Recent Advances in Gastroenterology" by Dr. Edward J. Lefeber.

The March program, for which Dr. Henry M. Winans will be moderator, will be offered by Dallasites. Topics and speakers will be "Diet in Cardiovascular Disease" by Dr. Donald Seldin; "Diet in Metabolic Disease" by Dr. Edwin L. Rippy; and "Diet in Gastrointestinal Disease" by Dr. Tate Miller.

Local Committees Named

Members of the local committees for the 1954 San Antonio annual session of the Texas Medical Association, which is to be held May 3-5, have been announced by Dr. L. Bonham Jones, chairman of the Committee on General Arrangements. Serving with Dr. Jones on this steering committee are the following physicians, all of San Antonio: Drs. Charles L. McGehee, Edward D. Dumas, John M. Smith, Jr., and Robert R. Nixon. Other committees are as follows:

Alumni.—William D. Montgomery, chairman; G. G. Passmore, University of Texas School of Medicine; C. C. Shotts, Baylor University College of Medicine; J. Walter Park, III, Southwestern Medical School of the University of Texas; James E. Pridgen, Tulane University of Louisiana School of Medicine; William M. Center, University of Arkansas School of Medicine; Mildred E. Ward, Louisiana State University School of Medicine.

Fraternity.—William J. Johnson, Jr., chairman; Edwin M. Sykes, Jr., Alpha Kappa Kappa; James E. L. Reveley, Nu Sigma Nu; S. Perry Post, Phi Beta Pi; James L. Mims, Jr., Phi Chi; John L. Matthews, Phi Rho Sigma; William J. Fetzer, Theta Kappa Psi; R. Bernard Pomerantz, Phi Delta Epsilon.

Halls and Lanterns.—Robert R. Nixon, chairman; John P. Heaney, Vernon S. Wier.

Hotels.—John M. Smith, Jr., chairman; Jack B. Lee, Ralph A. Munslow.

Information.—S. Perry Post, chairman; Benjamin B. Shaver, Pat I. Nixon, Jr.

Memorial Services.—B. F. Stout, chairman; J. L. Cochran, P. I. Nixon.

Publicity.—A. F. Clark, Jr., chairman; O. Roger Hollan, Jack M. Partain.

Scientific Exhibits.—Arthur C. Ressmann, chairman; Lawrence M. Shefts, Frank M. Posey, Jr.

Social.—Joseph W. Palmer, chairman; John C. Parsons, John J. DeLeon, William W. Sawtelle, Robert H. Vadheim, William J. Block, Jr.

Sports (Golf).—John B. Case, chairman; John C. Parsons, Arthur B. Pyterek.

Technical Exhibits.—Carl E. Bosshardt, chairman; Robert F. Gossett, Daniel D. Altgelt.

Transportation.—Adolfo Urrutia, chairman; Walter Walthall, Phillip L. Day.

Executive Council to Meet

As announced previously, the Executive Council of the Texas Medical Association will meet at the Association's building in Austin on January 24, beginning at 8:30 a. m. The preceding day a conference for presidents and secretaries of county medical societies will be held at the same place beginning at 10 a. m.

COUNTY SOCIETIES

Andrews-Ector-Midland Counties Society

October 15, 1953

Will Private Practice of Medicine Survive?—F. J. L. Blasingame, Wharton.

Dr. Blasingame, President-Elect of the Texas Medical Association, was principal speaker at a meeting of the Andrews-Ector-Midland Counties Medical Society October 15 in Midland, to which the Howard-Martin-Glasscock-Borden-Scurry-Kent-Dickens-Garza-King-Stonewall Counties Medical Society was invited. He spoke on the above subject.

Bell County Society

October 7, 1953

(Reported by H. H. Brindley, Secretary)

Mediastinal Tumors—G. V. Brindley, Jr., Temple.

After the business session of the October 7 meeting of the Bell County Medical Society, Dr. Brindley presented the above discussion with picture slide illustrations. John Henderson was co-author of the paper. The meeting was held in Temple.

A letter from Mrs. A. Ford Wolf, Temple, chairman of the local auxiliary's essay contest committee, was read, asking if the society again wanted to sponsor the Association of American Physicians and Surgeons essay contest. It was decided that Bell County would not participate this year.

The problem of venereal disease control was discussed and a report given by Harry Frey, Belton, of a meeting of various officials of Temple and of Bell County and Army officers from Fort Hood. J. H. Johnson, Temple, presented a revised report and recommendations by the public health committee, and the report and recommendations as presented were adopted.

Applications for membership of Frederick J. Fay and W. J. Bruce were accepted unanimously.

December 2, 1953

(Reported by H. H. Brindley, Secretary)

Mechanisms of Pain in Duodenal Ulcer—N. C. Hightower, Temple. Discussion—A. C. Broders, Jr., Temple.

The Bell County Medical Society met in Temple December 2 to hear the above scientific program and to elect officers. New officers are Hanes H. Brindley, president; Joe A. Fowler, vice-president; Fred M. Hammond, secretary; R. R. Curtis, J. B. Talley, and J. W. Pittman, censors; R. A. Murray and James C. Walker, delegates; and R. N. Bartels and Ralph Greenlee, alternate delegates. Dr. Fowler is from Killeen; Dr. Pittman is from Belton; all other officers are from Temple.

Dr. Curtis stressed the importance of the American Medical Education Foundation and the responsibility of the doctors in connection with the foundation.

The society voted to give its secretary's secretary $100 for her assistance to the society during the year.

Bexar County Society

December 8, 1953

(Reported by Catherine P. Chester, Executive Secretary)

The following officers of the Bexar County Medical Society were installed December 8 at the San Antonio Country Club: Merton M. Minter, president; Robert F. Gossett, president-elect; C. W. Tennison, vice-president; O. R. Hollan, secretary; Daniel D. Altgelt, treasurer; Charles L. McGehee, trustee; and E. W. Coyle, censor. J. Lewis Pipkin is delegate and Ralph A. Munslow, alternate. All officers are from San Antonio. Dr. Coyle, outgoing president, was installing officer.

Speaker at the dinner was Mr. C. R. Spearman, president of the San Antonio Chamber of Commerce, who presented an outsider's viewpoint of "A Doctor's Responsibility to His Community." Chairmen of the society's various committees reported on committee activities for the year.

Cameron-Willacy Counties Society

November 16, 1953

(Reported by David F. Nickell, Executive Secretary)

Clinical Significance of Intraglandular Thyroid Carcinoma—William O. Russell, Houston.

The above scientific program was presented in Brownsville at the November 16 meeting of the Cameron-Willacy Counties Medical Society after a social hour and dinner with the society's woman's auxiliary.

The group voted to write notes of thanks to the *Valley Morning Star* and the *Brownsville Herald* for their coverage of Texas Medical Association's one hundredth anniversary and to add copies of the special editions of both papers to the society's permanent records. Members who assisted in the publication of the editions also were thanked.

W. M. Hibbitts, Texarkana, was a guest at the meeting.

December 14, 1953

(Reported by David F. Nickell, Executive Secretary)

After the annual Christmas party of the Cameron-Willacy Counties Medical Society and its auxiliary in Raymondville December 14, the society held a business meeting and elected officers. J. C. George, Brownsville, became president; David F. Nickell, Harlingen, vice-president; Harry A. Miller, Brownsville, secretary-treasurer; Hunter Scales, San Benito, delegate; and Thurman Kinder, Brownsville, censor.

The society voted to pay each year the basic expenses incurred on the delegate's trip to the Texas Medical Association's annual session and also to contribute $150 yearly to the auxiliary's nurse scholarship fund.

Dudley Smith, Harlingen, president, presided over the business meeting, and Charles Spence, Raymondville, acted as master of ceremonies for the dinner party. Marcel Bedri, Harlingen, played a violin solo, accompanied by Mrs. Herbert Strass, Harlingen. Mrs. Martin Atchison, Harlingen, reported on the auxiliary's nurse recruitment program.

Approximately seventy members and their wives attended.

Dallas County Society

November 10, 1953

(Reported by W. W. Fowler, Secretary)

Hope for Control of Carcinoma of Breast—C. D. Haagensen, New York.

The Dallas County Medical Society met November 10 at Dallas. Dr. Haagensen, who is associate professor of surgery at Columbia University College of Physicians and Surgeons, presented the fourth annual Charles M. Rosser Lecture.

Jack G. Kerr, president, then conducted a business session, during which the nominating committee, with Charles L. Martin as chairman, submitted a report.

Ona Mae Austin, Thomas G. Price, and Jerry Culwell were elected to membership; and the society approved the proposal by which the Texas State College for Women, Denton, would take over the school of nursing conducted by Parkland Hospital. Elliott Mendenhall requested that society members renew their subscriptions to *Today's Health* through the local woman's auxiliary.

Gonzales County Society

December 2, 1953

(Reported by James C. Price, Secretary)

The Gonzales County Medical Society met for dinner and a business session December 2 in Gonzales to hear the Texas Medical Association's telephone postgraduate broadcast on "Obstetric Emergencies" and to elect officers. The 1954 officers are Henry S. Edwards, Nixon, president; Walter A. Sievers, Gonzales, vice-president; and James C. Price, Gonzales, secretary.

Grayson County Society

October 13, 1953

Roentgen-Ray Problems—Arthur Boyd, Sherman.
Tumor Clinic—Philip Montgomery, James Martin, Billie L. Aronoff, James Howard, and E. K. Siebel, Dallas.
Case Presentations—Stanley Clayton, T. A. Moorman, and Maurice Weisberg, Denison.

The three-point program outlined above was given at the monthly dinner meeting of the Grayson County Medical Society October 13 at the Woodlawn Country Club in Denison.

Gregg County Society

October 13, 1953

Peptic Ulcer—A. C. Broders, Jr., R. R. White, and A. W. Sommer, Temple.

The above staff members of Scott and White Clinic presented a panel discussion on peptic ulcer at the October 13 meeting of the Gregg County Medical Society in Longview.

Howard-Martin-Glasscock-Borden-Scurry-Kent-Dickens-Garza-King-Stonewall Counties Society

October 27, 1953

Care of Major Head Injuries in General Practice—J. Victor Ellis, Amarillo.

Members of the staff of the Big Spring State Hospital were hosts to the Howard-Martin-Glasscock-Borden-Scurry-Kent-Dickens-Garza-King-Stonewall Counties Medical Society for a dinner meeting October 27 in Big Spring. The above scientific discussion was given, followed by a question and answer period.

Roy Sloan, Big Spring, presided at the dinner session; he introduced guests including James Bethea and Sam Hoerster, Jr., both associated with the Board for Texas State Hospitals and Special Schools, Austin.

The local woman's auxiliary met with the society for dinner, followed by a separate business session.

Lubbock-Crosby Counties Society

November 2, 1953

(Reported by Frank C. Goodwin, Secretary)

Hip Fractures and Prostheses—John J. Hinchey, San Antonio.
Discussion—Richard Lewis, Lubbock; Harry Tubbs, Post; and Charles Ratcliff, Lubbock.

Wallace I. Hess, president, presided over the November 2 meeting of the Lubbock-Crosby Counties Medical Society in Lubbock.

A letter from J. A. Chatman asking the reaction of the medical society to presenting a five-hour scientific program at a forthcoming state meeting of the Lone Star State Medical Association in Lubbock was read, and the society was in favor of the proposal. The society also accepted Dr. Chatman's invitation to hold its December meeting at the Chatman Clinic-Hospital.

It was announced that the revised constitution and bylaws, which had been approved by Mr. Philip Overton, legal counsel for the Texas Medical Association, will be mimeographed and sent to the society members.

The society voted to adopt the recommendation of the executive board to hold an annual banquet after the first of the year to introduce new officers of the society and of the woman's auxiliary and to foster fellowship among the members.

The society endorsed the proposed project of the local chapter of the Texas Heart Association for checking pulse and blood pressure by registered nurses. Upon request of the president of the District 3 Medical Society, the local society voted to sponsor a speaker for the section on obstetrics and gynecology at the next district meeting.

Nominations were made for officers to be elected at the next meeting, and the above scientific program was presented.

Milam County Society

October 13, 1953

(Reported by Marvin H. Bartlett, Secretary)

The Milam County Medical Society met October 13 in Cameron and elected the following officers for 1954: Thomas S. Barkley, Rockdale, president; John T. Richards, Rockdale, vice-president and delegate; and Marvin H. Bartlett, secretary-treasurer, Cameron.

Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Society

October 15, 1953

Common Eye Problems—Willis T. Carson, Odessa.
Tumors of Ear, Nose, and Throat—Jack L. Turner, Odessa.

Following a buffet dinner in Pecos on October 15 with members of the local woman's auxiliary, the Reeves-Ward-Winkler-Loving-Culberson Hudspeth Counties Medical Society held a business session and heard the program outlined above.

San Patricio-Aransas-Refugio Counties Society

December 1, 1953

(Reported by C. A. Selby, President)

Significance of Back Pain—Joseph Platz, Corpus Christi.

After a dinner in Sinton on December 1, the San Patricio-Aransas-Refugio Counties Medical Society heard the above scientific discussion and elected officers for 1954. New officers are Josephine Shelton, Refugio, president; Rose Tunnell, Taft, president-elect; Harry Miller, Refugio, vice-president; Maurice Horine, Ingleside, secretary-treasurer; John H. Finn, Refugio, delegate; and John Tunnell and Y. S. Jenkins, both of Taft, alternate delegates. L. G. Wood, Rockport; T. C. Meitzen, Refugio; and Dr. Jenkins were chosen as censors.

Dr. Selby, retiring president, and C. H. Simpson, both of Sinton, were hosts for the meeting. About twenty-five physicians attended.

Tarrant County Society

December 10, 1953

(Reported by Joseph F. McVeigh, Chairman, Public Relations Committee)

Approximately 200 persons attended the fourth in a series of open forums and panel discussions sponsored by the Tar-

rant County Medical Society on December 10 in the auditorium of the new Fort Worth Academy of Medicine. The subject was allergy, and Sim Hulsey was moderator. Panel speakers were William Flood, dermatologist; O. J. Emery, allergist; D. E. Neal, general practitioner; and Thomas J. Coleman, internist.

Of special interest to persons in Fort Worth was the question of fluoride in connection with allergy, since the city was scheduled to begin putting fluoride into the municipal water supply to prevent tooth decay among children. Dr. Coleman said that fluoridation is a controversial question, but so far as he had been able to determine, the evidence was in favor of fluoride. Fluoride in water is not known to be connected with any allergy, he stated. Dr. Hulsey pointed out that fluoride is similar to chlorine which has been used for years in water supplies.

The next forum was to be on poliomyelitis January 14. The first three forum subjects were menopause, accidents, and the common cold.

Washington-Burleson Counties Society

October 13, 1953

The Washington-Burleson Counties Medical Society met October 13 at the clinic of C. E. Southern in Brenham to hear the telephone postgraduate broadcast on obstetric emergencies. The broadcast was one in a series sponsored by the Texas Medical Association.

Webb-Zapata-Jim Hogg Counties Society

December 1, 1953

(Reported by A. S. McGee, Acting Secretary)

Your Medical Society—Mr. N. C. Forrester, Austin.

The Webb-Zapata-Jim Hogg Counties Medical Society met for dinner and an election of officers in Laredo on December 1. The woman's auxiliary met with the society.

The following officers were elected: V. L. Puig, Jr., president; M. E. Malakoff, vice-president; Paul H. Powell, Jr., secretary-treasurer; E. M. Longoria, delegate; and F. M. Canseco, censor. All new officers are from Laredo.

Mr. Forrester, executive secretary of the Texas Medical Association, discussed the Association's headquarters building and some of the problems that face the medical society today, including legislation, veterans' care, socialized medicine, segregation of white and Negro doctors, the relationship between the pharmacist and the medical doctor, and the nursing shortage. He was introduced by Dr. Malakoff, program chairman, and A. C. King, president, presided.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

December 8, 1953

(Reported by Lorraine I. Stengl, Secretary)

On December 8 the Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society met in El Campo for a Christmas buffet dinner with the local woman's auxiliary and then elected the following officers: C. V. Nichols, Richmond, president; E. B. Sanford, Palacios, vice-president; and Stanley E. Thompson, Richmond, secretary-treasurer. R. G. Johnson, New Gulf, was elected to the board of censors and Joseph Bader, Edna, to the adjudication board. Delegate is L. B. Johnson, El Campo; and Harold Northington, Wharton, and R. G. Johnson are alternates. R. G. Johnson is the legislative representative, and the two new members of the executive board are C. A. Shoultz, Bay City, and Franz Amman, Rosenberg.

DISTRICT SOCIETIES

Tenth District Society

October 3, 1953

Preemployment Examinations in Sabine Area Industries—William R. Thornton, Port Neches.

Industrial Burns and Their Treatment—Elliott B. Hay, Houston.

More Common Industrial Injuries of Bones and Joints—William H. Ainsworth, Galveston.

The semiannual session of the Tenth District Medical Society was held October 3 in Port Arthur, and the above scientific program was presented. Edmund D. Jones, Beaumont, president, presided.

AUXILIARY SECTION

ANNUAL AUXILIARY REPORTS

With little more than three months remaining before the Woman's Auxiliary to the Texas Medical Association holds its annual convention in San Antonio, Auxiliary officers and committee chairmen are being reminded that annual reports soon will be due.

County auxiliary presidents are requested to submit two main types of reports: (1) a statistical report and (2) a narrative report. The statistical report is a tabulation of all auxiliary activities and is made by filling out a blank form which will be sent in February, along with a letter of instruction, to county presidents by Mrs. Paul Brindley of Galveston, State Auxiliary Recording Secretary. "No single auxiliary," Mrs. Brindley points out, "will be expected to answer all questions. Only those pertaining to activities in which the group has participated need be answered." The completed statistical report should be returned to Mrs. Brindley by March 15.

The narrative report, also due March 15, is the basis of each county president's oral report to be given at the state convention. This report becomes a part of the convention transactions, printed yearly in the July issue of the JOURNAL. It is from the narrative reports, too, that the State Auxiliary President, Mrs. E. W. Coyle, obtains information for use in her report to the National Auxiliary.

County presidents are reminded to include mention of any outstanding activities or programs to be held after the report is submitted. "This is the place to let your star shine," says Mrs. Brindley. "Tell about your new projects, parties, or what-have-you, or your new and original way of doing the old jobs common to all auxiliaries. Make it good; make it interesting."

The following instructions for preparing narrative reports are given by Mrs. Brindley:

1. Type and double space the report on 8½ by 11 inch white paper and leave ample margins.

Officers of the Woman's Auxiliary to the Texas Medical Association: President, Mrs. E. W. Coyle, San Antonio; President-Elect, Mrs. Mark H. Latimer, Houston; First Vice-President (Organization), Mrs. John D. Gleckler, Denison; Second Vice-President (Physical Examinations), Mrs. Cecil O. Patterson, Dallas; Third Vice-President (Today's Health), Mrs. Ralph B. Payne, Amarillo; Fourth Vice-President (Program), Mrs. Guy Knolle, Houston; Recording Secretary, Mrs. Paul Brindley, Galveston; Corresponding Secretary, Mrs. Charles L. McGehee, San Antonio; Treasurer, Mrs. Oscar M. Marchman, Jr., Dallas; Publicity Secretary, Mrs. Allen H. Neighbors, Jr., Austin; Parliamentarian, Mrs. H. S. Renshaw, Fort Worth.

2. Make an original and four clear carbon copies.

3. Send the original and one copy to Mrs. Paul Brindley, Recording Secretary, 4306 Sherman, Galveston; one copy to Mrs. E. W. Coyle, President, 213 Grant Avenue, Alamo Heights, San Antonio; and one copy to Mrs. Travis Smith, Historian, 849 Elmwood Drive, Abilene. Put one copy in the file for the incoming president.

At the 1954 convention, county presidents will be asked to limit their oral reports to two minutes each. Because of this time limit and the space limitations in the JOURNAL, length of narrative reports should be between 200 and 500 words, except in the case of auxiliaries having 100 or more members, which may use up to 1,000 words if necessary.

State officers and committee chairmen and council women also submit narrative reports at the annual convention. Rules and suggestions for preparing these reports are the same as those given for county reports except that the officer and committee reports are due April 1.

To obtain a breakdown on information of special concern to them, certain state officers and committee chairmen request county auxiliaries to send data on particular projects direct to them for use in their reports. The following deadline for these additional reports have been given:

February 1—Mental health survey data. Send to Mrs. A. B. Pumphrey, 100 Pumphrey Drive, Fort Worth.

February 1—Library Fund donations. Send to Mrs. S. F. Harrington, 3722 Cragmont, Dallas.

February 15—Report on number of physical examinations for physicians and families of physicians. Send to Mrs. Cecil O. Patterson, 3537 Southwestern Boulevard, Dallas.

March 1—Report on most interesting meeting of the year for Archives. Send to Mrs. F. F. Kirby, 2801 Sanger Avenue, Waco.

March 10—History of county auxiliary. Send to Mrs. Travis Smith, 849 Elmwood Drive, Abilene.

March 10—First three prize winning essays in AAPS essay contest from each county auxiliary. Send to Texas Medical Association, 1801 Lamar Boulevard, Austin, for judging for state prizes.

April 1—Report on number of *Bulletin* subscriptions sold since May 1, 1953. Send to Mrs. E. H. Marek, Yoakum.

April 30—Report on number of *Today's Health* subscriptions sold. Send to Mrs. Ralph B. Payne, 87 North Avondale, Amarillo.

Mrs. O. M. Marchman, Jr., State Auxiliary Treasurer, has placed in the mail to each county treasurer a letter plus a four-page instruction pamphlet from the National Auxiliary. Dues for former members are being accepted by Mrs. Marchman, 5539 Montrose, Dallas, from January 15 to March 1. New members' dues may be accepted until April 1. Donations to the philanthropic funds (Library, Student Loan, American Medical Education Foundation, and Memorial) go directly to the respective chairmen and are counted in the current year up until the treasurer's books are closed—about April 15. Vouchers from state officers and committee chairmen must be submitted to Mrs. Marchman by March 31.

COUNTY AUXILIARIES

"Medicine and Magic in Childbirth" was reviewed by Mrs. W. Frank Armstrong, Fort Worth, for the November 6 meeting of *Navarro County Auxiliary*. Turning to the latter end of life for its business session, the group voted to remember the aged at "Twilight Home" with Christmas gifts instead of exchanging gifts among its own membership, and a committee was appointed to formulate plans for a more permanent program of assistance to residents of the home. A dessert course was served by Mesdames Leslie Kelton and Bernard Rosen, Corsicana.

Recruitment of high school girls to enter nurses' training was discussed by *Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson Counties Auxiliary* in the home of Mrs. W. W. Brooks, Borger, October 14. Mrs. Claunch Brindley was named chairman of the recruitment committee and Mrs. Larry Hanson, co-chairman; both reside in Borger.

Mrs. E. W. Coyle, San Antonio, President of the Woman's Auxiliary to the Texas Medical Association, was guest speaker at a dinner given by the *Smith County Auxiliary* to honor doctors of the area October 17. Dr. Coyle also was present for the Tyler event. Mrs. Coyle likewise addressed the *Gregg County Auxiliary* at a luncheon meeting October 15 in Kilgore.

Hunt County Auxiliary entertained its medical society at dinner October 13 in the home of Dr. and Mrs. J. W. Ward, Greenville. An original skit under the direction of Mrs. E. T. Crim and piano selections by the daughter of Dr. and Mrs. Grady Bruce entertained guests.

A Christmas party was held by *El Paso County Auxiliary* in El Paso December 14 in connection with a luncheon for which Mesdames Frank O. Barrett and Harry H. Varner were chairmen. Mrs. Haskell D. Hatfield read two original poems, and a cake walk was conducted by Mrs. Russell Deter and Mrs. Joe Carter, cakes, cookies, and candies made and donated by members being prizes for the event. The auxiliary raised funds to help finance its nurse scholarship, nurse recruitment, hospital work, and othet projects.

Tarrant County Auxiliary members and guests learned the art of candlemaking and Christmas decoration at a guest day luncheon December 11 in Fort Worth.

The purposes and function of standing committees were reviewed by the *Harrison County Auxiliary* in Marshall early in October. Members heard from the following chairmen: Mesdames Maurice Murphy, Roger Harmon, Malcolm McNatt, Ray H. Carter, and John E. Hill. Mrs. George Bennett was in charge of the program.

Mrs. D. C. Bennett, Orange, president of the *Orange County Auxiliary*, outlined her plans for the year when the group met for luncheon October 13 in Orange. The main project is to be work for a treatment center for children with cerebral palsy.

October brought social events for the *Galveston, Dallas, Nueces, and Travis Counties Auxiliaries*. A luncheon in Galveston on October 18 honored Mrs. E. W. Coyle, San Antonio, President of the State Auxiliary; Mrs. W. D. Nicholson, Freeport, District 8 council woman; and Dr. Jesse B. Johnson, Galveston, president of the local county medical society. Officers of the Dallas County Auxiliary were honored at a coffee October 7 in Dallas. Honorees included Mrs. Sidney Baird, president; Mrs. Speight Jenkins, immediate past president; Mrs. Robert Sparkman, president-elect; and members of the board. Twelve new members of Nueces County Auxiliary were special guests at a coffee in the home of Mrs. Charles Mella, Corpus Christi. Mrs. Charles Clark was chairman of arrangements with Mrs. Thomas Edwards as co-chairman. The Travis County Auxiliary honored sixteen new members at a coffee October 20 in Austin, at which time W. A. Stiegler, a publisher, reviewed a book of which an auxiliary member, Mrs. Walter Goddard, is co-author.

POLIO MOVIES AVAILABLE

Auxiliary members are urged by Mrs. E. W. Coyle, San Antonio, State Auxiliary President, to take an active part in the 1954 Mothers' March on Polio campaigns currently under way.

Several films have been made available by the National Foundation for Infantile Paralysis for loan to Auxiliary members. They include "Marbles and Lollipops," an account of gamma globulin field tests; "1953 Newsreel," showing

how polio epidemics are fought; and "1954 Mothers' March on Polio," featuring Miss Helen Hayes. All of the films are 16 mm. sound reels running ten minutes each. Information on how to obtain the films may be had by writing to Mrs. Arleen Draker at the Association's central offices in Austin.

Mrs. Coyle is a member of the March of Dimes State Advisory Committee and represented the Auxiliary at the committee's December 12 meeting in Austin.

AUXILIARY DEATHS

Mrs. W. H. Brandau, Beaumont, a former president of the Woman's Auxiliary to the Jefferson County Medical Society, died November 8, 1953, several days after suffering a cerebral hemorrhage. An active civic and social worker, Mrs. Brandau is survived by her husband, her mother, a daughter, a brother, and a granddaughter.

DEATHS

E. H. CARY

Dr. Edward Henry Cary, Dallas, Texas, past president of the Dallas County Medical Society, Texas Medical Association, Southern Medical Association, and American Medical Association and former dean of Baylor University College of Medicine, died December 11, 1953.

A native of Union Springs, Ala., Dr. Cary was born February 28, 1872, the son of Joseph Milton and Lucy Janette (Powell) Cary. He came to Texas as a young man to work with his brother. Later he obtained his medical education in New York, being graduated from Bellevue Hospital Medical College in 1898, interning at Bellevue Hospital, and then serving at the New York Eye and Ear Infirmary, during which time he was chief of the Eye Clinic of Bellevue Dispensary and substitute professor of ophthalmology in New York Polyclinic. Returning to Texas in 1901, Dr. Cary became professor of ophthalmology and otolaryngology and head of the department first at Dallas Medical College and then, when the old school became part of Baylor University, at Baylor University College of Medicine. He also had been dean of Dallas Medical College and was instrumental in arranging for its absorption by Baylor. He immediately was named dean of the new college and served in that capacity from his appointment in 1903 until 1922; from 1929 until 1943 he was dean emeritus. He was chairman of the Department of Surgery from 1921 to 1929, chairman of the faculty from 1909 to 1929, and chairman of the advisory board of Baylor School and Hospital from 1909 to 1929. Under his direction was organized the Baylor Medical and Surgical Unit which served in France during World War I. He was chairman of the district medical advisory board at that time and was a member of the district appeal board of Selective Service during World War II. In 1939 Dr. Cary helped to organize and became president of the Southwestern Medical Foundation, which was designed to support a great medical center in Dallas. Failure to make agreeable arrangements with Baylor University College of Medicine, which soon moved to Houston, did not stop Dr. Cary and his associates, who assisted in establishing Southwestern Medical College in 1943 and have continued support of the latter institution since its inclusion in the University of Texas system.

When Dr. Cary first returned to Texas after completing his medical studies, he took over the management of A. P. Cary surgical supply company which had been founded by his recently deceased brother, and he continued as president of that business. He likewise was president of the Cary-Schneider Investment Company and of the Medical Arts Hospital of Dallas. In 1921 he built the Medical Arts Building, the first skyscraper especially for offices of physicians. He also was president of Group Hospital Service, the Texas affiliate of Blue Cross, which he had helped to launch as a hospital insurance plan for Dallas school teachers. He was president also of the Kessler Plan Association and a director of the Republic National Bank of Dallas.

Dr. Cary found time to practice his specialty of eye, ear, nose, and throat despite his many educational, business, and civic interests and wrote numerous articles in that field. In addition to holding membership in county, state, regional, and national medical associations, he was the first president of the Texas Society of Ophthalmology and Otolaryngology, a member of the American Laryngological, Rhinological, and Otological Society and the American Academy of Ophthalmology and Otolaryngology, and a fellow of the American College of Surgeons. President of the Texas Medical Association for the 1917-1918 term, Dr. Cary was elected to emeritus membership in 1948. He had represented Texas in the House of Delegates of the American Medical Association off and on over a period of forty years and was a trustee of the AMA from 1925 to 1929 before becoming president for 1932-1933, the only AMA president Texas has had. One of the first to recognize the dangers of socialized medicine, Dr. Cary was president of the National Physicians Committee from its inception until the need for its fight against socializing forces brought its liquidation.

DR. E. H. CARY

Dr. Cary was president of the Dallas Historical Society and of the Texas Philosophical Society, and a member of the Masonic Order (a thirty-second degree Mason and member of the Shrine), Phi Alpha Sigma, Alpha Omega Alpha, Society of Colonial Wars, First Families of Virginia, Critics Club, Dallas Athletic Club, Brookhollow Club, and Dallas Country Club.

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

In addition to honoring him with positions of leadership in numerous organizations, Dr. Cary's associates paid more specific tribute to him on several occasions. He was awarded the honorary degree of doctor of laws by Baylor University in 1916. A bronze bust of him was presented to Baylor University in 1929. He was honor guest at a formal dinner given by Dallas County Medical Society, the Woman's Auxiliary to Dallas County Medical Society, the Dallas County Dental Society, and the Kessler Plan Association in 1931 upon his election as President-Elect of the AMA. He was presented the Linz award as Dallas' most outstanding citizen in 1945. He was given another dinner to celebrate his seventy-fifth birthday in 1947, at which time a $20,000 gift was made in his name for scholarships at Southwestern Medical School.

In 1948 a biography of Dr. Cary, "More Than Armies," was written by Booth Mooney. In the introduction, Dr. Morris Fishbein said of Dr. Cary: "This man is a physician, a distinguished scientist, a medical statesman, a great builder, educator, idealist—all combined in the person of one dynamic, driving, courageous and at the same time gentle, friendly and affectionate human being."

Dr. Cary is survived by his wife, the former Miss Georgie Fonda Schneider, whom he married April 19, 1911, in Dallas, the first president of the Woman's Auxiliary to the Texas Medical Association and of the Woman's Auxiliary to the Southern Medical Association. Also surviving are a son, E. H. Cary, Jr., Dallas; three daughters, Mrs. Ogden Brower, North Tarrytown, New York; Mrs. W. L. Carwile, Jr., Oklahoma City; and Mrs. John I. Hill, Houston; a sister, Mrs. Lucile Cary Lowry, Dallas; and a brother, Joseph M. Cary, Houston.

M. L. GRAVES

Dr. Marvin Lee Graves, a former president of the Texas Medical Association, died November 19, 1953, in Houston, Texas.

The son of the Rev. George W. and Mary Priscilla (Fowler) Graves, Dr. Graves was born in Bosqueville, March 26, 1867. Two years before beginning his premedical studies under Dr. H. C. Ghent of Belton, he served as principal of Belton High School. He received a bachelor's degree in 1885 and a master's degree in 1891 from Bellevue Hospital, New York, now a part of New York University. Dr. Graves held honorary degrees from Southern Methodist University, Dallas, and Baylor University College of Medicine, Houston, as well as an honorary doctor of science degree awarded him in 1949 on the 190th anniversary of Southwestern University, Georgetown.

After receiving his medical degree, Dr. Graves moved to Waco where he practiced for seven years before moving to San Antonio to serve as superintendent of Southwestern Hospital for the Insane. In Waco he was physician for the Methodist Orphanage. In 1950, he opened a practice in Galveston and became professor of medicine and nervous and mental diseases at the University of Texas School of Medicine and physician-in-chief at John Sealy Hospital. More recently he has been emeritus professor of medicine at the Medical Branch in Galveston. He practiced in Galveston for twenty years before resigning his professorship and moving to Houston in 1925 to continue private practice. In Houston he was a member of the Methodist Hospital's executive board and later became an honorary member of the hospital staff. Following his retirement in 1949, Dr. Graves became medical adviser to the American General Insurance Company.

Dr. Graves was a member of the American Medical Association and Texas Medical Association through the Harris County Medical Society. A member of the State Association for forty-eight years, he was elected to emeritus membership in 1937. He served as President of the Texas Medical Association for 1913-1914, was a member of the Board of Trustees for ten years, and served as chairman of several scientific sections for Association annual sessions. He had been president of the Houston Society of Internal Medicine, Texas Club of Internists, Texas Association of Life Insurance Medical Directors, and the Texas Heart Association. He was a fellow of the American College of Physicians and a member of the Southern Medical Association. He was a member also

DR. MARVIN L. GRAVES

of the Phi Chi medical fraternity. He was a member for twenty-eight years of the Board of Stewards of the First Methodist Church of Houston, and for twenty-one years before that, held the same office in the First Methodist Church of Galveston. He attended the Methodist Ecumenical Conference in London in 1921. He was a member of the Masonic Lodge, Chamber of Commerce, and Houston Country Club.

In 1893, Dr. Graves married the former Miss Laura Ghent of Belton. In addition to his wife, who served as a president of the Woman's Auxiliary to the Texas Medical Association, he is survived by the following: a son, Dr. Ghent Graves, Houston; two daughters, Mrs. Laura Lee Steel and Mrs. Mary Alice Morse, both of Houston; two sisters, Miss Minnie B. Graves and Mrs. Gladys Stevenson, both of Waco; and five brothers, Newton Graves, Augusta, Ga.; E. F. Graves, Waco; and Judge George Graves, Ralf Graves, D.D.S., and P. F. Graves, all of Houston.

J. S. BUIE

Dr. James Shaw Buie, Mertens, Texas, died November 11, 1953, in a Waco hospital of coronary heart disease.

Born March 1, 1879, near Brandon, Hill County, Texas, the son of Dr. Whitefield and Julia (Shaw) Buie, Dr. Buie attended the old Southwestern University Medical College in Dallas, where he received his medical degree in 1904. He then interned at St. Paul's Hospital in Dallas. Dr. Buie practiced in Hill County for thirty years, moving from Brandon to Hillsboro and later to Mertens. For thirteen years he was connected with the Texas State Hospital system, working at Terrell, Rusk, Austin, and Mexia. While in Mexia he was

with the Mexia State School and Home. Dr. Buie became a member of the staff of the Central Oklahoma State Hospital, Norman, Okla., in 1951. In 1953, he retired from this position and returned to his home in Mertens, where he lived until his death.

Dr. Buie was a member of the American Medical Association and Texas Medical Association through Hill County Medical Society, and also of the Texas Academy of General Practice. He was a member of the Mertens Masonic Lodge and the Presbyterian Church.

DR. J. S. BUIE

Dr. Buie married Miss Ethel Cooper in 1906. His first wife preceded him in death in 1941. In 1945, he married the former Mrs. Georgia Pearl Elliott. She and the following survive him: a daughter, Miss Mary Frances Buie of Terrell; two sisters, Mrs. Julia Mae Wilhelm of San Antonio and Mrs. Margaret P. Williams of Terrell; two nephews, Willie S. Williams of South Houston and Judge Sterling Williams of Snyder.

H. D. KEARBY

Dr. Harold Donald Kearby died November 21, 1953, at Houston, Texas, of coronary infarction.

Dr. Kearby was born September 27, 1909, at Helena, Mo., the son of Dr. Howard Denton and Verda Eva Kearby. He attended St. Joseph Junior College, St. Joseph, Mo.; the University of Missouri, Columbia; and the University of Arkansas, Fayetteville, and received his medical degree from the University of Arkansas School of Medicine, Little Rock, in 1938. After interning at St. Margaret's Hospital, Kansas City, Kan., and serving a residency in urology at the Turner Urological Institute, Houston, Dr. Kearby specialized in urology at Houston until he entered the United States Air Force in 1951. A major, he had served as chief of urology at Lackland Air Force Base, San Antonio, and as head of the department of urology at the largest Air Force hospital in the Far East. He was recently discharged from the Air Force and had returned to Houston.

Dr. Kearby was a member of the American Medical Association and Texas Medical Association through Harris County Medical Society. He also held membership in the Postgraduate Medical Assembly of South Texas, South Central Section of the American Urological Association, Texas Urological Society, Phi Beta Pi medical fraternity, and Woodmen of the World, and was a member of the Baptist Church.

Dr. Kearby is survived by his wife, the former Miss Geraldine Arnold, whom he married July 30, 1934, in Lawrence, Kans., and his grandmother, Mrs. Belle Holland of St. Joseph, Mo.

J. H. BROWN

Dr. Joseph Hyal Brown died October 19, 1953, in Fort Worth, Texas, after suffering a heart attack.

Dr. Brown was born in Hillsboro, July 9, 1901. He received his academic education at Texas Agricultural and Mechanical College, College Station; Texas Christian University, Fort Worth; and Tulane University of Louisiana, New Orleans. He was graduated in medicine from Tulane University in 1930, and served his internship at St. Joseph's Infirmary in Fort Worth.

Dr. Brown was division surgeon for Rock Island Lines and Southern Pacific Lines and was in general practice, being associated for some years with his father-in-law, Dr. Will C. Duringer. He was a current member of the American Medical Association through Tarrant County Medical Society.

Survivors include his wife, the former Miss Dorothy Duringer; a 2½ year old daughter, Dorothy Duringer Brown; and his mother, Mrs. Maud A. Brown, all of Fort Worth.

J. A. RIEBEL

Dr. John Alan Riebel, Kingsville, Texas, died September 12, 1953, in that city.

Born in Columbus, Ohio, August 29, 1907, Dr. Riebel, whose father, brother, and uncle also were physicians, received his education at Ohio State University and the University's College of Medicine, Columbus, from which he was graduated with a medical degree in 1934. He interned at the White Cross Hospital in Columbus, after which he entered private practice in Columbus and later with his uncle practiced in Ashland, Ohio, where he remained until he joined the Medical Corps of the United States Army Air Force in 1941. During his five years in the service, Dr. Riebel was a flight surgeon in England and Africa and was stationed in Texas twice. He returned to private practice in Ashland until 1949, when he became chief surgeon at the United States Veterans Administration Hospital in Lexington, Ky. He moved to Kingsville in 1952. He was a general practitioner and a surgeon.

A member of the American Medical Association and the Texas Medical Association through the Kleberg-Kenedy Counties Medical Society, Dr. Riebel formerly had been a member of the Ohio State Medical Association. He belonged to the Presbyterian Church.

Dr. Riebel's wife and two daughters, Dawn Riebel and Dusk Riebel, survive.

F. L. ROBBINS

Dr. Frank Leonard Robbins, Baytown, Texas, died November 18, 1953.

Born in Freelandville, Ind., May 29, 1881, the son of Mr. and Mrs. Thomas Robbins, Dr. Robbins received his preliminary education in Vincennes University, Vincennes, Ind. He attended Louisville Medical College, where he was graduated in 1906. Dr. Robbins externed at Good Samaritan Hospital, Lexington, Ky., in 1905. He practiced in Carlisle, Ind., for eleven years, Goose Creek, Texas, for thirty-seven years, and Baytown from 1944 until his death. He was city health officer at Goose Creek and head of the Welfare Clinic of Baytown for several years.

Dr. Robbins was a member of the American Medical Association and Texas Medical Association through Harris County

Medical Society, and of the Houston Academy of Medicine. In 1952, he was elected to honorary membership in the Texas Medical Association. While practicing in Indiana, he belonged to the Sullivan County Medical Society. Dr. Robbins was a captain in the Medical Corps of the American Expeditionary Force during World War I. He was a charter member of the Baytown Rotary Club, a Mason, and a member of the Episcopal Church.

In 1909 Dr. Robbins married the former Miss Lena M. Grizzle in Carlisle, Ind. His wife survives as do two sons, Philip L. Robbins and Ruel H. Robbins, both of New Iberia, La., and a daughter, Miss Helen M. Robbins, Baytown.

F. S. REASONOVER

Dr. Farley Straughn Reasonover, Grand Prairie, Texas, died at the home of his parents in Dallas on October 25, 1953, as the result of an accident.

He was born to Mr. and Mrs. Farley Reasonover in Denison on February 27, 1926. Dr. Reasonover acquired his preliminary education at Highland Park High School, from which he was graduated with honors; Oklahoma Agricultural and Mechanical College, Stillwater; the University of California at Los Angeles; and the University of California, Berkeley. After his graduation from Southwestern Medical

DR. FARLEY S. REASONOVER

School of the University of Texas in June, 1952, Dr. Reasonover served an internship in Baylor Hospital. He had begun the practice of medicine in Grand Prairie this past July.

During World War II Dr. Reasonover received Army basic training at Camp Wolters, Texas, and was affiliated with the Eighty-Fifth Mountain Infantry Regiment and the Tenth Mountain Ski Troops. He was a medical clerk. During nine months' overseas duty he took part in the Italian campaign and was awarded a bronze star citation.

A member of the American and Texas Medical Associations through Dallas County Medical Society, Dr. Reasonover was a member of Phi Chi medical fraternity, the National Honor Society, and Alpha Tau Omega fraternity. He was affiliated with the Methodist Church.

Survivors are his parents, Mr. and Mrs. Farley Reasonover, Dallas.

G. L. CARLISLE

Dr. George Lawson Carlisle, Dallas, Texas, died of coronary occlusion in his home November 2, 1953.

Dr. Carlisle was born September 7, 1891, in Jackson, Miss., to George W. and Virginia (Fearn) Carlisle. He attended Dallas High School and Millsaps College in Jackson and was graduated in 1914 from Southern Methodist University Medical Department, Dallas. After internships at St. Paul's Hospital, Dallas, and St. Mary's Infirmary, Galveston, Dr. Carlisle was a resident in cardiology at Massachusetts General Hospital, Boston. Since 1915 he had practiced in Dallas with the exception of two years' military service as first lieutenant in the United States Army during World War I. Certified by the American Board of Internal Medicine, Dr. Carlisle was particularly interested in heart diseases.

The problem of lay health education was one to which Dr. Carlisle devoted a great amount of effort. As George Lawson, M. D., he was co-author with his wife, Helen Parker, R. N., of a health column "Your Health" which appeared thrice weekly in the woman's section of the Dallas *News*. For a time he also conducted a program on medical topics over a Dallas radio station, KRLD, and he wrote a book for general practitioners entitled "Practical Talks on Heart Diseases." Dr. Carlisle earned a reputation as a phi-

DR. GEORGE LAWSON CARLISLE

losopher as well as a scientist. His interest in the patient as a person and his understanding of sick people's problems, which were evident in his writings, earned for him a patient's comment that he was a "modern adaptation of the old-fashioned family physician."

A member for thirty-eight years of the Texas and American Medical Associations, Dr. Carlisle in 1927 served as president of the Dallas County Medical Society. He was a member as well of the Dallas Southern Clinical Society, Dallas Academy of Internal Medicine, and Texas and American Heart Associations. Dr. Carlisle was professor of physical diagnosis at Baylor University College of Medicine while it was located in Dallas and taught at Southwestern Medical School of the University of Texas, being a consultant in medicine there at the time of his death. He had contributed numerous scientific papers to national medical journals. In

1945 he was president of Baylor University Hospital staff. He was a member of Theta Kappa Psi medical fraternity and Pi Kappa Alpha fraternity and was affiliated with the Methodist Church.

Dr. Carlisle married Miss Mildred King in Dallas in 1915; their children, Mrs. Donald Gay, Dallas, and George L. Carlisle, Jr., Austin, and two grandchildren survive. Also surviving are a second wife, the former Miss Helen Parker, whom he wed January 16, 1949, in Dallas; and three brothers, Hugh P. Carlisle, G. Fern Carlisle, and John B. Carlisle, all of Dallas.

C. C. CARRICO

Dr. Carl C. Carrico, Houston, Texas, died in a Houston hospital September 7, 1953, of cerebral thrombosis.

Born August 30, 1901, in Dallas, the son of the late B. J. and Effie Mae Carrico, Dr. Carrico attended the University of Texas, Austin, and was graduated in 1928 from Baylor University College of Medicine, then in Dallas. After interning at Gorgas Hospital, Panama Canal Zone, he practiced at Scott and White Clinic, Temple, and served for a year at Huntsville as a hospital physician for the Texas Prison System. He then moved to Houston, where he was the physician for the Post Office for eleven years and a general practitioner until his death, with the exception of

DR. CARL C. CARRICO

the period between 1941 and 1946, during which time he was a captain in the United States Army Medical Corps and was chief of the communicable disease section of the Harmon General Hospital at Longview. With the Forty-Fifth Infantry Division, Dr. Carrico participated in the invasions of Sicily and Salerno and the Anzio beachhead. He was a favorite of the late Ernie Pyle, who referred to Dr. Carrico in news dispatches and later in his book, "Brave Men," as "the red-headed doctor." Dr. Carrico was on the staffs of St. Joseph's Infirmary and Methodist and Hermann Hospitals in Houston.

Elected to honorary membership in the Texas Medical Association through the Harris County Medical Society in 1950, Dr. Carrico was a member of the American Medical Association, Southern Medical Association, Postgraduate Medical Assembly of South Texas, Texas Academy of General Practice, and the American Academy of General Practice. He also belonged to the American Legion, Elks, and National Association of Retired Civil Service Employees.

Dr. Carrico married Miss Helen M. Murphy on August 4, 1934, in Denison. She survives him as do a son, Carl C. Carrico II, and a daughter, Miss Carolynn Murphy Carrico, both of Houston, and a sister, Mrs. J. K. Wilson, Los Angeles.

E. W. LOOMIS

Dr. Edgar Webb Loomis died November 18, 1953, at a Dallas, Texas, hospital.

Born in Dallas, February 21, 1886, he was graduated from the University of the South, Sewanee, Tenn., and received his medical degree from Southwestern University Medical College, Dallas, in 1910. After graduation, he served in Alaska as a medical missionary for the Episcopal Church. Upon his return to Dallas in 1912, he became assistant city health officer and later director of the Health Department. He resigned his post to accept a commission in the Medical Corps of the United States Army during World War I and served two and one-half years in France as a major. He returned to Dallas and his health department office after the war but resigned again in 1922 to begin private general practice. Several years later Dr. Loomis took special work at the Babies Hospital and Bellevue Hospital in New York and limited his practice to diseases of infants and children when he returned to Texas. One of the first Dallas doctors to specialize in pediatrics, he was admitted to the American Academy of Pediatrics in 1934 and was certified by the American Board of Pediatrics.

DR. EDGAR W. LOOMIS

Dr. Loomis was a member of the American Medical Association and Texas Medical Association through Dallas County Medical Society. He belonged to the Episcopal Church and Hella Temple Shrine.

His wife, the former Miss Addie Jane Walker of Quanah, whom he married on March 15, 1922, died February 21, 1936.

Surviving Dr. Loomis are three daughters, Mrs. J. P. Butler and Mrs. R. E. Collier, both of Dallas, and Mrs. C. R. Bryant of College Station; two brothers, Richard F. Loomis and John S. Loomis, both of Dallas; and four granddaughters.

President's Page

POLITICAL BACKGROUND FOR NATIONAL HEALTH PLANNING

The background upon which the present federal government policy concerning health planning is based is found in the political trend toward social liberalism during the past twenty years. In all fields of endeavor an ever expanding governmental invasion of private enterprise has made Uncle Sam the individual's greatest competitor. This invasion has been accomplished through an aggressive network of federal corporations. These corporations, rooted in many years of creeping socialism, now engage in competition with private enterprise in hundreds of classifications of business, industry, and commerce without regard for operation losses because these can be made up by taxing their competitor—the private citizen.

These enterprises are carried on by an intricate maze of federal agencies which is now said to contain some 2,500 bureaus which serve as a screen for gigantic federal corporations. These exist without constitutional authority or justification. Mr. Willis Stone has pointed out that "under the pretense of regulating commerce, the various administrations of government have gradually passed more and more legislation permitting bureaus of the government to compete actively with private industry; consequently the original intent of various sections of the constitution designed to protect us have been circumvented." There is an incessant clamor for more power, more capital, and more bureaus.

The movement toward this type of executive government began with the so-called "brain trusters" early in the Roosevelt era, and has continued to grow bigger and more powerful with the passing years. Now, the influence and pressure of this socializing group has grown so much bigger and more powerful than either political party that there is a coalition of party policies in matters regarding more government spending and more giving of what is called services and benefits. The only difference in party politics visible to the taxpayer now is a row among politicians as to which party is going to build an already overstuffed government bigger.

Ex-President Herbert Hoover said at Cleveland, Ohio, April 11, 1953, that "it is false liberalism that expresses itself by federal opera-

tion of business in competition with the citizen." It has been pointed out that 40 per cent of the land and 20 per cent of the industrial capacity of the United States is federally owned and operated. Eighty-three government corporations compete with private enterprise on a rent-free, cost-free, and tax-free basis. The reaction of the overtaxed and overcontrolled citizen to this type of perpetuated government is found in the proposed twenty-third constitutional amendment, proposed income tax lid law, and the Bricker amendment.

The twenty-third amendment provides that "the government of the United States shall not engage in any business, professional, commercial, financial or industrial competition with its citizens except as specified in the Constitution." This amendment is a practical method of returning the ownership of America back to American citizens who built and one time owned it. The effect of carrying this governmental formula into practice is simple and clear because it specifies only that the Constitution be followed and that circumventing practices will not be tolerated.

The now not too popular proposal among politicians to put a 25 per cent lid on income tax remains from the standpoint of the American citizen a protection against overtaxation. This proposed legislation provides for a constitutional amendment prohibiting the federal government from collecting more than 25 per cent of any individual's income as an income tax during any calendar year provided there is no existing national emergency.

The Bricker amendment as it concerns us provides constitutional protection against the socialization of medicine through the treaty-making power now vested in the President of the United States. The alarming thought is the possibility that in this era of statism and reform-by-treaty urge the United States might enter into treaties which would make effective the socialization of medicine.

The movement toward governmental controls is much broader than the field of medicine alone, and we must enlist and work with other affected groups of citizens if our efforts in the control of legislation are to be fruitful.

George Tierney M.D.

TPR diagnotes

REPORT OF PUBLIC RELATIONS COMMITTEE: Third annual meeting for county society presidents and secretaries held in Austin on January 23 with heavy attendance. County officers heard reports covering operation of Texas Medical Association's key boards, councils, and committees plus the latest report on Veterans' medical care from national viewpoint. Speakers on VA panel included Dr. Frank E. Wilson, director, AMA's Washington office, together with Dr. Everett C. Fox, Dallas, and Dr. F. J. L. Blasingame, Wharton.

Hospitality room downtown well attended. Displays showed visiting presidents and secretaries PR projects, plus brochures and services available to county societies.

The 1954 Presidents' and Secretaries' Handbook completed and distributed at meeting. It contains information invaluable to county societies ranging from duties of officers to congressional district maps and table of headquarters organization. Available on request.

PR Committee reported excellent reception of year's Medical Students' Day programs to Board of Trustees, recommending format for 1954. New procedure incorporates same material, more stress and time per topic.

PR recommendation on ways to bring in more attendance at annual session presented to Board of Trustees and received approval. Plan makes use of concentrated direct mail publicity.

Committee reported that results of doctor distribution test survey complete in District 7 reveal two general conclusions: either District 7 is not representative of communities statewide or community need of doctors is not as pressing as some critics of the profession would have the public believe.

ON THE NATIONAL SCENE: New horizons in field of undergraduate and post-graduate medical education were opened as California Medical Association establishes subsidiary, nonprofit corporation called the Audio-Digest Foundation. Through a system of tape recordings and synchronized visual slides or film strips, current medical literature and lectures will be summarized and distributed to doctors throughout the world. Taking the profession's outstanding teachers to the doctor practicing in rural or isolated areas will allow him to keep abreast of medicine's rapid scientific advances and at the same time continue home care for his patients.

The Eisenhower administration has recommended a reinsurance program of $25,000,000. AMA has adopted a wait and see tentative approval - think it might turn into a subsidy.

Hearings on insurance now scheduled by the House Interstate and Foreign Commerce Committee. Committee is looking into all phases of prepay plans, including catastrophic illness insurance, and hearing selected representatives from AMA, cooperative health plans, labor, Blue Cross and Blue Shield, Health Information Foundation, Committee for Economic Security, and others.

Dallas is now set to play host to Ninth National Conference on Rural Health, March 4 through 6. Meeting's theme - "Let's Put More U in CommUNITY." Predict large attendance, excellent opportunity to cement relations between doctor and rural layman.

OVER THE STATE: Eighteenth Annual International Medical Assembly held in San Antonio January 26 through 28. Many physicians heard scientific papers delivered by sixteen guest speakers from all over the United States and from as far away as Canada.

Woman's Auxiliary Handbook nearing completion - should be ready for distribution by March 1. Book contains pertinent information for county auxiliaries.

The Woman's Auxiliary to Harris County Medical Society has collected for bombed-out and looted medical schools in South Korea, 4,000 medical periodicals and 500 medical textbooks. Touching commendation came from Dr. Kook H. Koo, South Korean doctor in Houston for a year's scholarship.

Interest mounting for Texas Medical Association annual session to be held May 3, 4, and 5 in San Antonio. The importance of this key meeting should be stressed at county society level, all members urged to attend.

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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UNIFIED APPROACH TO GOOD WILL

When the county medical society presidents and secretaries held their third annual meeting in Austin January 23 and sat in on the Executive Council meeting the next day, they heard reviewed the function of each council and committee of the Texas Medical Association. Knowing the organization not only means a better operating society but is the first step in the direction of a strong internal public relations program. And as Dr. T. C. Terrell, Fort Worth, wrote in the February, 1953, President's Page, ". . . a better understanding of our own organization and its facilities will help in developing more fruitful external public relations, too. Without being able to tell other people about the Association and its services and without making use of those services in helping to build good will, the problem of creating pleasant relations with the public is made harder." To work together as a closely knit group, county society members must be informed as to policies and programs, must attend and take an active interest in their local meetings, and must avoid professional jealousy and unwarranted criticism of fellow physicians.

To help prepare future doctors to take their place alongside older members of the medical profession, Medical Students' Day programs have been held this school year at the three medical teaching institutions in Texas. The programs, sponsored jointly by the Association and the Dallas, Harris, and Galveston Counties Medical Societies and presenting indoctrination talks by some of the key men in the state's medical organizations, were so successful in acquainting medical students with the practical features of their future medical practice that they are to be continued annually.

Regardless of how well each member of an organization, young or old, knows its program and joins in it, the public will not be favorably impressed unless the program is inherently good. The Association's 1954 program, while emphasizing internal relations, also makes note of the four points stressed last year in an effort to present a positive public relations program of value to patients and public.

Mediation committees have been and are being established by most of the county medical

societies as one of the medical profession's answers to public criticism alleging the high cost of medical care.

Another point provides for around-the-clock emergency medical service, recommending the establishment of county society telephone panels guaranteeing the provision of a physician in an emergency at any hour.

A special effort is being made to learn of the areas of physician shortage and to assist in the remedy of such shortages.

The fourth point is designed to make doctors' offices more efficient, friendlier, and incidentally more profitable by properly training medical secretaries and clerical assistants. The Association's Committee on Public Relations has prepared and released several thousand kits outlining proper secretary training and is continuing to offer help in this field to individual doctors and county societies.

A well planned and executed joint program is of the utmost importance, but organization alone cannot do the job. Public relations is the personal responsibility of individual physicians, and not until each physician does his share can maximum success be obtained. A physician's actions reflect on the entire profession, and his deeds add to or detract from the prestige shared by medical men the world over.

PART OF THE ANSWER

One of the chief cries of opponents of the medical profession and apologies of some of its friends has been "doctor shortage." Knowing that the only way to answer adequately the challenge posed by this phrase, the Texas Medical Association some months ago determined to find out exactly what situation exists in Texas and to do something to correct maladjustments if sizable gaps in physician care exist. At least a partial answer now is available.

The whole question was turned over to a special Committee on Doctor Distribution, composed of persons already familiar with the problems of rural health, medical economics, and public relations. With one statewide survey complete and another finished in one district and ready for expansion into other areas, the committee has at hand a reservoir of important facts which had been guessed at or unknown previously. For example, the doctors of Texas, more than 6,000 of whom answered a questionnaire, think that additional general practitioners are needed, especially in communities of less than 5,000 population and in northwest Texas. In Texas as a whole the average is 1 physician per 813 population as compared with 1 physician per 730 population nationwide. Calls any hour of the day will be taken by 87 per cent of all general practitioners and by 62 per cent of all specialists. In District 7, the pilot area for a survey of opinion among community lay leaders, not a single community of more than 800 population complained of insufficient physicians. These facts and others already obtained or to be obtained by the Committee on Doctor Distribution will be invaluable in answering legitimate claims for help and misguided complaints from whatever source.

Since World War II, the Texas Medical Association has made a concerted effort to assist communities in need of physicians to obtain them. The Physicians Placement Service, operated in the central offices under the direction of the Council on Medical Economics, will continue to work closely with the Committee on Doctor Distribution to assist areas which should have additional physicians. This Placement Service recently has received recognition nationally for the service it is performing, not only for communities searching for doctors but for doctors attempting to establish practice in new locations.

Doctor distribution and health care as it affects the rural population, the spot at which most irritation occurs because of "doctor shortage," will be considered at length at the national Rural Health Conference to be spon-

sored by the American Medical Association in Dallas in March. Farmers, home demonstration agents, visiting nurses, and a wide variety of persons interested directly and indirectly in the promotion of better health will be present for the session in Dallas. With Texas the host state, more Texans than usual should attend this conference, and the exchange of information and opinion there should help in establishing a better understanding of the part which any community must play to assure for itself adequate health care and also of the aid which the medical profession is ready to provide. Physicians in attendance undoubtedly will get new insight into the life of rural people and will be more capable of accepting their role in the solution of mutual problems.

Possession of facts about doctor distribution, an aggressive program to place physicians where they are most needed, and establishment of liaison with lay leaders sharing a concern for better health give promise of creating not only a finer medical service but also a happier climate of public opinion.

CEREBRAL PALSY DATA SOUGHT

Help in obtaining authoritative information about the number of cerebral palsied patients in Texas and what facilities are available and needed for their treatment and training will be asked of physicians of the state within the next few weeks.

A voluntary committee of William G. Wolfe, Ph. D., director of special education in the Department of Educational Psychology at the University of Texas, Austin, chairman; Dr. Lewis M. Helfer, San Antonio; Dr. Ralph Hanna, Austin; and Leon Reed, graduate student in special education at the University of Texas, Austin, serving without pay, is administering a $10,000 grant from United Cerebral Palsy of Texas. A one year survey now beginning will be the first statewide study to ascertain just how big the cerebral palsy problem is and how it best can be met.

Doctors will be sent a simple form asking for the name, address, and birthdate of any cerebral palsy patients they have had. When this information is returned, the doctors will not be asked to spend more time on the survey; instead, parents, hospitals, and clinics will be asked to supply additional details. All information will be used for statistical purposes; individual case records will be kept confidential. The results of the survey will be generally available.

Cooperation with this survey may mean the compilation of data invaluable in the care of cerebral palsied patients.

Age in Medical School

As a group, older students are more likely to drop out without finishing medical school than are their younger companions, according to a study of the relationship between the ages at time of admission to Southwestern Medical School, Dallas, of students who were graduated and those who were not. A report of the study, conducted by Dr. Carmen Miller of the Department of Psychiatry at Southwestern and Dr. Don P. Morris, formerly of Southwestern and now professor of psychiatry and mental health at the University of Illinois, appeared in the January issue of the *Journal of Medical Education*.

Results show that a greater percentage of those who withdrew were in an older age group, suggesting that special care should be exercised by medical schools when considering the admission of older students.

Suggested explanations of the relationship between chronological age and success in medical school include the following: older students may not be as healthy physically; they may be dissatisfied more frequently with the work to a degree to cause illness; more are married and have financial burdens; they have more social obligations, making it difficult to keep up with school work; more of them were indecisive about entering medical school and lack real motivation; many have tried other fields and cannot adjust psychologically elsewhere or in medical school; many wish to take advantage of the GI bill and are not sufficiently motivated; certain intellectual abilities decline with age and disuse; and many older students have been away from the school situation for a period of time.

World Directory of Medical Schools

The first world directory of medical schools, listing more than 500 medical teaching institutions and giving essential data about each, has been issued by the World Health Organization. Of the 84 countries and territories listed as having medical schools, the United States has the most, 79. Next in order come Russia with 61, Japan 46, India 34, United Kingdom 27, France 25, and Italy 21.

ORIGINAL ARTICLES

GASTRIC CANCER
A Problem of the Internist

MANDRED W. COMFORT, M.D., Rochester, Minnesota

GASTRIC cancer is one of the challenging problems facing the medical profession. It is challenging because its management is far from successful. It is challenging because morbidity and mortality are staggering. Gastric cancer alone accounts for almost 15 per cent of the more than 200,000 deaths estimated to be the annual total of all deaths from cancer.[29] The statement that 1 out of every 200 patients who register at the Mayo Clinic has a gastric cancer always has brought home to me, as no other statistics have, the size and importance of the gastric cancer problem. This statement will undoubtedly interest others because the incidence of gastric cancer probably is not greatly different in other private practices. Such a problem invites continuing and critical review of the methods employed in its management.

Stimulating progress, nevertheless, has been made in the management of gastric cancer. Forty years ago it was the picture of advanced, inoperable gastric cancer with which the medical profession was familiar. A study by Berkson, Walters, Gray, and Priestley of mortality and survival among patients with gastric cancer seen at the Mayo Clinic between 1907 and 1916 disclosed that 60 per cent of the patients with this disease were subjected to laparotomy and only 22 per cent were found to have resectable lesions; 19 per cent survived resection, 7 per cent surviving for three years and 5 per cent for five years or more. Today the outlook has changed. Many more early lesions are being seen, as a similar study[5] of patients encountered between 1940 and 1949 disclosed. Of patients seen in these years, 80 per cent were subjected to laparotomy and 44 per cent to gastric resection; 40 per cent survived resection, 18 per cent surviving for three years and 14 per cent for five or more years. The statistical procedure whereby it is possible to know on January 1, 1951, the five-year survival rate among a group of patients, some of whom were seen as late as the end of 1949, is explained in a paper by Berkson and Gage.

Regarding the material from another statistical point of view gives a better idea of the improvement over the years than can be derived directly from the quantities given in the foregoing paragraph. In the earlier of the periods designated in the preceding paragraph, the operability rate was 60 per 100 patients on whom the diagnosis was made, and in the later of the two periods, it was 80 per 100, an improvement of 33 per cent. For the same periods other statistics were encouraging: resectability rate, 37 per 100 patients operated on as against 55 (improvement 48 per cent); hospital mortality rate, 16 per 100 patients subjected to operation as against 8* (improvement 100 per cent); three-year survival rate, 39 per 100 patients who underwent resection as against 43 (improvement 10 per cent); five-year survival rate, 29 per 100 patients with resection as against 35 (improvement 20 per cent).

To improved surgical technique much of these more favorable results may be attributed, but earlier diagnosis, improved preoperative and postoperative care, better anesthesia, the sulfonamide drugs, the antibiotics, and perhaps other factors have contributed. Gastric cancer clearly may be classified as a curable disease.

These data present the good side of the outlook today. To present the other side, it must be said that of the later group of patients, 20 per cent had hopelessly inoperable lesions on admission; that although 80 per cent underwent exploratory surgery, 36 per cent did not have resectable lesions; and that of the 44 per cent who had resectable lesions, 68 per cent died within five years of operation. Moreover, it is important to note that survival rates did not increase in proportion to resectability rates. Unquestionably there is room for improvement. Wherein does this lie? Many approaches have been suggested. These may be discussed under some such headings as prevention, early diagnosis, new and improved methods of diagnosis, and new and more effective methods of therapy.

PREVENTION

Heredity and environment play a role in the genesis of certain human cancers,[18] but the importance of these factors in the etiology of gastric cancer remains to be proved. Families in which gastric cancer apparently occurs with a frequency greater than in the general population occasionally are seen, but such families have not been well documented as have families subject to breast cancer. Carcinogenic agents, both

From the Division of Medicine, Mayo Clinic.
Read before the Section on Internal Medicine, Texas Medical Association, Annual Session, Houston, April 29, 1953.

**Mortality rate, of course, improves when it is reduced.*

physical and chemical, have been sought in man's food. Klein and Palmer raised the question of the importance of heat in esophageal and gastric cancer of man, because as pointed out by Lerche, carcinomas of these structures tend to predominate in regions just proximal to points of narrowing as do cicatricial strictures of these organs owing to ingestion of corrosive fluid. Gastritis, presumably a precancerous lesion, has been ascribed to food too hot or too cold, and it has been postulated that carcinogens are produced in the food by overheating of cooking oil and fats. However, experimentalists to date have failed to produce adenocarcinoma of the glandular stomach (the part comparable anatomically with the human stomach) of the rat or mouse by such physical and chemical agents orally administered, even after destruction of the mucous barrier[19] suspected of preventing their action, or for that matter by orally administered carcinogenic hydrocarbons of known potency.[3] Neither clinical nor experimental data at present justify screening of all members of the family in which gastric cancer appears (except the rare but frankly cancer-prone family) or the studied alteration of eating or working habits. A preventive approach to gastric cancer has not been found.

EARLIER DIAGNOSIS

Berkson, Walters, Gray, and Priestley's study of mortality and survival in gastric cancer disclosed that, while only about 1 per cent of patients who were subjected only to explorative or palliative operation lived five years, about 32 per cent of those who underwent resection lived this period of time; and while only about 20 per cent of those whose cancers had undergone metastasis lived five years after resection, about 50 per cent of those who did not have recognizable metastatic growths lived this period of time after resection. These data clearly imply that the earlier the lesion reaches the surgeon the higher the survival rate and that the kernel of the problem of increasing survival rates lies in getting more patients into the hands of the surgeon not only while the growth is resectable but before metastasis occurs. In other words, diagnosis must be made earlier than has been possible in the years gone by.

Early diagnosis of gastric cancer is difficult. It is difficult because early symptoms are mild and readily attributable to allergy, food intolerance, and functional disturbances; because the cancer may be superimposed on long-existing functional or organic dyspepsia; and because cancer may be advanced before symptoms appear. Nevertheless, early diagnosis should be possible more frequently if it has not been delayed by self-medication, erroneous interpretation of symptoms, and inaccurate diagnosis.

Early diagnosis may be accomplished in several ways, and the most important of these is education. The public can be educated to seek the physician for careful evaluation of all dyspepsia soon after onset and for yearly examinations. The physician can be urged to remain alert to the possible significance of dyspepsia or loss of weight, especially in those of cancer age, and to the need for promptly localizing the lesion responsible for dyspepsia. To him the point may be stressed that any gastric lesion may be malignant and that it should be treated nonsurgically for only a short time at most; that cancer of the stomach is not a hopeless situation, as the quoted data so well show; and that early exploration is advisable when there is doubt about the nature of the problem. Chairs of oncology currently being established in medical and dental schools will contribute importantly. They serve to increase the students' awareness of the disease, to present current knowledge of, and improve services to, the cancer patient, and to stimulate interest in cancer research. Cancer detection clinics likewise have an educational function. They serve to educate the public and alert the medical profession as well as to detect the cancerous and precancerous lesion.

Earlier diagnosis also may be achieved by frequent routine examinations for cancer. The more enthusiastic advocates of this method propose screening of the general population as is done for pulmonary tuberculosis and are encouraging the development of x-ray equipment and technique suitable for mass screening. The magnitude of the difficulties involved in, and the present impracticability of, such screening are apparent. The development of an easily performed blood test for cancer, one of great selectivity and reliability, appeals to many as a far more practical means of mass screening. Less enthusiastic advocates of screening methods propose screening only those segments of the population in which gastric cancer is more likely to develop than in the general population. These segments are composed of those with achlorhydria, pernicious anemia, and atrophic gastritis.

The assumption that gastric cancer is more likely to develop in persons with achlorhydria than in those with normal gastric acidity rests on the fact of the development of achlorhydria before gastric cancer in a large number of cases[8] and on the achlorhydric character of the gastric content after cancer develops in roughly 60 per cent of cases. Similarly, the assumption that gastric cancer is more likely to develop in the patient with pernicious anemia than in other persons lies in the recorded evidence that the incidence of gastric cancer and of the adenomatous gastric polyp[12, 25, 30, 33, 34] is greater among patients with pernicious anemia than among that portion of the general population which comes to necropsy. Evidence that the patient with atrophic gastritis, but without

pernicious anemia, is likewise especially liable to development of gastric cancer is less convincing, but the presence of achlorhydria in many cases of gastric cancer, together with frequent occurrence of atrophic gastritis in association with gastric cancer,[17, 41, 44] supports such a belief.

Roentgen-ray examinations of those persons within the cancer age whose gastric contents are achlorhydric, at intervals short enough to detect gastric cancer early, should alter significantly the five-year survival rate. It has been estimated[11] that there are 7 to 9 million or more people past the age of 40 years who have achlorhydria, that the incidence of gastric cancer in this group is eight to ten times greater than in the general population, and that about 50 per cent of gastric cancers should develop in persons of this group. Operation of a program of early detection of gastric cancer such as has been mentioned might be considered successful if the percentage of resectable lesions and the five-year survival rate among patients with resectable lesions were increased by 50 per cent. Attractive as the plan may be, the magnitude of the problem of accurately examining roentgenologically so many people renders it impracticable, at least with present methods of examination. Early diagnosis by screening is an idea sound enough to encourage the individual physician to screen some of his own patients by choosing those with low gastric secretory activity, and especially those with pernicious anemia and atrophic gastritis, for careful periodic observation.

The close relationship of two other conditions to gastric cancer requires critical management by the physician. The first of these is the adenomatous gastric polyp. It not uncommonly occurs in the same stomach with cancer, and as many as 35 per cent of polyps have been found cancerous.[28] In a recent study of 185 cases of pathologically verified adenomatous polyps made by Cromer, Butt, and me, the polyp was benign in 150 cases and malignant in 35 (about 19 per cent). The adenomatous gastric polyp justifiably is considered a precursor of gastric cancer and removal is indicated. The second of the two conditions is the benign appearing gastric ulcer. After long years of sometimes bitter debate the question of malignant degeneration of the benign gastric ulcer remains unsettled. The answer to this question is an important one, but from the practical clinical standpoint it is more important to have answers to two other questions. First, is the ulcerating lesion benign or malignant when first seen? And, second, is cancer likely to develop in stomachs diseased by benign gastric ulcer?

Regarding the first question, it is generally accepted that reliable clinical and roentgenologic criteria for prompt distinction between the small benign and malignant lesion do not exist (the meniscus sign—indicative of malignancy—properly interpreted is an exception to this statement). Even in the best of hands, from 10 to 20 per cent of benign-appearing ulcers have been found malignant on microscopic examination.[1, 14, 16, 24, 27, 40, 43]

As to the second question, certain data presented by Cain, Jordan, Gray, and me at least make us loath to deny that gastric cancer may develop in the stomach diseased from gastric ulcer. In a study of 414 patients whose small gastric ulcers had been medically treated, 226 were alive at the end of five years and had not undergone operation. Of these 226, 11 subsequently were found to have cancer. In 7 of the 11 patients, the diagnosis of cancer was proved by examination of tissue removed surgically or at necropsy. In these 11 cases it was difficult to believe that the gastric lesion was cancerous when first seen five or more years previous to the diagnosis of cancer, and it appeared that the cancer developed either in the ulcer or in the mucosa of the stomach diseased by gastric ulcer and at a rate far higher than that at which cancer develops in the general population (estimated rate 0.1 per cent). Because of such an incidence of gastric cancer among benign-appearing gastric lesions and such an incidence of gastric cancer appearing after years of medical treatment, it is difficult to take a casual attitude toward possible gastric malignancy in the patient with gastric ulcer. Prompt, complete, and permanent healing should be the criterion for continued nonsurgical management. The responsibility assumed by the physician who elects to prolong nonsurgical treatment of a gastric lesion that does not respond promptly when gastric resection is available at a mortality rate as low as 1 to 2 per cent has been emphasized repeatedly.

NEW DIAGNOSTIC METHODS

The mainstay in diagnosis of the intragastric neoplasm is the roentgenologic method. Its effectiveness is great. It will disclose a high percentage of the lesions, even small ones. However, in all frankness it should be said that its effectiveness naturally depends on the skill of the roentgenologist. Moreover, in all fairness in evaluating the method, one should remember that even in the hands of the most skilled persons, only lesions gross enough to be visible to the naked eye or extensive enough to produce recognizable rigidity and deformity of the gastric wall would be expected to cast shadows of diagnostic importance. Again, the roentgenologist not only has difficulty in visualizing a lesion but in distinguishing between the benign and the malignant lesion. It is important that the clinician be aware of the limitations of roentgenologic diagnosis, supplement roentgenologic diagnosis

with keen clinical judgment, and use to the fullest, supplementary methods, including surgical exploration when doubt persists.

Recognition of the limitations of roentgenologic diagnosis has led to search for, and appraisal of, methods more sensitive and more accurate than the roentgenologic method. These are many. Gastroscopic examination, which is of proved value in visualizing small gastric lesions, often fails in those cases in which the roentgenologic method likewise may fail, that is, when the lesion is in the cardiac portion or on the posterior wall of the stomach and when the infiltrative lesion is covered by a normal-appearing mucosa. Cytologic study of gastric washings[6, 39, 42] has not yielded satisfactory results to date, but perhaps variations of the methods now being proposed will make it a valuable aid. The use of papain[35] to dissolve mucus and increase the concentration of cells in the preparation to be examined or the employment of an abrasive balloon to remove the cells from the lesion itself[9, 31] are two more recent variations. Smears of the esophagus and cardia, obtained through the esophagoscope, have yielded valuable information.[2] Measurement of the differences in electropotential between the mucosa of the stomach and the skin is currently under study; it has been stated that the differences in potential in cases of cancer are unlike those in cases of ulcer,[15, 37, 38] but these differences may be attributable to variations in gastric acidity.[32] Rovelstad, Owen, and Magath have contributed to the understanding of the pitfalls of the method. Serologic methods, such as those proposed by Huggins and his co-workers[20-23] and investigated by Ellerbrook and his co-workers, as yet have failed to provide specificity or reliability to warrant their use to detect cancer in the stomach or elsewhere. The potential value of all such blood tests is so great that careful appraisal always is urgent.

New and more accurate methods of diagnosis are desirable but may be important only in proportion to the frequency with which gastric cancer gets into the clinician's hands early in the course of the disease.

NEW TREATMENT

Surgical removal of adenocarcinoma of the stomach is the sole therapeutic method of value in treatment of this disease. The increase in resectability and the decrease in surgical mortality rates are convincing evidences of the improvement taking place in application of this method. Roentgen therapy is of value in treatment of gastric lymphosarcoma. The high percentage of gastric cancers which reach the surgeon after the disease has spread beyond the stomach and a five-year survival rate of only 14 per cent point to the need for methods of therapy applicable to cases in which metastasis has taken place. Their discovery may await more fundamental knowledge of the cause of cancer.

COMMENT AND SUMMARY

A gratifying improvement in the outlook for the patient with gastric cancer has taken place in the past thirty years. It is a curable disease even with methods of therapy now applied. The surgeon has done a superb job and may be counted on for further technical progress. The increasing frequency with which total gastrectomy is being done for gastric cancer presages a further increase in resectability, but it remains to be seen whether increased survival rates will compensate for the large numbers of ensuing nutritional and dumping problems.

The gastric cancer patient, however, has not received full advantage of surgical therapy as now practiced. Slightly less than half of such patients are subjected to gastric resection, and of those who are subjected to it, about two-thirds die within five years. Even though resectable, the growth too often already has spread beyond the stomach into the neighboring nodes or organs. Without resorting to the more extensive surgical procedures, greater resectability and survival rates may be achieved by early and accurate diagnosis and institution of treatment before metastasis has occurred.

Critical appraisal of many of the problems involved in shortening the period between onset of the disease and diagnosis followed by surgical removal, together with the improvement in survival rates, suggests a program that should be attended by accomplishment to a gratifying degree. The program is fourfold:

1. The public will be informed that gastric cancer is a curable disease; that it is curable in proportion to the rapidity with which the patient reaches the surgeon and effective treatment is carried out; that certain symptoms indicative of gastric cancer require him to seek immediate and intelligent advice; and that self-medication may cause fatal delay.

2. The physician will be more alert than ever to the possibility of development of gastric and other cancer in patients entrusted to his care, particularly those with achlorhydria, pernicious anemia, and atrophic gastritis; properly conscious of the limitations of present methods of diagnosis, including roentgenologic diagnosis; fully aware of the potentiality of cancer in every intragastric lesion, even in a benign-appearing ulcer; fully aware of the danger of delay in dealing decisively with such a lesion; and convinced of the advisability of early surgical exploration in doubtful cases.

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3. Newer methods of diagnosis and skill in their application will be sought constantly.

4. Support will be given laboratory research into the basic nature of cancer and clinical research into the behavior of cancer, for from these researches will come the needed newer and more accurate methods of diagnosis and therapy.

Further advances in surgical technique probably will increase survival rates as they have in the past, but major dependence should be placed on diagnosis and surgical removal of a larger percentage of gastric cancers earlier in the course of the disease than is now done. In the successful operation of the aforementioned program, which is pointed toward early diagnosis, the physician—general practitioner and internist—will play a major role. It is he who will be most effective in education of the public, who will suspect and diagnose gastric cancer early in its course, who will direct the patient promptly to the surgeon, and who will secure for the patient the full benefits of today's surgical skill.

REFERENCES

A complete bibliographic list to which the reference numbers in the text refer will be included in the reprints.

ABSTRACT OF DISCUSSION

DR. MILFORD O. ROUSE, Dallas: We are indebted to Dr. Comfort for forcefully emphasizing the part played by the diagnostician—general practitioner, internist, or other physician—in improving the admittedly low salvage rate in patients with gastric cancer. At times it would seem almost that the public is more alert than is the medical profession. As Heller has said, we need to "evolve a sensibly cancer-conscious public mind—not a dangerously cancerophobic public." The great need is to find and to utilize effectively means to shorten the time between the onset of the condition, its diagnosis, and the initiation of treatment.

The tragedy of stomach cancer has three important components:

The first is the insidious, nonspecific onset of symptoms. In many instances the first real signs are of advanced disease. Unfortunately there are really no "early signs" of stomach cancer. Observations in cases coming to a second laparotomy where cancer recurs after a gastric resection would indicate a rather slow growth of gastric neoplasm in many instances. In most reports, six months is given as the average time from the probable start of a stomach cancer to the appearance of acknowledged symptoms. In an interesting paper by Cooper, "Patients, Physicians, and Gastric Cancer," in *The Journal of the American Medical Association* of October 18, 1952 (listed in Dr. Comfort's bibliography), a study at the New York Hospital brings out several unique observations on the "time schedule" of stomach carcinoma.

One must admit, regretfully, that at the present time there is woefully little the practicing physician can do to reduce this component. With optimism we may look forward to the future when research will produce a specific or universal diagnostic test which will mean to the cancer problem what the Wassermann test meant to syphilis and mass chest roentgen-ray surveys to pulmonary tuberculosis.

The second component is procrastination by too busy or indifferent patients. The active business man or the busy housewife tries home remedies first, then those suggested by well-meaning friends or the convenient corner druggist, until eventually increasing pain, vomiting, or gastric hemorrhage galvanizes such a person into tardily seeking a physician.

There are definite things to be done in reducing this component, mainly in sensible education of the public. The American Cancer Society has led in this endeavor for years. Practicing physicians should consider it part of their civic responsibility to speak on cancer to service clubs, parent-teacher associations, and women's groups and to make every use possible of access to radio and television programs. The women of the medical auxiliary cooperate splendidly. Modern health education through the health museum technique is worthy of widespread use. Physicians should beam all such education to the end of placing in the mind of the public the fact that cancer is curable when detected and treated sufficiently early. Such education can do much to remove the cancerphobia that makes miserable the lives of countless thousands who have heard just enough about cancer to make them thoroughly uneasy.

The third component of the tragedy of gastric cancer is the doctors' lack of suspicion and delay in establishing a diagnosis. Every patient with a digestive complaint has a right to expect that the physician whom he consults has the training, the intelligence, and a sufficiently acute suspicion of cancer to work out correctly the basis of trouble. We physicians have to be careful lest our commendable desire to bring all hope possible to fearful patients may make us optimists apparently hesitant to consider the possibility of such a grave condition as stomach cancer. Perhaps the press of too heavy a patient-load may make a physician slow to evaluate properly symptoms which should call for an immediate, intensive diagnostic study, which should be repeated if the findings are negative and the symptoms continue. The minimum responsibility of a doctor is to explain and recommend to his patient proper diagnostic procedures, especially roentgen-ray study, stool examination, and gastric analysis with gastroscopy where indicated. Failure to urge such a comprehensive study makes a physician *particeps criminis* if later a far-advanced stomach cancer is found.

We have to admit to ourselves that the existence of the three components mentioned is resulting in many, many unnecessary, preventable deaths. The solution rests in every physician's keeping uppermost in his diagnostic horizon the ever present possibility of cancer of the stomach in a patient with any digestive complaints.

CRIPPLED CHILDREN IN VALLEY GIVEN HOSPITAL

The Earl C. Sams Foundation has promised approximately $300,000 to erect a 50-bed center for the care and treatment of poliomyelitis victims and children crippled by disease and accident in the Lower Rio Grande Valley, the Harlingen *Press* reports. The Children's Center will be a part of the new Valley Baptist Hospital to be erected in Harlingen through the joint efforts of the Baptist General Convention of Texas and the people in the Rio Grande Valley.

The foundation was established by the late Earl Corder Sams, former president of the J. C. Penney Company, who with Mrs. Sams annually spent a month or more in Brownsville with their daughters, Mesdames Dean Porter and Larry Lightner. Mr. and Mrs. Porter and Mr. and Mrs. Lightner are trustees of the foundation.

MASSIVE HEMORRHAGE FROM THE UPPER GASTROINTESTINAL TRACT

Surgical Management

JAMES E. THOMPSON,* M.D., New York, New York

THE most common cause of massive hemorrhage from the upper gastrointestinal tract is peptic ulcer. It is the purpose of this paper to outline experiences in surgical management of this condition at the Roosevelt Hospital since 1946. During the six years from January 1, 1947, to December 31, 1952, there were 323 patients admitted to the hospital suffering from bleeding peptic ulcer. Of these, 174 were classified as hemorrhaging massively (table 1). This paper deals with this group, those whose lives were threatened by the extent of the hemorrhage. The main emphasis is placed on the emergency surgical treatment of this group, not only because it represents a radical departure from our former treatment, but also to add the report of our experiences to those of others.

TABLE 1.—*Hemorrhage from Peptic Ulcer at Roosevelt Hospital, 1940-1945 and 1947-1952.*

Type of Hemorrhage	No. Cases 1940-1945	No. Cases 1947-1952
Simple bleeding	97	149
Massive hemorrhage	50	174
Totals	147	323

The period 1940-1945 comprises only medically treated cases. The discrepancy in totals of the two six-year periods is explained by the fact that Roosevelt Hospital has a busy ambulance and emergency room service for which patients are accepted or transferred at the discretion of the resident physician and that during the 1947-1952 period the resident surgeons were actively interested in this type of patient.

Of the total number of patients with massive hemorrhage admitted to the surgical service in the indicated period, 85 were submitted to emergency surgery, while 40 were treated conservatively until bleeding had ceased and then underwent an elective or delayed operation (table 2). The remainder (49 cases) were treated conservatively, and all but the 4 patients in this group who died, ceased to bleed and were discharged from the hospital. Eight of these patients were readmitted later and underwent elective gastrectomy.

TABLE 2.—*Survival After Massive Hemorrhage from the Upper Gastrointestinal Tract, 1947-1952.*

Treatment	No. Cases	No. Deaths
Emergency operation	85	7
Elective operation	40	2
Conservative (nonoperative)	49	4
Totals	174	13

We did not have facilities to do blood volume determinations on these patients, so that other factors were relied upon in classifying them as massive bleeders. These criteria included visible evidence of the quantity of blood in vomitus or stool, rapidity of pulse, blood pressure, red blood cell count, hemoglobin determination, and hematocrit level. We found that a rapid pulse was the most consistent finding in those who had recently bled massively and was the most valuable indicator of recurrent bleeding. The blood pressure was unreliable at times because a fair percentage of our patients had hypertension, and we rarely had knowledge of the blood pressure levels they previously had maintained. The blood count and hemaglobin readings in some cases were completely misleading due to the extent of hemoconcentration and therefore could not be used as a reliable index to the extent of blood loss. In a few instances gross massive hemorrhage occurred after admission of the patient and the blood work-up which already had been performed was not repeated before proceeding with the operation. It is important to emphasize that not all of the massively bleeding patients had a blood pressure below 90 systolic or a red blood cell count below 2,500,000. In all instances, however, it was considered that life was threatened by the extent of blood loss.

It might be of interest to review the events which led us to abandon extreme conservatism in the management of severely bleeding peptic ulcer. At the Roosevelt Hospital until 1946, patients suffering from massive hemorrhage from the upper gastrointestinal tract were routinely admitted to the medical services. The medical management entailed cautious blood replacement and alternate trials with various types of dietary regimens. This was a procedure commonly followed in similar institutions all over the country. A surgical consultation was rarely requested at the onset of bleeding, and when the invitation came, it was usually as a last resort. The typical patient seen by the surgeon had ceased bleeding shortly after admission, only to suffer recurrent hemorrhage at intervals. He was slipping away in spite of repeated blood replacement and obviously would die unless the source of bleeding could be controlled. He was no fit

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**Chief of Surgical Service, Roosevelt Hospital.*

risk for surgery of the magnitude necessary to accomplish this objective.

This situation well illustrates the weakness of the surgical approach existing at that time. The surgical efforts to control massive hemorrhage in any of its stages were then so ineffective that a forbidding mortality resulted from their employment.

This was the status of our therapy until 1946. A surgical consultation occasionally was requested, but surgery rarely was attempted. The surgical literature at this time was beginning to rekindle interest in the subject and twice, once in 1945 and again early in 1946, we operated upon 2 patients who had been bleeding many days from duodenal ulcers. Both died; we believe they could have been saved had we followed the routine used today. The discussion aroused by these 2 deaths was responsible for the formulation of a plan of management that was employed in our hospital during the latter part of 1946 and put into effect on both surgical services beginning in 1947.

It was recognized by us at this time that after repetitions of blood depletion and replacement, a point is reached at which a patient cannot be relied upon to have the necessary recuperative powers to survive even though he is able to withstand the shock of operation. Accordingly it was arranged to have admitted to the surgical service all patients who were hemorrhaging from the upper gastrointestinal tract. The responsibility in this fashion was placed upon the surgeon to decide which patient was a candidate for operation and when it should be performed. On these two decisions lies either the success or failure of the surgical treatment of hemorrhage. We are more and more convinced that there are certain general rules to be followed but that they must not be too rigid.

MANAGEMENT

The patient or other source of information is carefully questioned as to the quantity and character of blood lost by vomitus or stool. Other important items of the history concern any story of indigestion or previous roentgen examinations that might indicate the existence of peptic ulcer. A hypertensive patient who knows the usual level of his blood pressure also can be helpful in an evaluation of the tension at the time of admission. Complete blood count, hematocrit, and blood urea nitrogen determinations are obtained.

Although blood in the intestinal tract may produce excessive blood urea nitrogen,[6] the levels shown in figure 1 indicate that clinically an elevation above 50 mg. per 100 cc. can be expected in only 10 per cent of the cases. The work of Gregory and others[4] has shown that prolonged drops of blood pressure into the shock levels will affect renal function and result in marked increases in the blood urea nitrogen. A reading above 50 mg. per 100 cc. therefore should be considered of serious import and, except under the most urgent circumstances, should be considered a reason for delaying operation until the patient's renal and cardiac status can be evaluated accurately. Some of these patients have hypertension with already established nephrosclerosis and thus represent poor risks for the added surgical trauma. In others the effect on renal function as shown at the time of admission may be secondary to a sustained drop in blood pressure into the shock levels. Such an effect on the kidney may have taken similar toll on myocardial nourishment, with the combination adding materially to the handicaps against the patient (cases 1 and 7). If more attention is paid to the fact that an elevated blood urea nitrogen level at the time of admission is of serious prognostic significance, we are sure the mortality can be lowered.

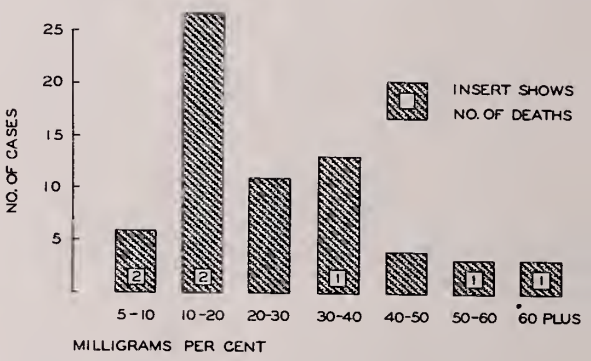

FIG. 1. Preoperative blood urea nitrogen determinations in 67 of 85 patients subjected to emergency gastrectomy for massive hemorrhage at Roosevelt Hospital, 1947-1952.

Following the taking of a careful history, nasogastric suction is commenced by placing a Levine tube in the stomach. It presents visible evidence of persistent or recurrent bleeding, and by removing gastric juices it seems to promote hemostasis. We never hesitate to order a swallow of diluted barium mixture to rule out esophageal varices if the patient gives a negative or doubtful history of ulcer. Great care is exerted to obtain this fluoroscopic and roentgen-ray examination with the least possible exertion on the part of the patient. In none of our cases was it harmful, and in many it has changed a doubtful to a positive diagnosis. A few patients, not included in this series, were shown to have esophageal varices and so avoided operation.

Transfusions of whole blood are commenced immediately. The amount given prior to operation has varied from 1 to 6 liters, depending upon the degree of depletion. Only occasionally has a patient in our group received more than 3 liters prior to operation.

If more was needed, the balance was given on the operating table.

INDICATIONS FOR SURGERY

We have no rigid rules by which to determine the patient who is to be submitted to surgery. A patient who has suffered previous hemorrhages of equal severity presents a strong indication for surgery, but

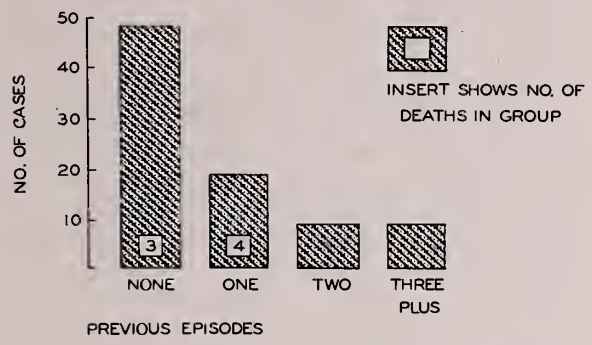

FIG. 2. Episodes of bleeding previous to the hospital admission for emergency gastrectomy for massive hemorrhage in 85 cases, 1947-1952.

this is not a necessary prerequisite. Of our 85 patients subjected to emergency gastrectomy 48 were experiencing their first hemorrhage (fig. 2) and 3 of these died. It had been our earlier misfortune to have patients succumb to fatal hemorrhage on the initial occasion and without the benefit of surgery. Age is definitely a factor, but never a limiting one (fig. 3). Our youngest patient was 22, and the oldest 81, but the majority were in the 40 to 60 year age group. It

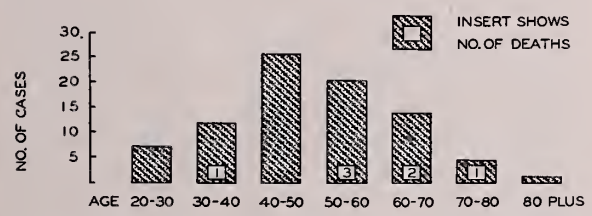

FIG. 3. Age incidence and related mortality in 85 cases of emergency gastrectomy for massive hemorrhage, 1947-1952. The only death in a patient less than 50 years of age occurred in the 1 total gastrectomy performed in this series (case 4).

is as great a mistake to rely upon the physiologic processes of youth to stop bleeding from an ulcer crater as it is to assume that an octogenarian cannot withstand emergency surgery.

We believe that the following are valid criteria for the employment of surgery:

1. Continued evidence of massive bleeding in spite of conservative measures.

2. Recurrent massive hemorrhage after a quiescent interval of hours or days.

3. Evidence of continuous oozing from an ulcer that makes it difficult to maintain normal blood levels by transfusion.

In general, we try to make our decision concerning surgery within seventy-two hours after admission of the patient, believing that delay beyond this period becomes dangerous procrastination. The poorest risk for surgical interference is the patient who has been bleeding for days or weeks and who has had his blood replaced time and again.

Contraindications for emergency surgery are the following:

1. Bleeding of doubtful origin.

2. Bleeding from esophageal varices.

3. Prompt cessation of hemorrhage under conservative management.

4. Admission blood urea nitrogen readings of 50 mg. per 100 cc. or above.

5. The presence of other serious disease, including hemophilia, which in itself would contraindicate surgery.

Many of the patients who presented contraindications to early surgery have had gastrectomy as an elective procedure. Elective operation has been performed during the same hospital admission when the patient has become a better risk or at a subsequent admission.

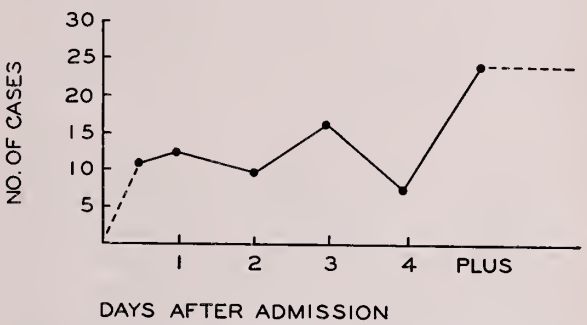

FIG. 4. Lapse of time between admission to the hospital and surgery in 85 cases of emergency gastrectomy for massive hemorrhage, 1947-1952.

The cases reported in this series come from two surgical services, and the operations either were performed or supervised by 18 attending surgeons. In spite of the rather large number of surgeons involved, the technique and surgical approach has been fundamentally similar. It is recognized that many of these patients bleed from an ulcer that cannot be seen or palpated through the walls of the duodenum or stomach. This fact has led us in such instances to employ exploratory gastrotomy which, as Amendola[2] recommends, may commence high in the fundus and extend well down into the duodenum. A more conservative gastrotomy incision is particularly useful in emptying the stomach of copious clots before attempting resection. Where esophageal varices or bleeding from

the lower duodenum and high jejunum were ruled out, we performed partial gastrectomy in all but 2 instances. In reviewing these 2 cases, in which the surgery was limited to a gastrotomy, one wonders if the surgeon was justified in the decision against performing a gastrectomy. This thought is expressed because in some of the gastrectomies the source of bleeding was discovered by the surgeon only after the stomach had been removed or subsequently it was shown by the pathologist to have arisen from a small previously undetected ulcer or from multiple gastric erosions. In the 2 cases negative by virtue of the gastrotomy, there still exists the possibility that a small acute ulcer or microscopic gastric erosion was present in the remaining fundus.

It is for this reason that one should not depend completely upon the gastrotomy incision to rule out the necessity for gastrectomy when inspection of the stomach lining fails to reveal the bleeding point. The rugal folds in the main body of the stomach often hide superficial ulcers that may not be discovered until the removed specimen is washed under a water tap.

The main values of a gastrotomy incision are (1) to rule out the presence of esophageal varices; (2) to note the presence or absence of fresh or old blood in the stomach; (3) temporarily to transfix actively bleeding ulcers; and (4) on rare occasions in the presence of high gastric ulcers, to aid in deciding the exact level of resection.

It would be unwise to recommend blind resection as a routine procedure because of the occasional case of bleeding from esophageal varices that cannot be detected without a gastrotomy. A stronger objection is the possible establishment of a principle that in inexperienced hands might lead to needless surgery.

When examination of the removed stomach specimen and careful scrutiny of the open duodenal stump fails to demonstrate the source of bleeding, the remaining fundus should be examined carefully. This of course means an open anastomosis. Following these principles, one can expect to find the lesion in practically every case (table 3). One must never overlook the rare possibility that the site of hemorrhage might be from a low lying duodenal ulcer, a lesion of the papilla of Vater, or an aneurysm communicating with the third part of the duodenum.

TABLE 3.—*Source of Bleeding in 85 Cases of Emergency Gastrectomy for Massive Hemorrhage, 1947-1952.*

Source of Bleeding	No. Cases
Duodenal ulcer	55
Gastric ulcer	22
Gastrojejunal ulcer	3
Gastric erosions	3
Carcinoma of stomach	1
Unknown	1

The type of gastrectomy employed has been uniformly the anterior Polya procedure with the Hoffmeister modification, placing the proximal loop of the jejunum to the lesser curvature, the operation ascribed to Von Eiselsberg. The amount of stomach removed varied from 65 to 75 per cent. In 1 case a total gastrectomy was performed on the erroneous impression that an ulcer high on the lesser curvature was carcinomatous. In this 32 year old woman the ulcer had perforated into the lesser omental sac and there was a copious amount of blood free in the general peritoneal cavity. The patient subsequently died (case 4).

We have not resorted to palliative surgery such as multiple artery ligations, local excisions of bleeding gastric ulcer, or any local, definitive hemostatic suturing of the ulcer base. It is thought that this type of operation is completely inadequate although artery ligation may be a useful adjunct during a gastrectomy.

TECHNIQUE

The ease with which these patients have tolerated the operative procedure has been a source of surprise and gratification. Adequate blood replacement is the major factor in this success. If necessary, blood should be given into two extremities from the start of the procedure, and it is recommended that a polyethylene tube be placed into a vein in the lower extremity preliminary to bringing the patient to the operating room. Once the blood supply to the stomach is ligated, and just prior to the actual removal of the organ, the active bleeding in the ulcer will cease as a rule. The case presenting an erect stump of artery in an ulcer base is often observed by the operator through a preliminary gastrotomy incision, and here transfixion of the bleeding point as a preliminary adjunct to definitive surgery is of value. Occasionally the bleeding gastroduodenal artery is buried so deeply in the scar tissue of the ulcer that it cannot be isolated until the later stages of the gastrectomy. In this insance it may be necessary to do a pylorotomy and temporarily control the bleeding before proceeding with the gastrectomy.

A drain is almost routinely placed down to the duodenal stump and usually brought out through a right upper quadrant stab wound. The method of abdominal wall closure varies considerably, the most popular being a layer closure with interrupted chromic gut. In addition there are inserted closely placed stay sutures that include all layers but the peritoneum. On occasion only closely spaced interrupted stay sutures of silk or wire are used to include all layers of the abdominal wall in the closure. In a few, wire sutures are similarly used, buried against the fascia but not including the skin. In our cases, it

cannot be said that any of these forms of closure have provided complete insurance against disruption.

The Levine tube is left in the resected stomach and continuous suction applied. The usual practice is to remove the tube when the material aspirated from the stomach either is clear bile or no longer shows evidence of old blood. This occurs from twelve to thirty-six hours after operation. Once the Levine tube has been removed it is wise to have it reinserted at twelve hour intervals (morning and evening) to estimate and remove the residual gastric contents. Once the residue is below 100 cc., this procedure of "bailing out" the stomach is no longer desirable.

In contrast to the ease with which these patients withstand the trauma of operation, the postoperative course has been hazardous as compared to the recovery period following elective gastrectomy. Notably frequent among the complications encountered has been wound disruption. It occurred in 8 cases (table 4). This high incidence is explained on the basis of

TABLE 4.—*Major Complications in 85 Cases of Emergency Gastrectomy for Massive Hemorrhage, 1947-1952.*

Complication	No. Cases	Deaths
Wound disruption	8	
Small bowel obstruction	4	
Pneumonia	4	
Duodenal fistula	3	
Pancreatic fistula	2	
Coronary occlusion	2	1
Uremia	2	2
Thrombophlebitis	3	
Postoperative wound hemorrhage (hemophilia)	1	1
Cardiac arrest (at operation for complication)	2	2

blood loss and protein imbalance. We have discovered no preventive for it and it continues to cause serious concern. It was a factor in 2 deaths in our series.

Duodenal fistula was also a more frequent complication than we are accustomed to observe under less urgent circumstances. It was encountered only following the removal of ulcers of the duodenum and immediate prepyloric area. The high incidence of this complication is attributed to the fact that we have attempted perhaps unwisely to remove too many of the technically difficult duodenal and prepyloric ulcers. The operator in his eagerness to remove a firmly fixed ulcer often finds himself irrevocably committed to an insecure duodenal closure even before dissection of the ulcer from the head of the pancreas has been accomplished. This is particularly likely to occur in the presence of a large bleeding ulcer on the posterior and postero-superior surfaces of the first part of the duodenum. The only escape from this dilemma is to dissect beyond the ulcer and obtain healthy duodenum, but the danger of damaging the common duct may prevent the necessary prosecution of this dissection.

Complete mobilization of the second part of the duodenum, a maneuver suggested by Marshall,[5] has been a great help to us, and we recommend its use early in the gastrectomy. The common duct is thus exposed above and below the point where it passes behind the duodenum, and its relationship to the indurated ulcer area can be plainly seen. The exposure thus afforded has been extremely helpful in differentiating between the case in which safe removal of the ulcer bearing duodenum can be accomplished and the one in which the ulcer should be left undisturbed and the duodenal stump closed proximal to it.

When the decision is made not to remove the ulcer, and where such a step means cutting across the stomach proximal to the pylorus, it is important to excise the antral mucosa and close the stump as suggested by Bancroft.[3]

Other complications played a minor role to that of wound disruption (table 4). There were 4 cases of small bowel obstruction that required reoperation. One of these patients died from cardiac arrest during the induction of anesthesia (case 6) and another from associated nephrosclerosis and uremia (case 3). There were 2 known cases of coronary occlusion, one of which was fatal, and 1 patient (case 7) who died suddenly on the fifth postoperative day from what was probably a massive myocardial infarction (unlisted in table 4 because there was no autopsy). There were 2 cases in which uremia played a major part in the fatal outcome (cases 1 and 3).

There were many minor complications including atelectasis, mild wound infection, and 4 cases of transient mild jaundice. There were 2 cases in which mild postoperative gastric hemorrhage was thought to have arisen from the line of anastomosis.

In treating wound disruption it is our opinion that the use of general anesthesia is hazardous because it enhances the possibilities of death from aspiration or cardiac arrest. Sedation of the patient with morphine and closure of the wound after generous infiltration of the abdominal wall layers with Novocain is an extremely easy and a safe method. The technique of closure entails the insertion of closely spaced interrupted sutures of braided silk or wire to include all layers of the abdominal wall.

A helpful method of treatment of an established duodenal or pancreatic fistula which persists beyond the usual period and which shows no tendency to spontaneous cessation is the use of strong suction. A snugly fitting catheter is placed into the fistulous tract a distance of no more than half its depth, and continuous suction applied. The strength of the suction is sufficient to collapse completely the tract

beyond the tip of the catheter, thus promoting closure. In 1 case, drainage permanently ceased after twenty-four hours of this treatment.

ANALYSIS OF DEATHS

An analysis of the deaths in the emergency operation group of patients in our series follows:

CASE 1 (1947).—J. H., a 56 year old man, began to have "coffee ground" vomitus fifteen hours before coming to the hospital. He was admitted in marked shock. Blood pressure was scarcely obtainable at 30 systolic, and blood urea nitrogen measured 94 mg. per 100 cc. (not reported until after operation). Subtotal gastrectomy was done forty-eight hours after admission for bleeding duodenal ulcer. The common duct was injured in removing the ulcer, and a T tube was placed in the rent to act as a common duct drain. Death occurred on the fourth postoperative day from uremia. No autopsy was performed.

Comment: This patient was not a proper subject for emergency surgery. Delay, with a drop in the blood urea nitrogen level, might have permitted safer elective surgery.

CASE 2 (1948).—T. S., a 56 year old man and a known hemophiliac since youth, had had one previous gastrointestinal hemorrhage eight months before. Profuse hematemesis of "coffee ground" material began the day before the patient entered the hospital and continued until gastrectomy twenty-four hours after admission. A bleeding duodenal ulcer was found involving the posterior wall of the first part of the duodenum. A stormy convalescence followed with continual oozing of blood from the drain that led to the duodenal stump. Multiple small transfusions were given in an attempt to reduce the clotting time. Wound separation on the tenth postoperative day was controlled by adhesive strapping. The patient died on the eighteenth postoperative day. At autopsy the only significant finding was an abdomen filled with old blood clots and considerable fresh blood.

Comment: This was a desperate case. Hemophilia probably represents a contraindication to the surgical approach to massive hemorrhage.

CASE 3 (1950).—W. P., a 68 year old man with severe hypertension, was admitted for treatment of low back pain. He suffered massive hemorrhage five days after admission to the hospital. Hemoglobin measured 4.0 Gm. per 100 cc. of blood, the red blood cell count was 1,970,000 per cubic millimeter, and the blood urea nitrogen was 8.0 mg. per 100 cc. A 6,000 cc. blood transfusion was given preoperatively. Operation was performed twenty-four hours after hemorrhage commenced; the blood pressure was 60/0 at the start of the procedure. An additional 4,000 cc. of blood was transfused on the operating table. The blood pressure was not obtainable during the first hour of the operation. At this time bleeding was controlled and the blood pressure gradually rose and stabilized at 140/100. The patient was well until the seventh postoperative day, when he developed signs of incomplete obstruction. This progressed, and on the twenty-first postoperative day, an entero-enterostomy for efferent loop obstruction was performed. The patient developed oliguria, then cardiac decompensation, and died nineteen days after the second operation. Autopsy revealed nephrosclerosis and tubular necrosis as the main cause of death.

Comment: This patient would have died without the emergency surgical intervention and probably would have lived had he not developed small bowel obstruction.

CASE 4 (1950).—E. T., a 32 year old woman, was admitted with severe epigastric pain. A gastrointestinal series and gallbladder visualization were negative. On the fifteenth hospital day she had a massive gastric hemorrhage of bright red blood and dark red blood in her stool. The blood pressure dropped to 80/50 and rose to 115/70 after a pressure transfusion. She bled again one hour later and was then taken to the operating room. A 5,000 cc. blood transfusion was given during the operative procedure. Exploration revealed a perforated lesion of the posterior aspect of the cardiac end of the stomach near its junction with the esophagus, and quantities of fresh blood were found in the peritoneal cavity. The incision was converted into a thoracoabdominal wound, and a total gastrectomy was performed in the belief that the lesion was malignant. The final pathologic report was "chronic perforated gastric ulcer." Convalescence was stormy with considerable cyanosis requiring an oxygen tent. On the seventh postoperative day the abdominal part of her wound disrupted but was temporarily closed with adhesive strapping. The following day formal closure was attempted under Pentothal anesthesia. The patient aspirated jejunal contents, developed a cardiac arrest, and died in spite of an attempt at cardiac massage.

Comment: As a result of similar experiences in closing wound disruptions under general anesthesia, we now resort to local anesthesia.

CASE 5 (1951).—L. O., a 55 year old man, a chronic alcoholic, was admitted to the surgical service for the care of varicose ulcers and dermatitis of the lower extremities. His blood pressure was 200/110 and he was known to be suffering from a duodenal ulcer. On the second hospital day he vomited 200 cc. of "coffee ground" material and subsequently had brown but guaiac positive stools. During the next few days he became disoriented, probably due to alcohol withdrawal, but the disorientation was transient. Three weeks after admission he had a massive hemorrhage, and the hematocrit level, which had been within normal limits, dropped to 25 per cent and the blood pressure fell to 140/80. The blood urea nitrogen level at this time was 32.5 mg. per 100 cc. Clinical evidence of bleeding persisted in spite of transfusions, and on the twenty-fourth hospital day an emergency gastrectomy was performed, and a posterior wall duodenal ulcer was removed. The postoperative course was progressively downhill. Blood urea nitrogen increased to 55 mg. per 100 cc. The patient excreted little urine, and he died on the fifth postoperative day. Autopsy revealed death to be due to an acute massive myocardial infarction.

Comment: This patient should have been considered too poor a risk for surgery.

CASE 6 (1952).—H. B., a 66 year old man, was admitted to the hospital with a three day history of tarry stools and with bright red vomitus on the day of admission. The hematocrit level was 25 per cent, blood urea nitrogen 30.8 mg. per 100 cc., and blood pressure 125/75, and his general condition was good. Surgical intervention was not contemplated, but on the third hospital day bleeding recurred and an emergency gastrectomy was performed. Convalescence was uneventful until the fourth day, when he began to show evidence of some gastric retention. This symptom progressed and a roentgenogram showed evidence of a high, efferent loop, partial obstruction which on the tenth

postoperative day became complete, and the patient was taken to the operating room for an exploratory laparotomy. During the induction of anesthesia with Pentothal and Intocostrin, he suffered a cardiac arrest and died in spite of an attempt at cardiac massage.

CASE 7 (1952).—J. W. B., a 75 year old man, was admitted to the hospital eighteen hours after the onset of weakness and the passage of black stools. He gave the history of one similar episode three years before. There had been no nausea or vomiting. On admission he was weak but not in shock. The pulse rate was 90 per minute and his blood pressure 100/60. The hemoglobin was 10.1 Gm. and the blood urea nitrogen 51.8 mg. per 100 cc. It was decided to treat the patient conservatively, and he was given 500 cc. of blood by transfusion. Late on the second hospital day the bleeding recurred massively and the patient went into shock. The hemoglobin, which had already dropped to 9.0 Gm., fell to 8.0 Gm., and the patient was given 1,000 cc. of blood. At this time the blood urea nitrogen had dropped to 49.9 mg. per 100 cc. The morning of the third hospital day, fifty hours after admission, a gastrectomy was performed as an emergency because the patient showed clinical evidence of continued bleeding. Two duodenal ulcers were found and both were removed with the stomach specimen. Convalescence was uneventful except for an elevation of temperature to 104 F. on the second postoperative day. While in a wheel chair on the fifth postoperative day, the patient developed extreme dyspnea, became red faced, and then complained of severe bilateral lower abdominal pain. He died within three minutes of the onset of the symptoms. No autopsy was done.

Comment: It is assumed that this patient died from a massive myocardial infarction. His high blood urea nitrogen level (above 50 mg. per 100 cc. on admission) represented what we now believe to be a danger signal. Except under the most urgent circumstances delay is indicated until the renal and cardiac status of such patients can be accurately evaluated and perhaps improved.

An analysis of the deaths in the delayed or elective surgery group follows:

CASE 8 (1948).—H. M. W., a 69 year old man, was readmitted to the hospital for medical treatment of a chronic duodenal ulcer. He was also suffering from pulmonary emphysema and cor pulmonale. There was no previous history of melena or hematemesis. Shortly after admission he began to have almost continuous tarry stools, and blood studies at this time showed hemoglobin 7 Gm. and red blood cells 2,500,000. Bleeding ceased after several weeks only to recur at intervals, and he was given many transfusions. On several occasions surgical consultations were obtained, but the patient was considered too poor a risk for operation. Finally, 116 days after his admission to the hospital, a rapid pyloric exclusion type of gastrectomy was performed; the duodenal ulcer not being disturbed. The patient died on the fourth postoperative day with oliguria and a blood urea nitrogen of 67 mg. per 100 cc.

Comment: This patient should have been considered too poor a risk for surgery.

CASE 9 (1952).—R. A., a 54 year old man, was admitted to the hospital following a twenty-four hour period of bleeding massively from the upper gastrointestinal tract. He had a long history as a sufferer from a chronic duodenal ulcer with several previous episodes of bleeding and had hypertension with a blood pressure of 210/120 on admission. A total of 6,000 cc. of blood was administered by transfusion during the first forty-eight hours, and at the end of this period, there was no further clinical evidence of bleeding. The blood urea nitrogen on admission was 99 mg. per 100 cc.; it rose to 107 mg. and on the eighth hospital day came down to 44 mg. A partial gastrectomy was performed on the eleventh hospital day as an elective procedure and a prepyloric gastric ulcer was removed. The postoperative course was marked by gradually increasing disorientation; the blood urea nitrogen level gradually rose to 175 mg. per 100 cc., and the patient died on the nineteenth postoperative day. At autopsy the kidneys were found to be small and markedly nephrosclerotic.

Comment: This case illustrates a real contraindication to surgery: the combination of hypertension and an admission blood urea nitrogen level of 99 mg. per 100 cc.

RESULTS

In analyzing the results of our approach to the management of massive hemorrhage, attention is directed to table 2. It compares the 85 patients who underwent emergency gastrectomy and the attendant mortality with the 40 who ceased hemorrhaging and underwent an elective procedure later during the same hospital admission. It also lists 49 patients who had no surgery because they were considered to be candidates that could safely weather the storm. Two deaths in the latter group represent two mistakes in judgment. Another patient was considered too poor a surgical risk and died shortly after admission without surgical intervention. Still another was on the medical service two days before being treated for massive myocardial infarction before the true cause of his shocked state was discovered. He died before we were able to get him in shape to withstand surgery.

A review of the deaths in the emergency group (cases 1 to 7) reveals that a few deaths might have been avoided if surgery had been delayed. Each added year of experience has modified our ideas, and our initial enthusiasm for surgery is being tempered with conservatism. We have made mistakes in a few instances in which we believed early surgery was safer than delay, but only once have we repeated the old mistake of delaying too long (case 8).

Death as a result of emergency gastrectomy occurred in less than one-tenth of the cases, the same level which prevailed in those who were subjected to no surgery during the 1947-1952 period. Deaths in only one-twentieth of the patients subjected to elective gastrectomy brought the overall mortality for massive hemorrhage down to less than 1 death in 13 cases. The surgical management employed during the past six years thus seems justified when this figure is compared with the 1 death in 5 cases which prevailed during the previous six year period of conservative, nonoperative management.

SUMMARY

A six year experience with the surgical management of 174 cases of massive gastroduodenal hemorrhage is reviewed. Eighty-five patients were subjected to emergency gastrectomy; 40 underwent elective gastrectomy after hemorrhage had ceased and during the same hospital admission; 49 were treated conservatively without operation.

The treatment of these cases is outlined, and the indications and contraindications to operation are discussed. A blood urea nitrogen elevation above 50 mg. per 100 cc. upon admission of the patient to the hospital is considered a serious prognostic sign and, except under the most urgent circumstances, warrants delay until the patient's renal and cardiac status are thoroughly evaluated.

Duodenal ulcer represented the most common source of hemorrhage (55 of 85 cases), and carcinoma as a cause was encountered only once.

The patients withstand operation well if bleeding has not been allowed to continue over too long a period, and if they receive adequate blood replacement before and during the operation.

The postoperative convalescence following emergency gastrectomy for hemorrhage is likely to be a stormy one with wound disruption occurring in 10 per cent of the cases.

Patients suffering from massive gastroduodenal hemorrhage present potential surgical problems and should be admitted to the surgical service. Gastrectomy with or without preliminary gastrotomy is the operative procedure of choice. Only a small proportion of the total will require operation within twenty-four hours of admission. A larger number will suffer serious recurring hemorrhage after a quiescent interval and then should be subjected to a gastrectomy. The remainder can be discharged under medical management. Many will need to return at a later date for an elective operation.

The surgical management which we have employed during the past six years has reduced the mortality of massive hemorrhage in our hospital from 1 death in 5 cases to less than 1 death in 13 cases.

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ABSTRACT OF DISCUSSION

Dr. GEORGE W. WALDRON, Houston: Dr. Thompson has given an excellent report of progress in the treatment of a serious and sometimes baffling problem. His emphasis upon an immediate surgical appraisal of each case is important. A surgeon should be on the job from the time of admission of the patient, not only to decide whether surgery is indicated at once, but also to be able to follow through with a decision as to whether surgery is needed at all and if so, at what point.

On a hospital service such as Dr. Thompson directs it is possible to control admissions to various services, but the same cooperation in reference to massive hemorrhage must be attained throughout private practice if the death rate in such a condition is to be widely reduced. Recent conversations with a number of internists indicate that they, as a group, are greatly interested in early surgery in these cases.

I believe that there should be no question about blood replacement on admission and also during surgery. It always has seemed unsafe to allow a patient to bleed down to a point at which the blood pressure is so low that coagulation may be enhanced. Needless loss of life will occur if such a course is pursued.

The patient's age or the number of previous hemorrhages will not necessarily determine the urgency of surgery at the time the patient is first seen, though these facts may have some bearing on any decision. Certainly the importance of judging when surgery is to be done is just as great as whether it is to be done at all.

There is one group of cases which has been uppermost in the minds of surgeons in this area recently and that is the group having massive hemorrhage from the entire gastric mucosa or a large part if it is mainly the upper half. Three such cases have been reported in Houston in the past year or so. Apparently the condition is a type of hemorrhagic gastritis and the ulcerations are punctate in character. The lesions are hard to find at operation and the usual subtotal gastrectomy will not stop the bleeding, nor will an attempt to tie off the blood supply to the stomach. If this condition is confined to the stomach, a total gastrectomy will stop the bleeding, but if the upper small bowel is likewise affected, it will not control it.

I recommend Dr. Thompson's opinion regarding gastrotomy and open anastomosis. One must see the inside of the stomach and the duodenum to keep out of trouble in many cases. An open anastomosis also allows definite control of hemorrhage and causes less trauma to the remaining tissues.

One point regarding the duodenal stump is helpful and that is the utilization of a catheter in the stump for external drainage in cases in which the stump cannot be satisfactorily closed following the resection of a duodenal ulcer. In seven to ten days the catheter can be removed and the tract will close almost immediately. There is no skin irritation. In such a case I find this method preferable to leaving a soft rubber drain in the region of the poorly closed stump.

Regarding closure of the abdominal wall, I believe that the so-called secondary type of closure should be done at the initial operation. Few of these will break down.

"Should our towns and cities be attacked, a civil defense program instantly ready to minimize casualties and restore facilities vital to the prosecution of the war may mean the difference between victory and defeat. . . ."—U. S. Congressman Melvin Price.

DUODENAL DIVERTICULA

Radiologic Evaluation

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Fort Worth, Texas

SACCULATIONS in various parts of the gastrointestinal tract have stirred the interest of many radiologists. Although diverticula rarely produce much discomfort, their presence often is strikingly outlined and commands one's attention. In spite of good contrast there are times when the limitations of fluoroscopy and radiography impose restrictions upon the radiologist's interpretation. Such a difficulty was encountered in the following case.

CASE 1.—A 60 year old white woman with known lung metastases, who had had a carcinomatous breast removed in September, 1950, entered the hospital March 3, 1952, because of massive melena. A transfusion using 1,500 cc. of blood was required to bring the blood picture to a normal state.

A gastrointestinal tract examination performed a short time thereafter revealed that the duodenal bulb was of normal shape and activity but lay closer to the midline than usual. The loop extended far posteriorly and upward almost to the diaphragm. It filled rapidly and remained greatly dilated. Little barium passed through the duodenojejunal junction, which lay far to the right and in the usual position of the bulb. Multiple diverticula were present in the third portion and averaged 1 cm. in diameter. The findings were puzzling and the true interpretation was not evident.

Because of impending obstruction a laparotomy was carried out April 9. The surgeon reported the presence of a diverticulum measuring 15 by 20 cm. which arose from the lateral aspect of the descending duodenum and which had a large stoma. It was adherent to the posterior peritoneal surface and was not removed because of the patient's condition. The hepatoduodenal portion, as well as that portion of the gastrohepatic ligament attached to the antrum, was absent and allowed considerable mobility of the distal part of the stomach and the proximal portion of the duodenum. Several large serous cysts on the liver were present and one impinged upon the duodenojejunal flexure producing a partial obstruction. These were aspirated and the obstruction relieved.

A congenital deformity, the absence of the hepatoduodenal and gastric ligaments, therefore accounted for the unusual position of the organs. The large rapidly filling diverticulum had mistakenly been taken to be the duodenum. Its peculiarly large size and position may have been attributable to the congenital absence of the ligaments. The unanticipated and invisible cysts on the liver acted as the obstructing agent.

The unexpected surgical findings in this case first awakened our interest in diverticula. Since then we have observed much of interest, and in this paper we are presenting the fruits of our studies. In sequence are discussed the various types of diverticula, their origin, their incidence with the factors involved, their location, and finally their clinical significance.

Read before the Section on Radiology, Texas Medical Association, Annual Session, Houston, April 28, 1953.

NOMENCLATURE AND TYPES

The diverticula most commonly encountered probably belong to the false variety and could be called much more correctly mucosal herniations. By this term is meant that the diverticulum is a protrusion of the mucosa, submucosa, and muscularis through a defect in the longitudinal and circular muscular layers. It is lined externally by the serosa. In contrast, the true diverticulum is a bulge composed of all layers. Both the false and true diverticula may be of congenital origin; in the false the mucosa pushes through a developmental defect in the muscular layers, whereas in the true all layers form a sac from a bud during differentiation in growth. False diverticula most frequently are acquired. True diverticula also may be acquired but the premise would postulate disease in an adjacent organ. Inflammation in a lymph node followed by contracting adhesions might bring about such a defect.

One group of diverticula called pseudodiverticula must be distinguished from other types since diverticula in this class lie only in the duodenal bulb and represent the uninvolved remains of the bulb which has been puckered by contracting ulcer scars. Although the prefix "pseudo" is commonly translated by the word "false," in this case it does not refer to the commonly accepted classification of false diverticulum.

A chart derived from Blackwell's[3] discussion may make the differences clearer.

1. True diverticula include all layers of the gut. They may be (a) congenital (primary) or (b) acquired (secondary).

2. False diverticula include only mucosal layers protruding through the outer musculature. They may be (a) congenital (primary) or (b) acquired (secondary).

3. Pseudodiverticula are sacculations produced by the puckering action of contracting ulcer scars.

Radiographically, it is difficult to differentiate between the various types excepting pseudodiverticula in the first portion of the duodenum.

Whatever their type, diverticula consist of blind flasklike structures lined with mucous membrane, having a tunica muscularis and usually having a well formed neck. In consequence of a lack of muscularis propia they have no well defined peristaltic activity. They vary considerably in size and are characterized by a wide mouth which opens into the duodenum. In studies on cadavers Grant[10] noted that 60 per cent of diverticula had a mushroom or globular appearance, 15 per cent had a conical shape, and 25 per cent were tubular. At times they may be bilobed. Of interest with regard to the previous description, Knetsch[13] reported the instance of an unusually large diverticulum from the region of Vater's papilla which exhibited regular intrinsic peristaltic activity. One might conjecture that it represented a duplication of the duodenum or perhaps a true diverticulum of congenital origin.

Diverticula vary considerably in size. In our series of 22 cases the smallest measured 5 mm. in diameter, but it is evident that smaller ones exist. The largest was 8 cm. in diameter and was exceeded only by that in case 1, which was not included in this series. The latter, measuring 15 by 20 cm., may represent the largest recorded in the literature. One that may have been larger is attributed to Lockwood,[14] who mentioned a diverticulum containing 1,000 cc. of fluid.

ORIGIN

Although diverticula are frequently seen and studied, their origin is still shrouded in conjecture. The explanation based on a defect in development is easily accepted since one is accustomed to see congenital variations in other portions of the body.

The origin of acquired diverticula is less readily explained. The postulate that an area of lowered resistance exists in the wall where the vessels penetrate is commonly accepted. Beck[2] presented a theory of the origin of diverticula in the stomach which is unique and difficult to understand without a knowledge of the postulate of Gösta Forssell.[9] Gastritis is required. As the increased blood supply incident to the inflammation subsides, the volume and viscosity of the submucosa changes leaving a depression into

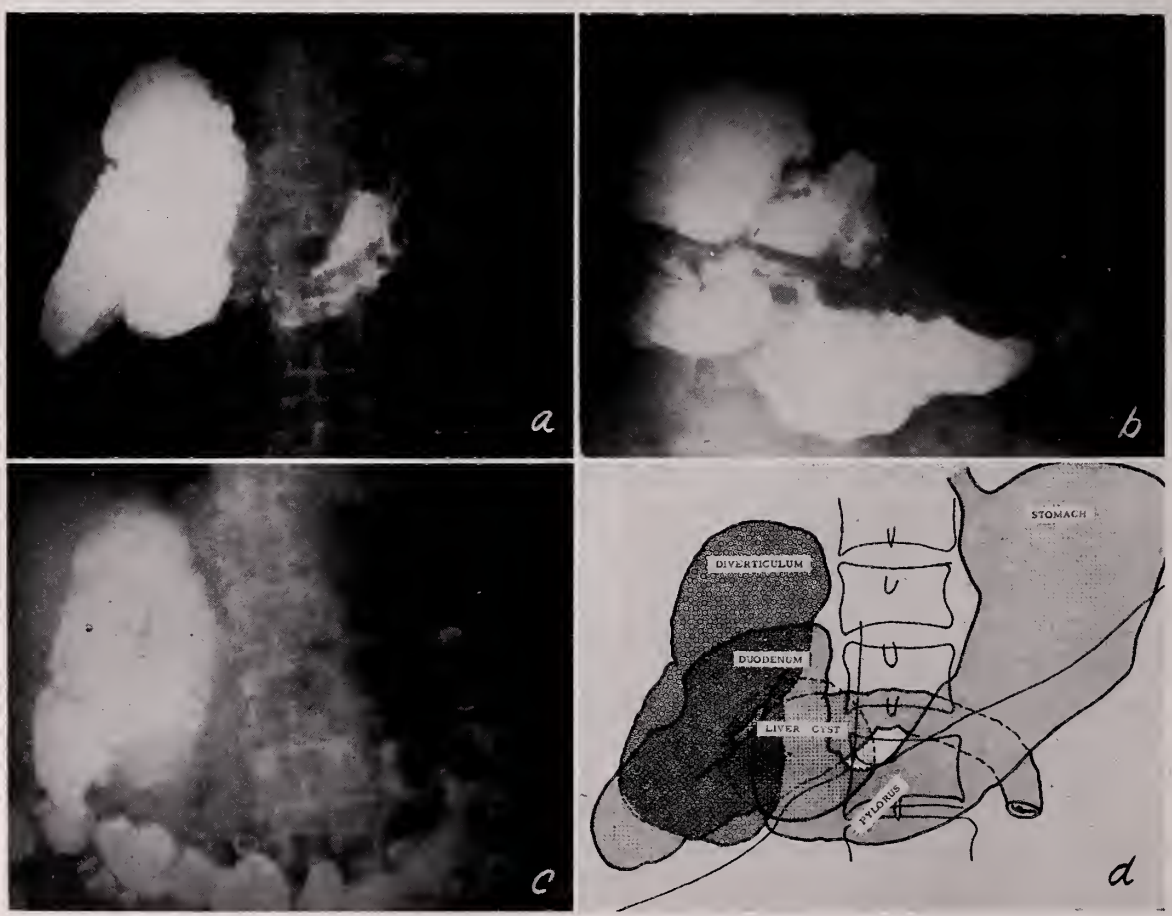

FIG. 1. Case 1. a. Anteroposterior view of the stomach and diverticulum.
b. Lateral view of the stomach and diverticulum.
c. Retention of barium in the diverticulum twenty-four hours later.
d. Diagram of the operative findings. Note the anomalous position of the duodenum, the cyst on the liver, and the large diverticulum.

which the mucosa flows by "autoplasticity." It is difficult to see how this theory could be applied to the duodenum.

Since the incidence of duodenal diverticula increases as the age of the person increases, Butler[4] suggests that they originate as traction diverticula at the site of arteriosclerotic intraduodenal vessels. In this early phase they still possess all the muscle coats, which split as the defect enlarges. Undoubtedly associated with vascular changes are senile changes in the supporting tissues such as are encountered in instances of hiatus hernia and inguinal hernia which frequently become manifest in later life.

Additional theories regarding the mode of development of diverticula may be summarized as follows: Some believe that traction of the adjacent blood vessels secondary to changes in nutrition and occasioned by visceroptosis may produce the focal points; others believe that local defects are produced by fatty degeneration, others that the inherent greater duodenal pressure occasioned by the closure of the pyloric sphincter plays an important part, and still others that a localized pancreatic necrosis is important. The merits and failings of the collected theories have been reviewed by Odgers.[17]

The theory which is probably the most acceptable, though not completely convincing, is set forth in Odgers' article in a passage which reads as follows:

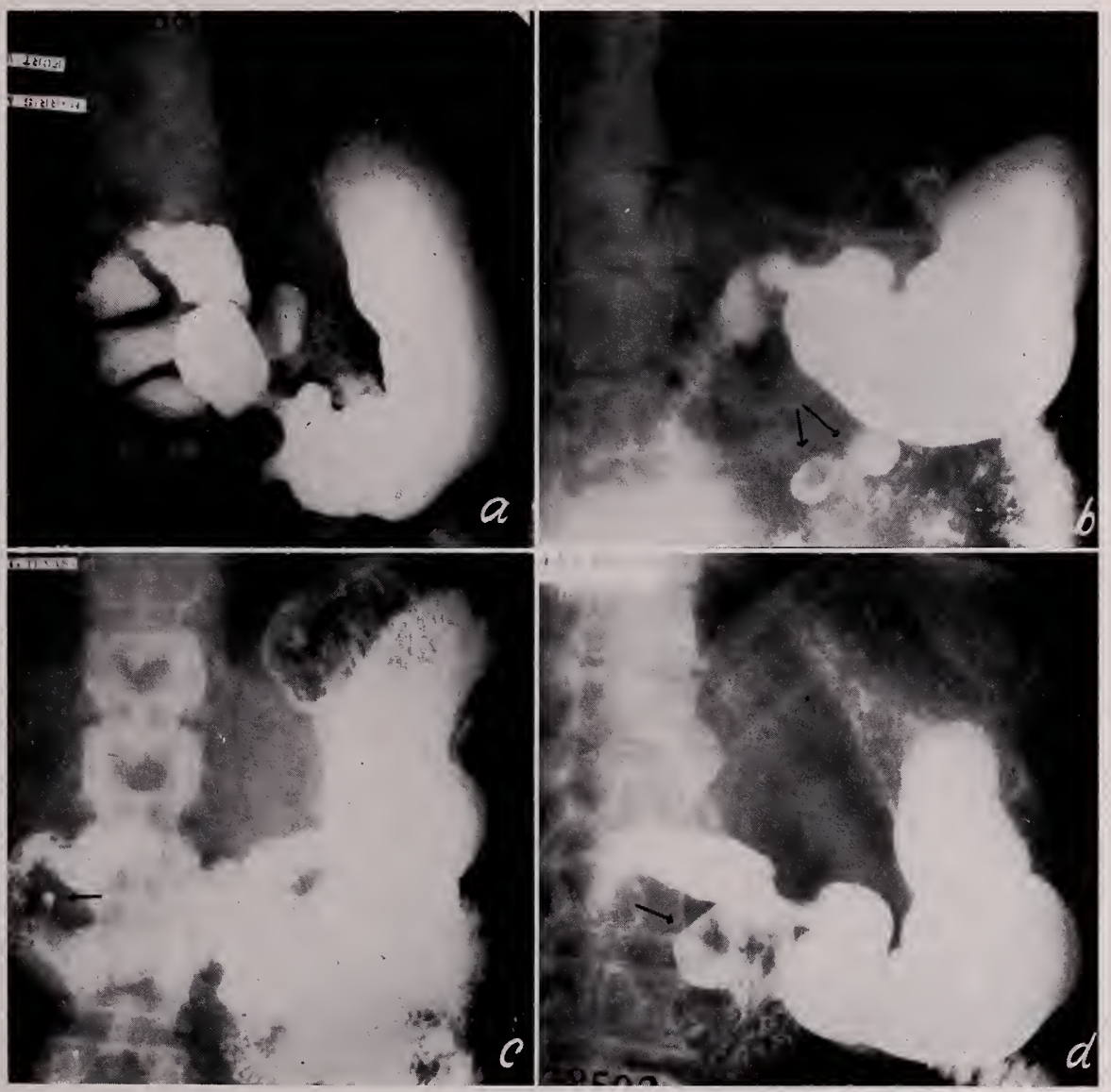

FIG. 2. a. Multiple diverticula in the descending and ascending portions of the duodenum.
b. A bilobate duodenal diverticulum.
c and d. Small (*a*) and large (*b*) duodenal diverticula.

"It is suggested that, at some time during the later six months of fœtal life, an exaggerated downgrowth of Lieberkühn's crypts may reach lacunæ in the muscular coat, where this is pierced by the blood vessels: the perivascular sheaths of the latter will then provide an easy path for any further extension. From such weak spots pulsion diverticula may arise during adult life."

Of particular interest and representing a source of speculation is the frequency with which deposits of aberrant pancreatic tissue are observed in the neighborhood of diverticula. At times this has been true in the esophagus, stomach, and duodenum. Horton and Mueller[11] have studied this phase thoroughly in postmortem material and have concluded that ectopic pancreatic tissue is the cause of the small local areas of decreased resistance which later allow the mucosa to protrude. They disagree with Odger's theory and maintain that vessels suitable for the production of weak areas do not commonly occur at the site of the diverticula.

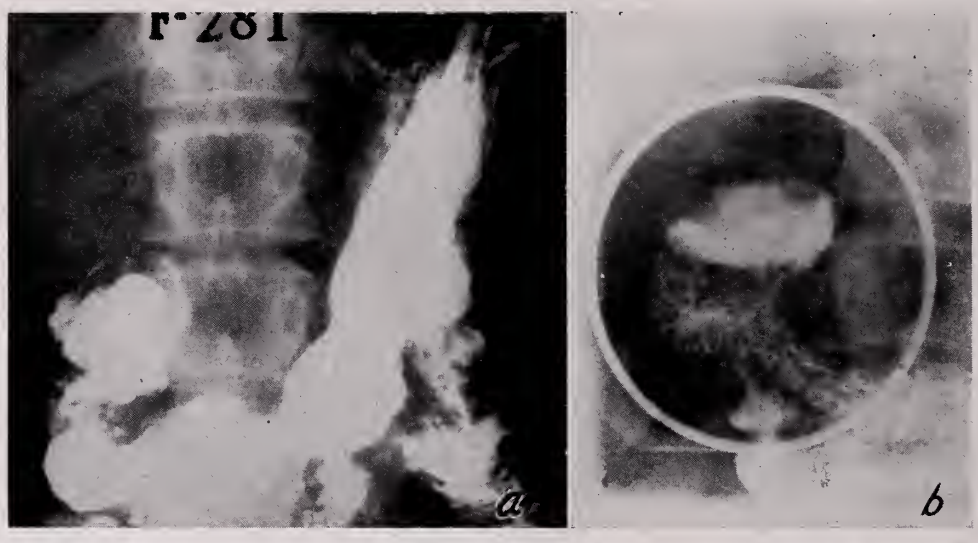

FIG. 3. The effect of spot film radiography with compression. a. Routine film which is difficult to interpret. b. A spot film made with compression clearly reveals the diverticulum.

Such are some of the common theories. They represent a great deal of thought but leave much for speculation.

INCIDENCE

Statements in the literature regarding the incidence of diverticula are difficult to harmonize since the percentages vary from 0.32 to 22 per cent. An excellent comparative table made by Ackermann[1] might be consulted for further information.

The examination of cadavers in the dissecting room should be the most accurate, yet here the incidence varies from 16 to 22 per cent. Obviously some difficulty in detecting diverticula was anticipated since both Grant and Ackermann injected specimens with a solidifying mass before studying them. Because of the care taken, one would expect that their figures should be the more representative.

Information obtained from the autopsy table also should be fairly accurate, yet percentages from this source vary from 3 to 13.3 per cent. The undertaking of an autopsy is a large task. Although the approach may be conscientious, limitations are inherent. Interest in a particular organ; limitations of time, technique, experience, and conscientiousness of the prosector; and complexity of the anatomy about the diverticulum may determine the number of diverticula detected. Statistics drawn over a period of many years from the work of many prosectors in a department may not be as accurate as the large figures lead one to believe.

The radiographic examination is limited by similar factors; witness the variation in the incidences reported by radiologists in the literature, which vary from 0.16 to 5.19 per cent. Case,[5] who first discovered the duodenal diverticulum roentgenologically, developed an interesting technique which required the patient to turn rapidly from his right side to the supine position, holding his breath in deep inspiration, while the examiner occluded the duodenojejunal juncture and simultaneously forced the barium through the pylorus. By this method he was able to show an incidence of 1.3 per cent in 6,847 examinations. Although only a few examiners use this maneuver, for the most part the patient assumes the various positions and experiences pressure of varying degree to the duodenojejunal area during the examination.

Weig[19] has expressed the opinion that an extra ef-

fort to demonstrate diverticula is in order since they do not fill readily in the upright position. Davis and Budd[7] have thought that the size is important, in that the smaller diverticula fill less rapidly. It is interesting to note that the smallest one recorded in the dissections of Ackermann,[1] who reported an incidence of 22 per cent, was only 5 mm. We encountered two of similar size in 22 cases. We do not believe that special methods of examination are ordinarily necessary. An observant eye alert for any unusual findings, synchronized with the use of one's ingenuity to demonstrate the presence of diverticula, is all that is required.

As suggested by Weintraub and Tuggle,[20] the diverticulum must at times be considered a dynamic rather than a static structure. They mean that diverticula may be present at one time and absent at another. Several instances of such an observation are in the literature. A parallel phenomenon might be seen during curling in the esophagus when the contraction may be so severe and prolonged as to suggest multiple diverticula.

In review, the variability in reported incidences may be dependent on the (1) source of material—whether from the dissecting room, the autopsy table, or radiographic examination—and on the (2) qualifications of the observer—his experience, training, conscientiousness, and interest.

Aside from the irreducible minimum of oversight inherent in the examination, one factor, the views of several authors notwithstanding, must be considered important, namely, the age of the patient in whom a diverticulum is present. The age was first stressed by Grant.[10] Only by such a postulate is it possible to explain the extraordinarily low incidence of 0.32 per cent reported by Whitmore,[21] who observed only 18 cases in 5,712 examinations; the material for his paper was obtained primarily from the examinations of military service personnel. In an addendum he reported an increase in incidence to 3.9 per cent in civilian practice. Fawcitt[8] likewise reported a low incidence of 0.63 per cent in 3,000 examinations done on military personnel.

We have kept records on a series of 400 routine examinations of the upper gastrointestinal tract. Although a definite interest in the detection of diverticula was manifest, no special procedures were carried out to determine their absolute presence or absence. From this group 22 cases of diverticula were obtained, representing an apparent incidence of 5.5 per cent. Since our figures were somewhat higher than those in the literature, which varied from 0.16 to 5.19 per cent, we examined the group according to age decades but failed to note an unusual predominance in any decade. We were of the opinion that the ages of our patients were representative of the average clinic and hospital population.

The findings of our study are summarized in table 1.

TABLE 1.—*Incidence of Duodenal Diverticula According to Age Decades in 400 Gastrointestinal Studies.*

Decade	No. of Patients	Patients with Diverticula	
		No.	%
1-9	7	0	
10-19	6	0	
20-29	51	0	
30-39	71	3	4.2
40-49	78	3	3.8
50-59	100	6	6.0
60-69	60	7	11.7
70-79	22	3	13.6
80-89	5	0	

Horton and Mueller[11] and Davis and Budd[7] also recorded the number of diverticula according to age decades but did not include the number of patients in each decade examined, so that no true age relationship can be drawn.

Grant[10] divided his patients into two groups; the age of 52 years formed the division point. He noted a percentage of 3.9 for those younger and 15.8 for those older. It was on this basis supported by statistical testing that he maintained there was a greater incidence after the age of 52. If our group is divided in the same manner, an incidence of 2.8 per cent for those younger than 50 years and of 8.5 per cent for those older is obtained. These figures and the trend of the percentages noted in table 1 give added weight to the factor of aging in the appearance of duodenal diverticula.

LOCATION

The location of diverticula is also of interest. The majority lie in the inner curve of the second portion of the duodenum, that portion in closest association with the pancreas. It represents the mesenteric portion of the bowel. Though many of the sacculations may lie within the pancreatic parenchyma, a goodly number also lie anterior and posterior to the organ so that no absolute relationship between diverticula and the pancreas can be drawn. The usual findings in the area represent false diverticula. A comparison of the location of diverticula according to various authors is made in table 2; our observations are in close agreement with those of other authors.

TABLE 2.—*Anatomic Distribution of Duodenal Diverticula.*

	Portion of Duodenum			
	First %	Second %	Third %	Fourth %
Fifth Avenue Clinic and Harris Hospital	0	64	16	20
Weintraub and Tuggle	1.7	72.5	14.9	10.9
Davis and Budd	1.7	85	13.3	
Whitmore	0	60	30	

SIGNIFICANCE

To many, the presence of diverticula represents only an incidental finding indicating that a complete examination has been performed. The attitude is based on fact, since the incidence of secondary disease in such a lesion is infrequent. No conclusive evidence of disease could be ascribed to the diverticula found in our study. However, at frequent intervals a warning in the literature that diverticula may become diseased and require surgical removal if medical care fails is recorded.

Diverticulosis of the colon is relatively common and retention of fecal material for long periods is accepted. The frequency of diverticulitis in diverticulosis, however, is not great. It would therefore be probable that even less secondary disease would be anticipated in the duodenum, where the material is sterile, the ostia large, and drainage rapid. In retrospect, there are probably times when unneutralized acid contents of the stomach might reach them and cause irritation.

We do not believe that retention of material in the duodenum is common. In 18 consecutive cases, Case[5] observed that barium was retained for eleven hours. This we were unable to confirm since in the majority of our cases no retention could be demonstrated after six hours. A few of the moderate or larger diverticula in which the fundus was directed upward frequently collected air. It also must be remembered that portions of barium retained in the stomach may be intermittently propelled into the duodenum. The diverticula also may collect a portion of barium giving the impression of retention.

No classic symptomatology of diverticulosis has been detected nor are the symptoms of secondary disease clear cut. Almost invariably the literature indicates that disease in adjacent organs has to be ruled out first and that a diverticulum is implicated by exclusion. With an ulcer of the duodenum the classic symptoms of peptic ulcer appear and are improved by medical management. An unexplained source of gastrointestinal bleeding has been traced at times to a bleeding diverticulum. Carcinomatous changes have repercussions in adjacent organs and the whole body. Increase in the size of a diverticulum with constriction of the neck, foreign body incarceration, and the presence of parasites all may play a part. It is interesting to note that Chomel[6] in the first description of a supposed diverticulum described the presence of 22 gallstones.

Disturbances in adjacent organs such as disease of the bile duct, pancreatitis, carcinoma of the pancreas, or visceroptosis may produce trouble in otherwise benign diverticula by causing an obstruction. Conversely, diseased diverticula may produce profound changes in adjacent organs by occluding bile ducts or pancreatic ducts, and even by causing thrombosis of the superior mesenteric artery. It is said that perforation of a diseased diverticulum in the retroperitoneal spaces is generally fatal probably because of the surgeon's inability adequately to mobilize the structures and protect the pancreas.

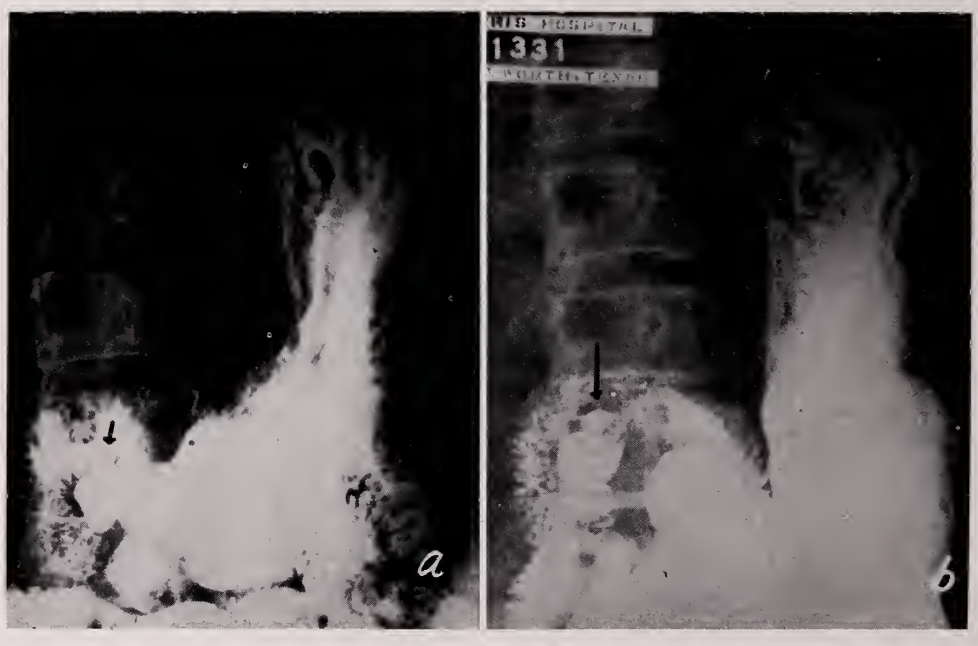

FIG. 4. Case 2. a. The arrow points to a defect interpreted as an ulcer. b. Six months later the defect resembles more closely a diverticulum.

A few cases of diseased diverticula from the literature might be cited. Weig[19] described a 4 mm. ulcer in a diverticulum occurring in a 77 year old man who had developed severe epigastric pain. Kinzer[12] reported an obstruction produced by a saccular structure covered by mucous membrane within the lumen of the descending limb of the duodenum which he considered to be an intraluminal inverted diverticulum.

Nash and Palmer[16] cited a defect in the second portion of the duodenum which was considered to be a diverticulum but which disappeared after therapy. We would like to mention a similar case.

CASE 2.—A 38 year old woman developed epigastric discomfort, had tarry stools four days later, and vomited coffee ground–like material. Gastrointestinal examination revealed a defect in the second portion of the duodenum which was thought to be an ulcer. Six months later after a good recovery on medical management reexamination revealed the presence of a diverticulum in this same location. Does this represent a diverticulum formed from a previous ulcer as some authors infer?

More and more instances of effective excision of duodenal diverticula are being reported. Although considered by some to be relatively difficult, such a procedure is definitely required should evidence of secondary disease be demonstrated. Patterson and Bromberg[18] enumerated 34 cases of diseased diverticula removed. Mahorner and Kisner[15] listed an additional 4 cases. The cases of Kinzer[12] might also be added. Surgeons are fairly consistent in requiring that any disease in adjacent organs be ruled out before the duodenum is considered the source of difficulty.

CONCLUSION

Four hundred radiologic gastrointestinal examinations revealed 22 cases of diverticulosis of the duodenum, a relatively high incidence in spite of limitations inherent in the mode of examination. The distribution of diverticula resembled that described in the literature with the greater number lying in the second portion of the duodenum. The higher incidence in patients older than 50 years of age was noted, as was emphasized by Grant.[10]

The presence of diverticula for the most part is best explained on the basis of inherent sites of weakness which lie about the vessels perforating the musculature and which are further weakened by aging. Although the greater number are asymptomatic, diverticula must nevertheless always be closely examined and considered since occasionally they have been shown to be the site of a secondary lesion.

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ABSTRACT OF DISCUSSION

DR. V. H. SHOULTZ, Abilene: The question I am asked by the clinician is, "What is the significance of the diverticulum in this gastrointestinal study?" The literature indicates that from 2 to 10 per cent of those demonstrated cause symptoms. I am of the opinion that 2 per cent is probably a high figure; at least I have not recognized symptoms in 2 per cent of cases of diverticulosis of the duodenum which I could say were definitely due to a diverticulum.

However, the symptoms produced are worth remembering. In order of frequency they are:

1. Pain, which occurs in 85 per cent of the symptomatic cases. This may be mild epigastric distress or severe dull aching pain; it often occurs during or after eating.
2. Nausea and vomiting.
3. Diarrhea due to pancreatic disease or to putrefaction in the pocket.
4. A feeling of distention in the epigastrium.
5. Tenderness in the right lower epigastrium.
6. Febrile reaction.
7. Gastrointestinal hemorrhage.

These symptoms may be brought on by inflammation or distention of the sac, inflammation of surrounding tissue, or pressure on surrounding organs. The complications of these disorders have been well covered by Drs. O'Bannon and Grunow.

Radiologically speaking, diverticula are considered signifi-

cant when symptoms cannot be explained by other disease and/or when on roentgen examination there is localized tenderness over the diverticulum; changes such as a persistent fleck are demonstrated in the mucosa; mucosal changes are seen in the adjacent duodenum; irritability in the duodenum about the lesion is demonstrated; or stasis in the duodenum or in the diverticulum is present.

With these symptoms and radiographic signs in mind, the examiner should be able to decide whether a diverticulum needs surgical intervention or medical treatment.

LESS COMMON MANIFESTATIONS OF ULCERATIVE COLITIS

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WHEN the term chronic ulcerative colitis is used, one immediately visualizes a fibrotic, shortened, "pipe-stem" colon with complete loss of the normal haustral markings. So accustomed have physicians become to thinking of this type of lesion that many are prone to overlook the other appearances of this disease, and in his practice a radiologist may find many a "doubting Thomas" who will be reluctant to accept his interpretation of other findings in a barium enema study as chronic ulcerative colitis. This was brought to my attention recently in the handling of 2 interesting cases which were excellent examples of the less common forms of ulcerative colitis.

The formation of islands of nonulcerated hypertrophic mucosa resulting in a pseudopolyposis is one of the appearances of chronic ulcerative colitis. Fistulas are commonly encountered in ulcerative colitis in the rectum and sigmoid colon, but I have found only 2 reports or accounts of a gastrocolic fistula such as I wish to discuss momentarily. In surveying the literature I have found the incidence of involvement of the terminal ileum to be as high as 28 per cent and yet I find this fact is not generally known.

I have 2 cases with which I should like to illustrate these points.

CASE 1.—L. T., a 50 year old white woman, was admitted to John Sealy Hospital on June 25, 1949, with a chief complaint of fistulas, weakness, and weight loss. For the past three years the patient had had diarrhea consisting of three to seven thin stools per day. She frequently passed pus and occasionally had bleeding from the bowels. She had lost 80 pounds in the past year. Two years previously, a rectal fistula had been lanced and had continued to drain. At the time of admission she had 10 to 12 fistulas throughout the perineum from which pus exuded.

Roentgen-ray examination revealed a markedly irregular contour of the colon with multiple filling defects in the lumen of the bowel. There was a long fistulous tract encountered at the splenic flexure, and as this was observed under the fluoroscope, the tract was seen to lead into the stomach (fig. 1a). The entire length of the colon was thought to be somewhat shortened. The filling defects were better visualized on the next examination, which was a double contrast study of the colon (fig. 1b). The findings were interpreted as pseudopolyps, gastrocolic fistulas, and rectal fistulas secondary to chronic ulcerative colitis.

An examination three months later revealed the gastrocolic fistula to be almost closed, there being only a small tract leading half way to the stomach. Conservative therapy was continued.

In 1952, the patient was readmitted to the hospital after an exacerbation of the colitis. Reexamination revealed some improvement in the appearance of the colon, but there were still ulcerations and pseudopolyps (fig. 1c and d). A total colectomy was performed. The specimen showed no evidence of the old gastrocolic fistula, but ulcerations, pseudopolyps, and much scar tissue were evident (fig. 2).

Let us consider the mechanism of the development of such a picture. The first pathologic changes of ulcerative colitis are hyperemia and edema of the mucosa, followed by shallow erosions. As the inflammatory process continues, the edema and ulcerations become more marked. The mucosal surface may be covered with an adherent inflammatory membrane in places. Then the ulcers begin to coalesce, and denudation of the mucosal surface occurs. In many cases a totally irregular mucosal surface results. Polypoid and proliferative hyperplastic tissue occurs in some areas, a smooth, denuded surface in others. Eventually there is replacement of the muscular fibers by inflammatory tissue, and contraction of scar tissue occurs. If the colon were smoothly denuded, one would expect the scar contraction to result in the shortened pipe-stem colon. If the process were irregular and allowed the formation of hyperplastic tissue, pseudopolyps would occur and the contraction of scar tissue would serve to emphasize the projection of the polypoid areas into the lumen of the bowel.

When ulcerations penetrate the wall of the colon, they tend to form small abscesses. These abscesses may involve adjacent bowel or other structures in their walls, and with the attempt to drain themselves the abscesses may open into adjoining structures and produce fistulas.

From the Department of Radiology, University of Texas Medical Branch.

Read before the Section on Radiology, Texas Medical Association, Annual Session, Houston, April 28, 1953.

The second case illustrates the third point I wish to emphasize.

CASE 2.—J. G., a 52 year old white man, was admitted to John Sealy Hospital on December 7, 1951, with a chief complaint of having had diarrhea since 1950. He had begun to have cramping abdominal pains recently. In February, 1951, he had had a perineal fistula lanced; it had continued to drain.

Roentgen-ray examination when the patient came to John Sealy Hospital revealed extensive involvement of the colon with ulcerations and pseudopolyps. In addition there was involvement of the ileum for nearly 2 feet (fig. 3a).

The patient was treated conservatively and discharged improved. He was readmitted on July 18, 1952, with an exacerbation. At this time he had 4 perineal fistulas. Barium enema study showed improvement in the appearance of the colon, but there was still evidence of disease (fig. 3b). The postevacuation roentgenogram was particularly helpful in determining this fact as it demonstrated nicely the change of the mucosal folds to a more parallel arrangement produced by the hypertrophic changes which had been noted previously (fig. 3c). The terminal ileum could not be filled on this examination, and as its condition is of prognostic importance, a motor meal was used to obtain adequate visualization of the small bowel. It appeared unchanged (fig. 3d).

On September 12, 1952, a colectomy was performed and the involved ileum resected. Long areas of coalescent ulcers were found and many pseudopolyps. The right side of the colon was relatively free of disease. The ileum was ulcerated and contracted for 2 feet (fig. 4).

Involvement of the ileum is said to occur in 20 to 28 per cent of cases of ulcerative colitis. The process is the same as that taking place in the colon, but there is usually a lesser degree of narrowing of the lumen and shortening as is seen in the colon. There is a loss

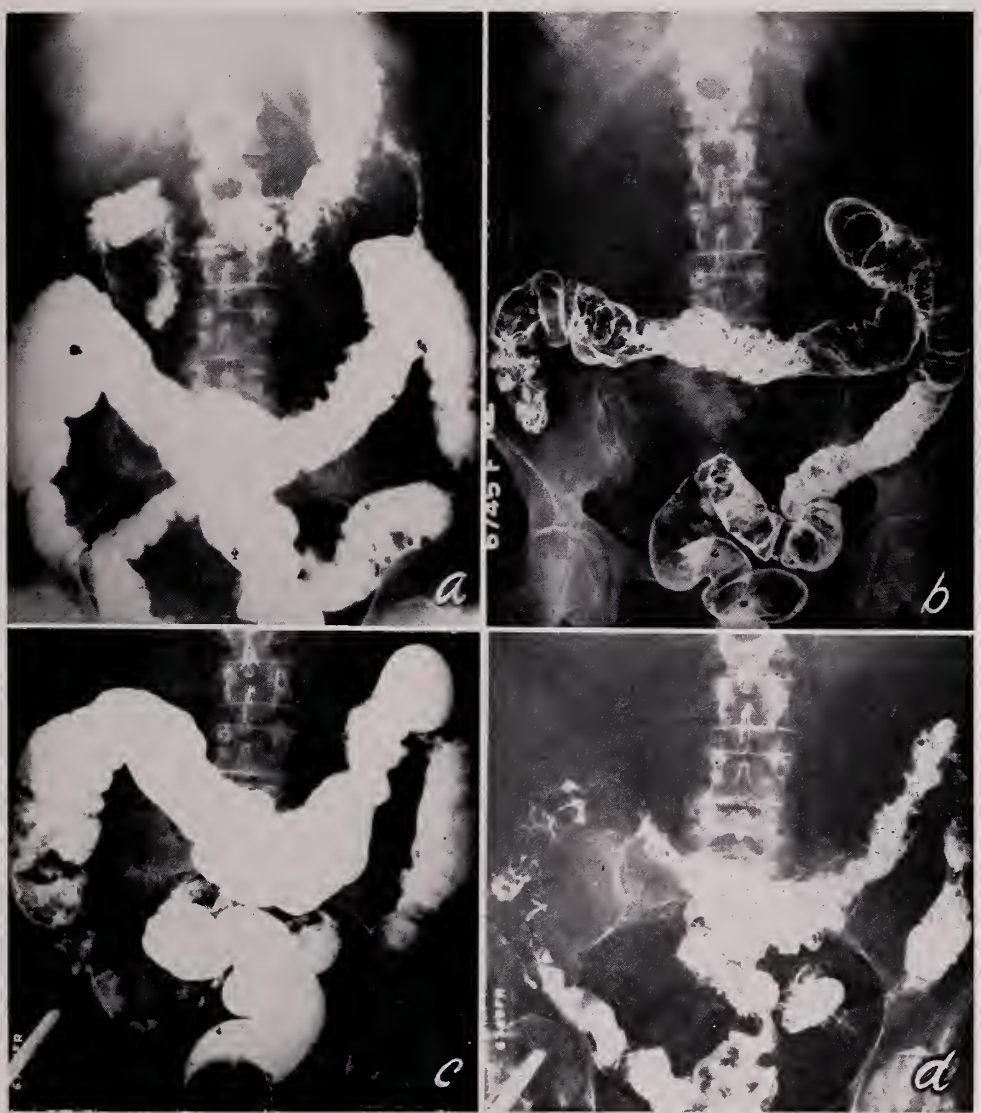

FIG. 1. Case 1. a. A roentgenogram showing marked irregularity of the contour of the colon with some shortening and multiple filling defects in the lumen. A long fistulous tract leads into the stomach.

b. A double contrast study demonstrates multiple pseudopolyps.

c. A roentgenogram showing that ulcerations and pseudopolyps remained after conservative treatment.

d. A postevacuation roentgenogram made at the same time as *c* showing the pseudopolyps.

of the markings of the valvulae conniventes and the outline of the ileum is serrated because of small ulcerations. The length of the involvement may be from a few centimeters to several feet.

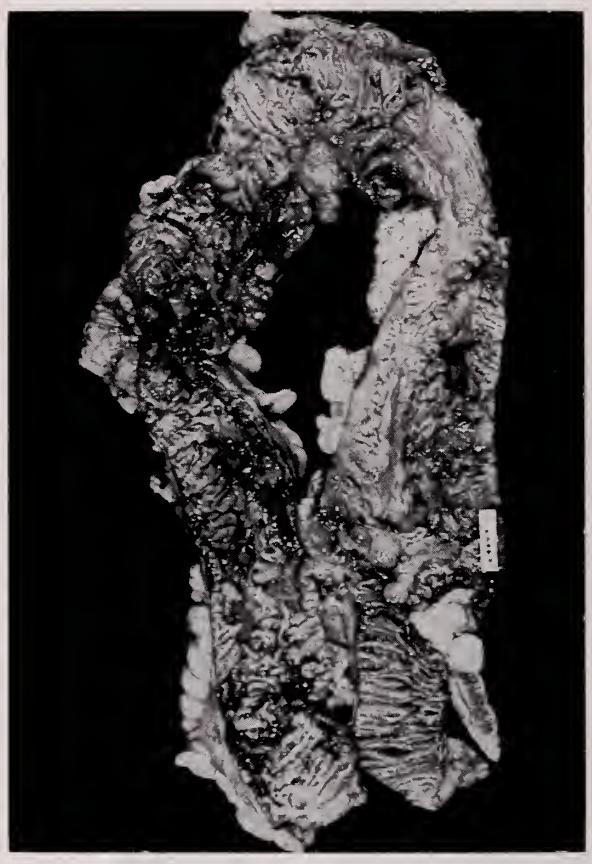

FIG. 2. Case 1. A photograph of the removed colon confirms the roentgen-ray findings.

DISCUSSION

The majority of the reports in the recent literature concerning ulcerative colitis have dealt with the treatment of these cases. There are few articles on the roentgen appearance and especially on that of these less common manifestations.

The formation of pseudopolyps has been mentioned for many years but for the most part only casually or as inclusions in statistical analyses. It is of interest to note that in 1721 Menzel described a case of generalized inflammation of the colon with a number of wartlike excrescences. This specimen was obtained from a soldier who had died of chronic bloody diarrhea. In 1861 Virchow named this condition colitis polyposa. In 1915 Hewitt and Howard[5] published an article on ulcerative colitis with polyps. In1942 Brown, Buie, and Weber[4] at Mayo Clinic found 41 cases which did not conform with the usual picture of ulcerative colitis. These authors described the usual roentgen-ray appearance as general contraction, narrowing and shortening of the colon, destructive changes in the intestinal wall and mucous membrane, and diminished flexibility and mobility. In the cases under consideration in their paper, there were hyperplastic and productive elements. A patchy, irregular distribution of the ulcerative and hyperplastic process was found. Since that time there have been no articles in the literature dealing with this appearance as such. Statistical studies show the occurrence to range from 10 to 15 per cent. Surely this interesting feature of this disease deserves more emphasis.

The gastrocolic fistula is of interest because of its rarity, at least as the paucity of reports in the literature would indicate. The fistula in case 1 was unusually long, and it was interesting to watch its spontaneous closure.

The involvement of the ileum should be emphasized, I believe, because of its prognostic importance. There was one excellent article dealing with this in 1949 by McCready, Bargen, Dockerty, and Waugh[6] from Mayo Clinic. They pointed out that the disease of the ileum was the single most important factor for the high mortality rate and failure of operative procedures such as ileostomy in these cases. Therefore, it is important that the ileum be studied adequately, and since it is not uncommon for the diseased ileum to fail to fill in the barium enema study, it is necessary to be persistent and to demonstrate it one way or another.

DIFFERENTIAL DIAGNOSIS

When cases such as these are encountered, there are few conditions to be considered in the differential diagnosis. Amebic colitis may assume the appearance of the polypoid type of ulcerative colitis and may be indistinguishable roentgenographically. The discovery of the etiologic agent in amebic cases should not be difficult, and the differentiation is up to the clinician and the laboratory technician. The type of ulcerative colitis showing the contraction, fibrosis, and shortening offers additional possibilities for a differentiated diagnosis which I shall not discuss.

When the ileum is involved, there is more cause for speculation. In 1932, Crohn described a necrotizing and cicatrizing inflammation confined to the terminal ileum which he termed regional ileitis. The original description emphasized diarrhea, abdominal pain, fever, weight loss, symptoms of partial obstruction, and formation of fistulas from the ileum. There was no evidence of involvement of the cecum. Later, the same pathologic and clinical features were reported in other segments of the small intestine, and the original report describing the failure of the lesion to pass the ileocecal valve into the colon had to be revised. The dis-

ease in the colon does not differ pathologically from that seen in ordinary idiopathic colitis. Therefore, it is sometimes a question of whether the disease began in the ileum and later involved the colon or vice versa. Bockus has expressed the opinion that the rectosigmoid area is not involved when the colon is diseased secondary to regional ileitis. This belief is an aid in differentiation as the rectosigmoid area is thought to be the first site of involvement in chronic ulcerative colitis. The conditions to be differentiated from regional ileitis are tuberculosis and, rarely, amebic infection. However, when there is such marked involvement in the colon as in these cases, the other possibilities are remote.

The same is true in considering the differential diagnosis of the gastrocolic fistula. If seen without the generalized involvement of the colon, one would think first of carcinoma. Carcinoma does occur in the presence of ulcerative colitis (some say in 5 per cent of the cases), but there should be characteristic findings to distinguish cancer. Tuberculosis, fungus disease, and simple ulcer are other rarer causes of gastrocolic fistula.

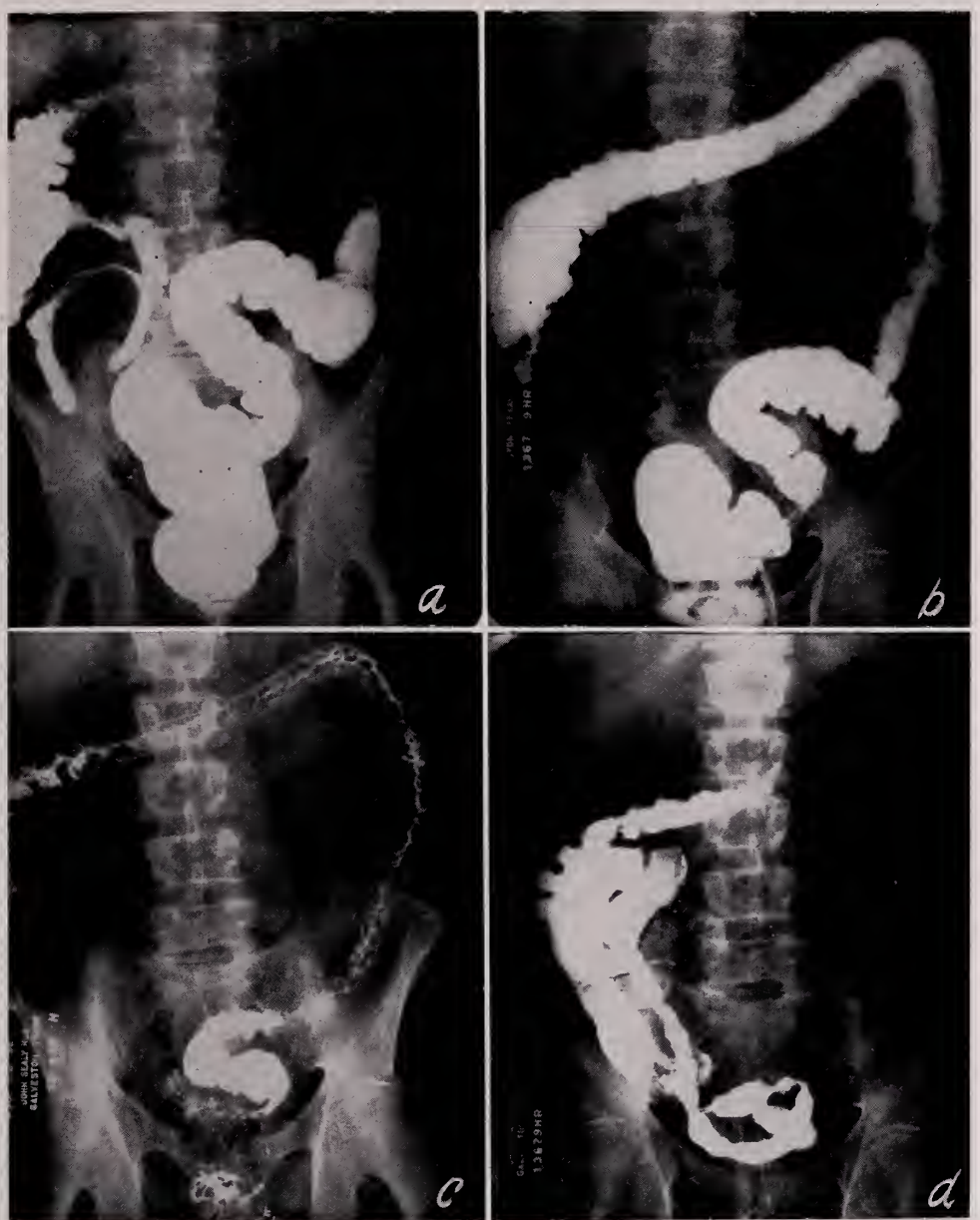

FIG. 3. Case 2. a. A roentgenogram demonstrating ulcerations and pseudopolyps as well as involvement of the terminal ileum for 2 feet.
b. Barium enema indicated improvement after treatment, but evidence of disease is still seen in the roentgenogram.
c. A postevacuation roentgenogram made at the same time as *b* shows hypertrophic changes causing the mucosal markings to lie in a more parallel arrangement.
d. The terminal ileum is demonstrated by means of a motor meal, and the diseased ileum is again noted.

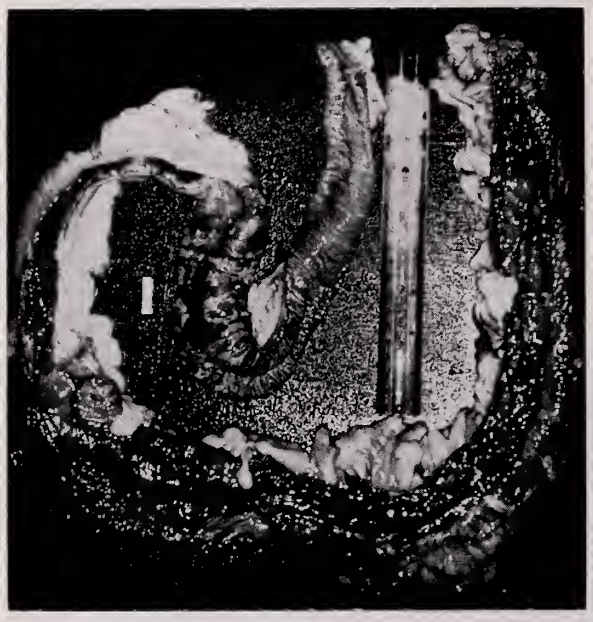

FIG. 4. Case 2. Photograph of the specimen after resection of the colon and 2 feet of ileum showing multiple pseudopolyps and long coalescent ulcers. The ileum is ulcerated and contracted.

SUMMARY

The less common manifestations of chronic ulcerative colitis are discussed. The formation of pseudopolyps occurs in 10 to 15 per cent of the cases, involvement of the terminal ileum in 20 to 28 per cent, and gastrocolic fistulas rarely. These appearances are interesting radiographically, of prognostic as well as diagnostic importance, and deserve more emphasis than has been given them in the past.

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ABSTRACT OF DISCUSSION

DR. HERMAN C. SEHESTED, Fort Worth: Dr. Rowe has shown three unusual features of ulcerative colitis, or rather of advanced ulcerative colitis. Pseudopolyposis is a well recognized and generally accepted manifestation of advanced ulcerative colitis.

Gastrocolic fistula, however, is an unusual complication of ulcerative colitis. Dr. Rowe pointed out carefully in discussing differential diagnosis that ulcerative colitis is not the most common cause of gastrocolic fistula, and when we see a gastrocolic fistula, we should not think first of ulcerative colitis because we have heard of her case.

The third unusual feature of ulcerative colitis which she has shown is involvement of the terminal ileum. She mentioned that this feature had particular prognostic significance. It has been noted that the terminal ileum is involved with a particularly fulminating type of ulcerative colitis and often in right-sided cases of ulcerative colitis in which the sigmoid is not implicated. Her case, however, did show involvement of the sigmoid.

She mentioned particularly the difficulty in filling the terminal ileum. The first essential in filling the terminal ileum is to have the colon well prepared, preferably with castor oil. Maneuvers to fill the terminal ileum should include having the patient lie prone and then lean to the right. Of course, in some cases it cannot be filled no matter what the maneuver. It might be well to state that it is not always desirable to fill the terminal ileum. To be sure, the only way of having definite proof the cecum is filled, that is, that the entire colon has been filled, is to demonstrate filling either of the terminal ileum or the appendix. However, routine filling of the terminal ileum or especially overfilling of the terminal ileum will cover up more lesions than it uncovers by obscuring the sigmoid. Again, let me emphasize that we should know what we are attempting to demonstrate and individualize the examination accordingly so that we will come up with the information we want rather than simply carry out a routine procedure.

Tennessee Postgraduate Courses

Scheduled for 1954 by the University of Tennessee College of Medicine, in cooperation with the John Gaston Hospital and Le Bonheur Children's Hospital, Memphis, are the following postgraduate courses: pediatrics, March 10-12; abdominal surgery, March 31-April 2; obstetrics and gynecology, May 19-21; trauma, July 28-30; management of simple fractures, September 15-17, and clinical electrocardiography, October 6-8.

Further information may be obtained from the University's Postgraduate Department, 4 South Dunlap, Memphis.

Medical Tour of Europe

Texas physicians have been invited to join members of the California Medical Association in a tour of Europe, April 5 to May 5, which will include visits to France, England, Italy, Holland, Belgium, Germany, and Switzerland and will offer opportunities to attend scientific meetings and meet medical leaders in several cities en route. Arrangements have been made for wives of physicians to attend style shows by Parisian couturiers and to participate in special entertainment.

Interested Texans should write immediately to the California Medical Association, 450 Sutter Street, San Francisco 8.

MANAGEMENT OF COMMON ANORECTAL CONDITIONS

With Special Emphasis on Prevention of Pain

R. HARVEY BELL, M. D., F.A.C.S., Palestine, Texas

THE patient with an anorectal condition requiring treatment is apprehensive if not actually afraid, and anything that will reduce or prevent his pain is greatly appreciated by him. The physician should not fail to spend sufficient time with the patient before examination or operation to reassure him and to explain that much of the pain in the anal region is caused by spasm of the sphincter muscles. The patient also can be told that he will have relief from pain or discomfort in the same degree that he is able to accomplish relaxation of the sphincters. In cases in which the patient cannot relax, less painful examinations can be made if the physician uses an anesthetic lubricating jelly instead of a plain one. A satisfactory anesthetic lubricating jelly is 5 per cent Intracaine in potassium yttrium or a similar jelly.

In the presence of a tight or spastic anus, the physician should use his little finger instead of his index finger for the digital examination. Examination of a fistulous tract can be done painlessly if the physician injects the tract with a 2.5 per cent Intracaine solution using a medicine dropper with a round bulb end instead of a sharp tip and if he leaves a small cotton tipped applicator dipped in the same solution in the tract for five to ten minutes before passing a probe into it. A good procedure is to prepare the patient for the examination, inject the tract with the anesthetic as described, and leave to examine another patient. When the physician returns, the tract will have become anesthetized and can be examined readily.

External Thrombotic Hemorrhoids.—External thrombotic hemorrhoids are common. If the patient is seen the first day or two after the clot forms and becomes firm, much later discomfort can be spared him. The lesion should be washed gently with soap and water using cotton rather than gauze to wipe the area. No shaving should be done. The region may be washed with a Zephiran Chloride solution, 1:1,000 strength. One stick of a small hypodermic needle is all that is necessary to anesthetize the mass with a procaine solution. An elliptic incision is made over the hemorrhoid and the clot removed completely. The bleeding point and cut edges are then desiccated with a uniterminal electric needle such as a Hyfrecator, and an anesthetic ointment such as Surfacaine is applied on a pledget of cotton. No further ointment dressings ordinarily are used since in a draining wound such as this quicker healing and less discomfort is had if wet dressings are used. My preference is to have the patient cleanse the wound several times a day with a 1:1,000 Zephiran Chloride solution and apply a small moist sponge or piece of cotton to the anus when there is discomfort or when the dressing drops off. If the physician does not have an electric needle, he may touch the skin edges lightly with fuming nitric acid with equally good pain control.

Internal and External Hemorrhoids.—Markedly less pain and associated bladder neck spasm will follow an operation for removal of internal and external hemorrhoids if the bleeding is stopped by using an electrocoagulating needle rather than by tying the bleeding points. The need for postoperative catheterization, therefore, will be much less. If the physician does not desiccate the skin edges, he should touch them lightly with nitric acid for pain prevention. Another procedure to lessen pain following hemorrhoidectomy is to have the patient soak in a tub of warm water for twenty to thirty minutes several times daily beginning the day after operation. If this plan is followed, the patient will require many less hypodermic injections to relieve pain and may not require any. It is not unusual for my patients to require no narcotics following hemorrhoidectomy, and all have standing orders for morphine when they have pain that disturbs their rest. Soaking in a tub is soothing and relaxing, and nearly all patients find it of much value during their convalescence.

Postoperative gas pains can be prevented in most patients by disturbing the bowels as little as possible prior to surgery and feeding the patient normally and fully immediately following surgery. The empty bowel forms the gas. No enema should be given the day of the operation; if one is given at all, it should be the day before operation and of small quantity using plain water. It is my usual practice not to give any preoperative enemas.

A piece of gauze, which can be removed before the patient leaves the operating room following surgery, should be placed in the rectum at the beginning of the operation to absorb blood. This will leave no

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blood clot masses in the lower rectum to cause discomfort later. No gauze or rubber tissue should be left in the anus after operation to act as a drain or plug. Hemostasis should be complete before concluding the operation so that such agents are unnecessary.

The first bowel action following surgery will not be uncomfortable if a solution of 3 teaspoonsful of Hydrocil or Metamucil in a quart of warm water is injected into the bowel and allowed to remain until the patient has the urge for the bowels to act. The physician should use a well lubricated catheter and pass it himself rather than leave the procedure to an orderly.

Cryptitis and Papillitis.—Cryptitis and papillitis are managed similarly. Both require surgical removal of the lesions if they do not clear up promptly under conservative management of hot sitz baths. Treatment consists of injecting with a procaine solution, excising, and touching the wound and skin edges with either the desiccating needle or nitric acid. The wounds are kept clean with a Zephiran Chloride solution until healing is complete.

Fissure in Ano.—The fissure in ano is an elongated or slitlike ulcer in the lining of the anal skin at or above the anorectal line. It is characterized by paroxysmal pain usually brought on by defecation. Several methods of treatment may effect a cure, but excision of the ulcer accompanied by division of the superficial bundle of fibers of the external sphincter muscle, all under anesthesia, offers practically 100 per cent cure. Division of the sphincter adds materially to the postoperative comfort of the patient since it lessens the anal spasm. The skin edges should be touched with nitric acid or uniterminal current should be used as described previously. Postoperative care includes hot sitz baths. The operation may be done in the office and the patient allowed to go home for his sitz baths if the physician considers him a suitable patient for home care; otherwise, he should be hospitalized for a day or so.

Fistula in Ano.—Fistula in ano usually requires the complete removal of the fistulous tract to eradicate the condition. The tract or tracts usually pass external to the external sphincter muscle or between it and the internal sphincter so that division of the external sphincter muscle only is required. Care should be taken to divide the muscle at right angle to the direction of the muscle fibers and to divide it only in one place to preserve anal continence. The after care of the wound is very important. Packs should be removed entirely the first time they are disturbed, usually at about forty-eight hours postoperatively, and rarely replaced. Sitz baths are begun the day following operation and are continued two to four a day until the wound has healed. Pocketing is prevented by gently wiping the wound out to its bottom as often as necessary and by irrigating the wound with a 1:2,000 Zephiran Chloride solution. After a few days this becomes a painless procedure. A small wet Zephiran Chloride sponge dressing is placed over the wound and changed as often as necessary to maintain comfort. A Furacin dressing can be used for this wound. Neither Zephiran Chloride nor Furacin is irritating, but occasionally a patient is allergic to Furacin.

Pruritus Ani.—Pruritus ani is a condition in which many factors may play a part. Volumes have been written about its management. The physician must consider systemic causes, allergies, and local causes. Hemorrhoids, fissures, and fistulas are causes at times chiefly because of their irritating discharges. It is safe to say that in a large percentage of cases the offending agent is an irritant leaking from the anal canal; the neutralization or removal of this irritant will relieve the condition.

In milder cases simple cleansing with cotton wipes rather than paper and witch hazel applications on cotton swabs often will effect a cure. Alcohol injections, using 95 per cent strength, with a ¼ inch needle at ¼ inch intervals around the anus will cure some cases. The injections must be carried out under spinal, caudal, or general anesthesia since local anesthesia will dilute the alcohol. In severe cases I have found the best treatment to be an undercutting operation, usually clover leaf type. Then Oxycel or Gelfoam is placed beneath the skin and left until it has absorbed. All local conditions should be attended to prior to this part of the operation and all hypertrophied skin trimmed away smoothly.

Polyps.—Polyps require removal and fulguration of their bases. The physician must be careful not to tent the area and burn a hole in the bowel wall in this fulguration. Subsequent frequent periodic examinations should be carried out to be sure that there is no recurrence of the growth.

Anorectal Abscess.—Anorectal abscesses cause great pain and discomfort. In general the treatment consists of immediate wide incision and drainage. The incision should be anteroposterior or parallel to the anal slit; it should be made beyond the outermost fibers of the external sphincter muscle but as near the point of fluctuation as possible. Usually it is better to make the incision elliptic or triangular and large enough to assure adequate drainage. Much pain can be spared the patient after the operation if the abscess cavity is swabbed with nitric acid after opening it. Hot compresses and tub soaks will afford additional relief.

Proctalgia Fugax.—Proctalgia fugax is a well defined symptom complex of obscure etiology and pa-

thology. The pain is irregular and intermittent and appears to be 2 or 3 inches above the anal outlet. It is apparently a spasm of the internal sphincter muscle. There are possibly different trigger mechanisms in different persons affected with the condition. Sexual excitement seems to cause it in some persons at times; infection, vasospasm, venous stasis, allergy, and other factors cause it in others. The pain has been described as boring, gnawing, cramping, aching, and expanding. It usually does not last longer than fifteen to twenty minutes and may be less. Hot sitz baths, warm water enemas, firm application of pressure, and the assumption of various positions such as the knee-chest are pain relievers in some persons. It now has been found by several observers that nitroglycerine soluble tablets, grains 1/100 to 1/200, stop the attacks or modify them at once.

Carcinoma.—Carcinoma of the anus is mentioned here only to say that most cases of this condition require abdominoperineal resection because the lymphatic drainage of the anus spreads the disease. Lymphatic vessels below the anorectal line drain into the inguinal chain of glands, and those above this line drain into the median lumbar glands, which are high and far away from the site of the lesion. More than 77 per cent of cancer in the rectum and sigmoid colon can be felt by digital examination, and there is little excuse for missing cancer in this region.

SUMMARY

A plea is made for the physician to spend more time to reassure the patient with an anorectal condition and to explain to him more about the mechanics of the pain of his condition.

Some practical points regarding the lessening of pain or discomfort in examination and treatment of such common anorectal conditions as hemorrhoids, cryptitis, fissure in ano, fistula in ano, pruritus ani, polyps, anorectal abscesses, and proctalgia fugax are given.

Use of the uniterminal desiccating needle and of nitric acid applications is advocated in certain conditions.

ABSTRACT OF DISCUSSION

DR. HOLLAND T. JACKSON, Fort Worth: It is a well known fact that the patient with an anorectal condition is probably the most apprehensive of any patient with a common condition that we, as physicians, encounter. I certainly agree with Dr. Bell that reassurance on the part of the physician is a great aid for this patient. One of the most appreciative patients we encounter is the patient with thrombotic hemorrhoids. Simple removal of the thrombus usually gives the patient complete relief.

In the postoperative care of hemorrhoidectomies the sitz bath is probably one of the most valuable procedures. The idea of maintaining a full diet and amply full bowel to avoid stress is certainly good. Bulk laxatives by mouth are much better than enemas and, I think, better than the suggested enema as outlined by the essayist. In the management of cryptitis as well as fissure in ano, it has been my experience that usually some associated disease probably has necessitated hospitalization.

In fissure a complete cure is difficult unless the sphincter is divided. Pruritus ani continues as a challenge to the medical profession. It is important that all possible organic etiologic factors be considered and removed. It has been my experience that, in most of these instances, pruritus ani continues. The psychogenic factor in these cases never can be overlooked; it must be considered and the patient reassured as well as treated for the organic condition. After all apparent organic phenomena have been controlled and as a last resort before the surgical undermining operation, roentgen-ray therapy is a good agent for trial.

I have nothing to add in regard to the treatment of proctalgia fugax, but I do wish to reemphasize the importance of digital examination of all patients and certainly the importance of the sigmoidoscope for any patient who had the slightest suspicious history of a possible neoplasm of the lower bowel or rectum.

It is my opinion that it is not necessary to treat the wound edges with some desiccating agent but to establish adequate drainage and handle the tissues gently. This will cause far less pain than adding another pathologic process to the operative procedure. I wish also to stress the importance of cold compresses for twenty-four to thirty-six hours following the surgery. Cold gives far greater relief than warm applications during these early hours.

Regarding catheterization, despite what the doctor does, at least one catheterization is necessary in as many as 50 per cent of all male patients. And, again, let me stress the importance of biopsy of all suspicious lesions. It is important that the surgeon see that all tissue removed goes to a pathologist; then the pathologist should examine all the tissue submitted to him. Many times the tissue has gone to the pathologist but when he found it to be from a hemorrhoidectomy or something of that type, he has merely looked at the tissue grossly and reported it hemorrhoidal tissue. This type of attitude should be avoided.

FACTOR U COMPLICATES BLOOD TRANSFUSIONS

A new common factor in blood, designated as factor U, which causes blood to clump and complicate transfusion, is described by Dr. A. S. Wiener, Dr. L. J. Unger, and E. B. Gordon, all of Brooklyn, in the December 19 *Journal of the American Medical Association.*

Tests of the blood of a Negro patient who died following a blood transfusion for bleeding peptic ulcer and anemia and of the blood of the donors indicated that the patient's serum contained an abnormal antibody that caused the blood cells of the donors to clump together upon transfusion. Further tests with the serum on a series of other blood specimens showed them all to be incompatible. This indicated the presence in a high frequency of the population of a hitherto unknown factor which was lacking in the patient's blood, the report points out.

In additional tests on 690 Caucasoid and 425 Negroid persons, all of the Caucasoids were found to have the new factor U in their blood, whereas 4 of the Negroids were found lacking in it.

CASE REPORTS

MASSIVE SMALL BOWEL RESECTION IN POSTGASTRECTOMY PATIENTS

Report of 2 Cases

ELVIN L. SHELTON, JR., M.D., F.A.C.S., and M. H. BLAINE, M.D.,
Houston, Texas

EXTENSIVE small bowel resection is by no means a rare operation. In 1880, Koeberly removed 205 cm. of small bowel from a 22 year old woman.[8] In 1912, Flint[6] found more than 58 cases reported in which more than 200 cm. had been resected. Today there are many such case reports, but we were able to find only 2 instances in which even short-term survival had followed resection of the small bowel in a patient who previously had had a gastrectomy. Weckesser, Chinn, Scott, and Price[19] reported 1 such case; the patient lived for nine months with 24 to 30 inches of small bowel between the remaining portion of his stomach and his ileocecal valve.[19] This patient died apparently of inanition. Johnston and Reagan[10] recently reported a similar case in which the patient had extensive enterectomy three and one-half months after subtotal gastrectomy. Approximately 17.5 cm. of small bowel remained distal to the gastrojejunostomy. Inanition and reactivation of an old pulmonary tuberculous condition in the patient caused death five months after his second operation.

Since the combination of extensive enterectomy and gastrectomy in the same patient is so unusual, we wish to report 2 such cases.

CASE REPORTS

CASE 1.—The patient was a poorly nourished Negro man who appeared ten years older than the stated age of 58. A subtotal gastrectomy with a Hofmeister-type retrocolic gastrojejunostomy was performed on the patient October 2, 1950, because of almost complete pyloric obstruction secondary to a duodenal ulcer of approximately twenty years' duration.

On January 9, 1951, three months after his operation, the patient was seen for a complaint of mild periumbilical, cramping pain which subsided within a few hours.

On April 5, the patient again returned to the hospital. For two or three weeks he had noted dizziness and weakness following meals. Lying down would give the patient some relief, especially if he was able to vomit or "belch up" a small amount of gastric contents. On the evening of admission he had belched up about a cupful of "thin black blood." His bowel habits had remained normal.

From the Department of Surgery, Baylor University College of Medicine, and the Veterans Administration Hospital.

Read before the Section on Surgery, Texas Medical Association, Annual Session, Houston, April 29, 1953.

The patient appeared critically ill and was able to give only a fair history. He was stuporous, cold, and sweating and had a weak pulse of 89 per minute, a temperature of 98 F., and a blood pressure of 80/0 mm. of mercury. His abdomen was moderately distended but only slightly tender throughout. Peristalsis was hypoactive.

Laboratory studies were normal except for a leukocytosis of 18,100.

Flat and upright roentgenograms of the abdomen showed dilated loops of small intestine containing fluid levels, suggesting intestinal obstruction.

The patient was given 3,000 cc. of blood during the next ten hours. His general condition improved, but his abdomen became tenderer. He was scheduled for an exploratory laparotomy with a preoperative diagnosis of intestinal obstruction secondary to adhesions.

A right paramedian incision was made, and when the peritoneum was opened, many loops of markedly distended, black, gangrenous small bowel were extruded. Approximately 400 cc. of malodorous, thin, brownish fluid was aspirated from the peritoneal cavity. It was noted that the entire small bowel and its mesentery had rotated approximately 360 degrees in a counterclockwise direction. The volvulus was reduced, revealing no adhesive band or other abnormality which might have encouraged the volvulus. All the small bowel except the 26 inches just distal to the gastrojejunostomy and the 2 inches proximal to the ileocecal valve was gangrenous (fig. 1a). A resection of the nonviable bowel and a two-layer, end-to-end entero-enterostomy was accomplished without delay, and the incision was closed. The patient received 2,500 cc. of blood during the operation, and his condition remained remarkably stable.

The immediate postoperative course of the patient was satisfactory. By the ninth postoperative day he was taking a high carbohydrate, medium protein, low fat diet with frequent small feedings, and it became obvious that he would be a nutritional problem. He was having five to seven semiliquid stools daily, the stools being of a greasy, foamy nature and containing undigested food. The urge to defecate followed shortly the ingestion of food. Carmine red given by mouth was detectable in the stool seventeen minutes later. Barium by mouth was seen by fluoroscopy to reach the ileocecal region in three minutes.

The patient's weight dropped from 128 pounds on admission to the hospital on April 5 to 110 pounds on May 20. He then gradually gained to 118 pounds and stabilized at that weight within a month, a rather typical course for this type of patient.

Bismuth subcarbonate and paregoric were given frequently in an effort to lessen bowel motility and decrease the diarrhea. Ammonium chloride and calcium lactate were given

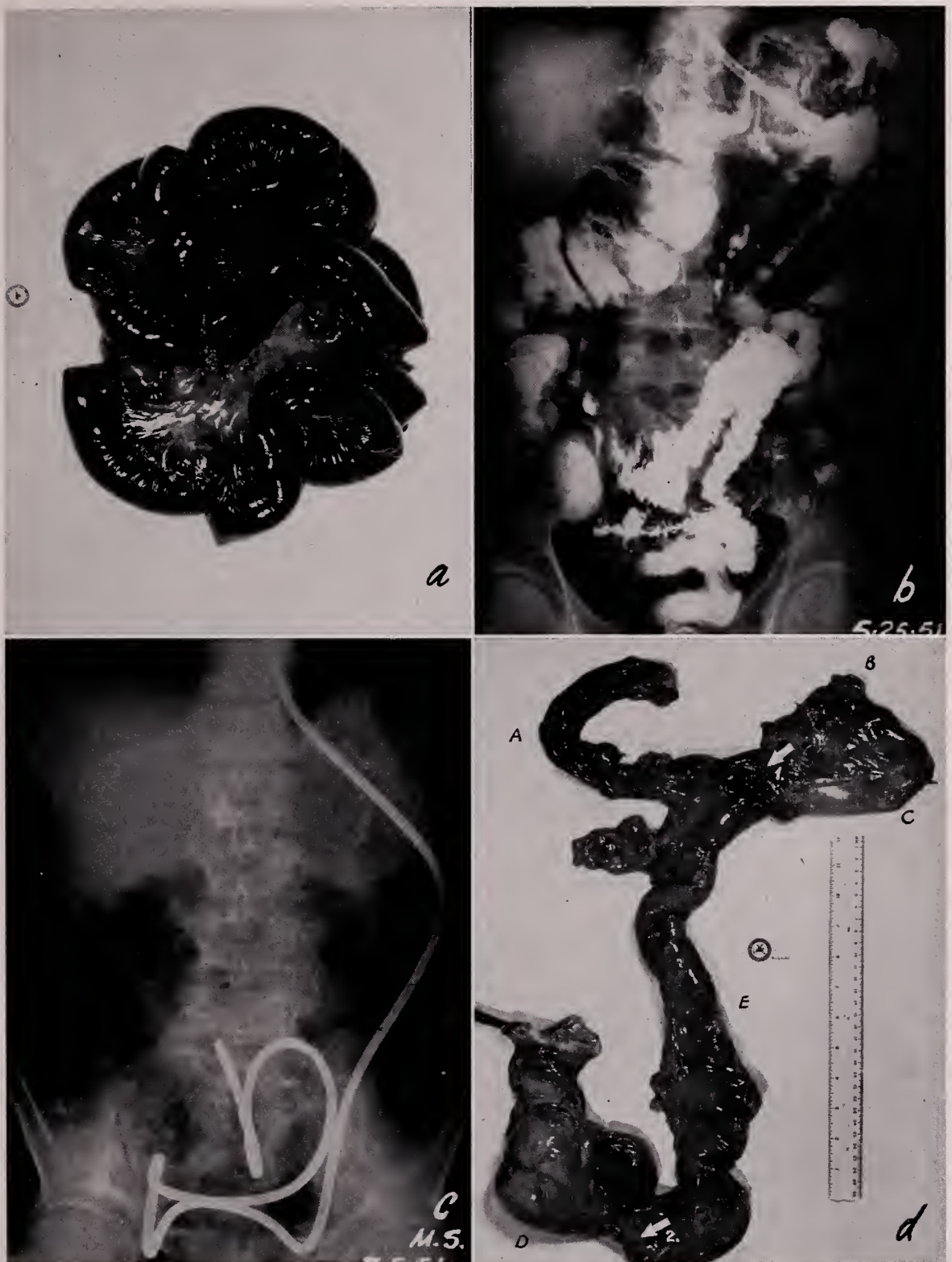

FIG. 1. Case 1. a. Gangrenous small bowel resected April 6, 1951.

b. A barium study May 25 after small bowel resection shows some barium remaining in the stomach; the entire extent of the small intestine can be outlined vaguely.

c. A roentgenogram made sometime later shows the distal end of the Miller-Abbott tube apparently at the ileocecal valve. Repeated efforts failed to advance the tube farther.

d. Autopsy specimen showing (*A*) duodenum, (*B*) short esophageal segment, (*C*) entire stomach, (*D*) cecum, and (*E*) entire length of small bowel. Arrow 1 points to a perforated ulcer, and arrow 2 indicates the site of an old enteroenterostomy.

to facilitate the absorption and utilization of calcium. Ascorbic acid, crude liver extract, vitamin B complex, and vitamin K were administered parenterally to forestall vitamin deficiencies and anemia. Repeated blood chemistry examinations were done, and at no time prior to the patient's temporary discharge from the hospital July 15, 1951, did the blood urea nitrogen, total blood cholesterol, blood sugar, total serum protein, serum albumin-globulin ratio, serum chlorides, serum amylase, blood carbon dioxide combining power, blood calcium, serum sodium, or serum potassium show anything but normal variation. A gastrointestinal series

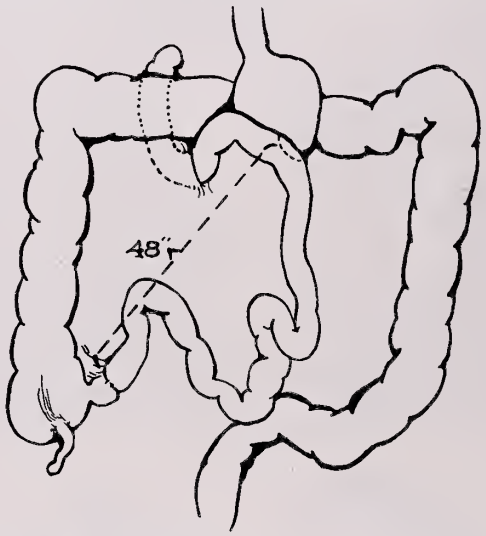

FIG. 2. Case 2. Diagram of the reconstructed gastrointestinal tract following massive small bowel resection.

on May 25 showed filling of the entire intestinal tract and revealed no abnormality (fig. 1b and c).

The patient was seen frequently until August 20, 1951. On that date he weighed 121 pounds and appeared in good health. He then failed to return for routine examination and was not seen again until February 9, 1952. Eight days previously his bowels had failed to move, and he considered this especially significant since he usually had several bowel actions daily. He developed a mild distention and vomited once before admission to the hospital.

On physical examination the patient was found to be markedly dehydrated, poorly nourished, and chronically ill. His temperature was 100 F.; the pulse feeble, 120 per minute; and the blood pressure 80/0 mm. of mercury. The abdomen was distended, tympanitic, and silent. There was mild, generalized abdominal tenderness without rigidity.

A roentgenogram of the abdomen was not remarkable. The leukocyte count was 9,100 with a normal differential. The hemoglobin was 9.7 Gm. with an erythrocyte count of 3,200,000.

The unusual findings were a serum protein level of 3.1 Gm. per 100 cc., a serum chloride level of 86 milliequivalents per liter, a serum potassium level of 1.4 milliequivalents per liter, a serum sodium level of 133 milliequivalents per liter, and a blood calcium level of 2.9 milliequivalents per liter.

A vigorous but unsuccessful attempt was made to correct the fluid and electrolyte imbalance, but the patient's condition grew progressively worse, and he died on the fifth day in the hospital.

Postmortem examination revealed a generalized, purulent peritonitis secondary to a large perforated jejunal ulcer at the margin of the gastrojejunostomy. The entire segment of small bowel excluding the afferent loop measured 70 cm. (28 inches), and no compensatory hypertrophy had occurred as has been noted in other cases (fig. 1d).

CASE 2.—The second case has one or two interesting differences from the first. The patient was a much younger and healthier man from the beginning. He had a high subtotal gastrectomy with a Hofmeister-type antecolic gastrojejunostomy performed on January 31, 1952, for a chronic duodenal ulcer that had perforated on three separate occasions in the preceding ten years.

On May 4, 1952, the patient returned to the hospital with a note from his family physician stating that the patient had suffered several attacks of what appeared to be incomplete intestinal obstruction. The night before admission an attack more severe than usual had begun and had not relented. He had vomited several times.

Physical examination revealed a well developed but thin patient in good general condition but in moderate distress. The abdomen was tender throughout but not distended. There was definite rigidity.

There was a leukocytosis of 19,850 white cells per cubic millimeter. All other laboratory findings were normal. A roentgenogram showed small bowel distention with fluid levels and no free air.

The patient was operated upon, the findings at surgery being similar to the preceding case. Approximately 120 cm. (48 inches) of jejunum distal to the gastrojejunostomy was viable and only 5 cm. (2 inches) of ileum just proximal to the ileocecal valve was viable. An end-to-end enteroenterostomy was accomplished after quick resection of the gangrenous bowel (fig. 2). Many adhesions secondary to the previous operations were noted.

This patient had a gratifying convalescence. By May 10, he was passing flatus. When given a full diet, he had approximately ten stools a day. He ate well and gained 4 pounds in one week. He was discharged in good condition May 26.

A gastrointestinal series on August 22 showed unusually slow progression of the head of the column of barium. At four hours all the column had reached the cecum (fig. 3). It is likely that the patient had multiple adhesions which slowed the passage of barium, perhaps accounting for his good nutritional status despite the minimal amount of small intestine remaining.

The hemogram and blood chemistry results have remained normal. The patient's weight has maintained at about 130 pounds compared with his usual weight of 160 pounds.

DISCUSSION

It appears definite now that our second patient will not succumb from the effects of his extensive enterectomy. He never presented the serious nutritional problem which we expected from our experience with the first patient. There may be several reasons for this. He was twenty years younger and in better physical condition prior to his operation than the patient of case 1. He was decidedly more cooperative and has followed dietary restrictions well. Very likely his meals at home have been more nutritious. One also might conclude that the 48 inches of small bowel exceeds slightly the minimum amount necessary to maintain

life whereas the 28 inches remaining in the first patient was perhaps short of the minimum requirement.

Where is this critical point? It is interesting to note that in 1912, Flint[6] was trying to answer the same question. He said, "In these days of aggressive surgery, it is important to know the limits of resection of various organs and tissues. . . ."[6] After extensive experiments on dogs, he estimated that 50 per cent of the small intestine could be resected and good health be maintained. Prioleau[17] in 1944 agreed with that estimation. Perhaps the required amount of functioning small bowel is somewhat less than 50 per cent, but Meyer,[13] Johnston and associates,[10] and others[1,11,13,17] have noted that although survival is possible after more extensive resections, the patient loses weight which he never regains and does not have perfect health thereafter.

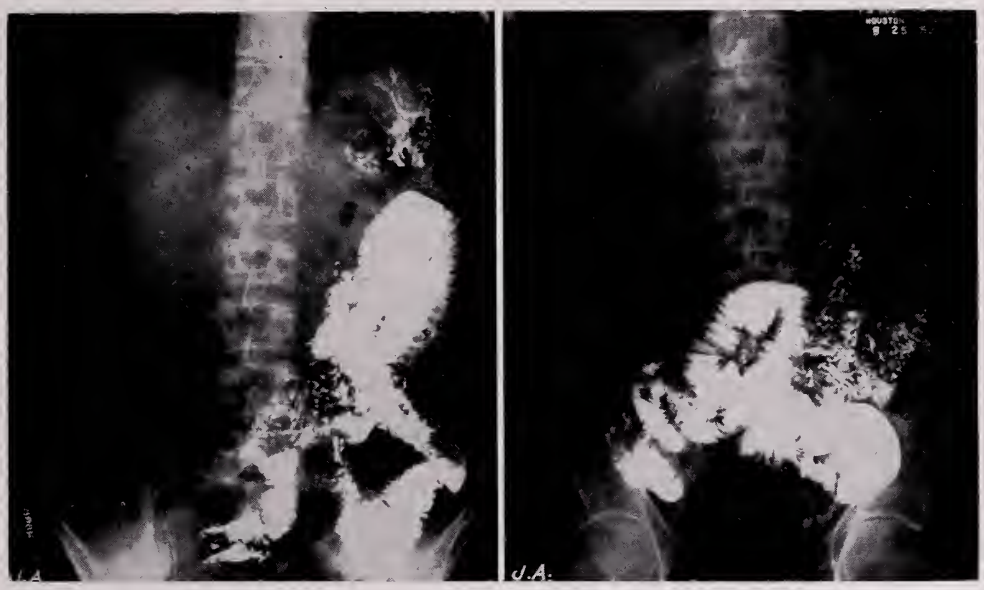

FIG. 3. Case 2. Gastrointestinal series three months after small bowel resection. *Left:* Roentgenogram made at one hour shows barium in the stomach and proximal one-third of the small bowel. *Right:* Roentgenogram at two hours shows barium in the cecum and faintly throughout the entire extent of the small bowel. The slow progression of barium is not explained.

It has been interesting to speculate how much the previous gastrectomy affected our 2 patients. The small intestine is the most important part of the gastrointestinal tract from the standpoint of physiologic function.[11] As we know, the small intestine can assume the function of the stomach or colon when necessary, but for adequate digestion it needs assistance, and certainly in these 2 patients it would have been desirable to have a large normal stomach with a pyloric sphincter and a duodenum that had not been short-circuited. Under such conditions the ingested food would have been churned, partially digested, and acidified. This process would have initiated the breakdown of all foods and prepared them for further digestion and absorption in the acid medium.[12] Without the normal stomach and the sphincter, the food dropped almost immediately into the alkaline jejunum, progressed rapidly, and in case 1 had reached the colon in only a few minutes. It might be assumed that this patient would be living now had he not lost most of his stomach earlier.

Flint's experimental work on dogs in 1912 indicated that, following extensive enterectomy, a compensatory process consisting of a hypertrophy as well as hyperplasia of the remaining portion of the small intestine occurred. It seemed probable to him that "in favorable cases approximately the original epithelial area of the intestine is restored by the hypertrophic process."[6] Similarly, Coleman and Bennet[4] believed that postoperatively the rate of absorption proximal to the resection becomes twice the normal rate. The slight weight gain after an initial loss in case 1 suggests that the patient probably did benefit from increased absorption. Autopsy findings, however, showed a distinct failure of the remaining jejunum to increase in diameter or length. It has not been possible yet to confirm any changes which may have occurred in case 2, but the patient's good general condition at present possibly may be attributed to such changes.

SUMMARY

Extensive enterectomies in postgastrectomy patients must be rare. A careful search of the medical literature revealed reports of only 2 previous cases.

We report 2 cases of our own, 1 with a ten month survival and the other being alive and well almost twelve months postoperatively. The autopsy findings in case 1 are presented.

The probable effect of the previous gastrectomy on the nutrition of the 2 patients is discussed.

Our patients conform to the pattern of other similar cases reported regarding persistently frequent soft stools, a lower weight level plateau, and a tendency to improve gradually with time. However, autopsy findings in case 1 did not show compensatory hypertrophy or hyperplasia of the remaining small bowel which others have felt occurred.

ADDENDUM

As of January 1, 1954, the second patient is living and well.

The authors wish to express their gratitude to Mrs. Ella S. Breckenridge and the Medical Illustration Laboratory, Veterans Administration Hospital, Houston, for the preparation of the illustrations in this article.

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Dr. Blaine, Veterans Administration Center, Temple, Texas.

ABSTRACT OF DISCUSSION

DR. DENTON A. COOLEY, Houston: In 1951, I reported a case of a 52 year old housewife who six years previously had undergone gastric resection with inadvertent gastroileostomy.* Diagnosis of the condition had not been made previously although multiple barium studies had been done. Not until a Miller-Abbott tube was passed from the gastric pouch directly into the colon was the radiologic appearance explained. Subsequent laparotomy revealed that the gastrointestinal anastomosis had been done 18 inches from the ileocecal junction. A short bowel syndrome, similar to those reported by Dr. Shelton, was thus available for study after a prolonged period of progressive deterioration of the patient.

The most striking feature in my case was the appearance of spontaneous fractures involving the left clavicle, right radius, and multiple ribs. Serum calcium measured 8.1 mg. per 100 cc., which in the presence of a total serum protein level of 4.0 Gm. per 100 cc. was well above tetanic levels. Serum phosphorus was 1.8 mg. per 100 cc., and the alkaline phosphate was 29.4 Bodansky units. Thus the chemical pattern was similar to that of juvenile rickets or adult osteomalacia. The fact that the serum phosphorus increased to 3.5 mg. per 100 cc. with massive doses of calciferol indicated that a deficit of vitamin D, a fat soluble vitamin, was the cause of the osseous decalcification. Soon after correction of the gastroileostomy, the fractures healed, and the patient has completely recovered. Perhaps Dr. Shelton should give his patient a larger dose of the fat soluble vitamins.

DR. ALANDO J. BALLANTYNE, Houston: The problem of maintenance of nutrition after resection of various portions of the gastrointestinal tract is an interesting study in applied physiology. Studies such as those reported in Dr. Shelton's paper indicate that our knowledge of gastrointestinal physiology is far from complete, particularly in relation to the amount of compensation that can occur in the face of extensive resections. Furthermore, it would seem that inferences from animal studies regarding the amount of intestine that can be resected with survival cannot be directly applied to human material. Some animal studies also tend to show that resection of the jejunum is tolerated better than resection of the ileum, but Dr. Shelton reports that reasonable nutrition is possible after resection of the entire ileum, most of the jejunum, and even the right colon.

After extensive subtotal gastric resections, gastrointestinal physiology is altered, and there may be nutritional disturbances resulting therefrom. The most apparent alteration is the loss of much of the reservoir function of the stomach with a resultant more rapid filling of the jejunum with material which has not been processed by the stomach. The material reaching the jejunum does not have what is considered to be an optimum hydrogen ion concentration, osmotic concentration, or fluidity. These changes and the absence of the normal controls of gastric emptying lead to an increased hurry of the intestinal contents in the upper jejunum and in some instances through the entire small bowel. Deficiencies in absorption may result, particularly in the absorption of fat, and subclinical steatorrhea is common after subtotal gastrectomy. There are also perhaps deficiencies in absorption of iron and vitamins resulting from this derangement in physiology, but usually these deficiencies are less apparent clinically.

When a considerable loss of absorptive surface resulting from massive intestinal resection is added to the defects produced by subtotal gastrectomy, a situation in which nutri-

*Cooley, D. A., and Hartmann, R. C.: *Inadvertent Gastro-Ileostomy: Successful Operative Correction Six Years After Gastrectomy, Bull. Johns Hopkins Hosp.* 89:133-142 (Aug.) 1951.

tional problems are likely to develop is present. With only a small segment of small bowel remaining, absorption of carbohydrate is ordinarily good, protein is absorbed fairly well, and fat is absorbed poorly. Chlorides, sodium, and potassium seem to be absorbed reasonably well. The absorption of adequate amounts of calcium is more difficult. Calcium is absorbed chiefly from the upper small intestine where its rate af absorption is influenced chiefly by the hydrogen ion concentration, the amount of phosphates and fat in the diet, and the presence of vitamin D. In patients who have undergone gastrectomy and have minimal small bowel remaining and who are losing large amounts of fatty acids, conditions for calcium absorption are about as poor as could be imagined. It is interesting that in Dr. Shelton's first patient during the final admission to the hospital the blood calcium was 5.8 mg. per 100 cc. and yet clinical tetany was not present. Had vomiting been prolonged sufficiently to result in alkalosis, tetany certainly should have occurred. The other findings of marked hypoproteinemia and anemia are fairly characteristic of the findings reported in the literature in the terminal phases of these nutritional problems.

What can be done to improve the nutrition of these patients? A diet rich in carbohydrate, medium in protein, and low in fat given in frequent feedings seems to be tolerated best. The use of Tweens-80 to facilitate the absorption of fat has met with indifferent success. Hexamethonium bromide taken before each meal has been said to facilitate the absorption of fat in some patients after gastrectomy, but I have seen no reports of its use after massive small bowel resection. Theoretically, the administration of synthetic diets containing amino acids should result in better utilization of ingested protein; but in the reports with which I am familiar, there has been a better utilization percentagewise of whole protein, and patients will not follow a synthetic diet long enough for extensive studies.

When a surgeon is faced with the problem of resecting the small intestine in such quantity that the remaining absorptive surface seems inadequate to sustain life, he can be comforted by the fact, pointed out by Drs. Shelton and Blaine, that other surgeons have living patients who have had most of the stomach as well as most of the small bowel removed and yet maintain a reasonable state of nutrition. We can hope that in the future new facts may be uncovered which will lead to an improvement in the nutritional state.

Ulcerative Colitis with Sarcoid-Like Lesions Treated by Total Colectomy

REPORT OF A CASE

JOHN A. HART, M.D., F.A.C.S., Beaumont, Texas

THERE are many forms of ulcerative colitis, but the term is best used to denote a clinico-pathologic syndrome. This syndrome may develop as a result of infection by one or more of several bacteria or animal parasites.

Thromboulcerative colitis accounts for about 66 per cent of such cases. It often appears in the second or third decade of life and is characterized by periods of exacerbation and remission. However, the tendency is to progression and extension. It usually begins in the rectum or lower colon and tends to spread upward and involve the entire colon and even the terminal ileum. Perirectal abscesses and ulcers frequently are complications.

The pathologic changes as described by Bargen[1] begin in the wall of the colon as a thrombosis of the capillaries. Edema, miliary abscesses, and ulcers appear as the mucosa is secondarily involved. Fibrosis and uniform strictures follow and result in pseudopolyposis. In the acute phase fever and all the symptoms of intense toxemia are present. Severe diarrhea with passage of purulent hemorrhagic exudate ensues. Death frequently occurs as the result of the fulminating toxemia or from perforation or peritonitis.

The case herein reported followed this pattern and differs only in the pathologic findings in the resected specimen.

CASE REPORT

J. M., an only child, adopted, family history unknown, developed signs of rickets at the age of 6 months. He slept at only short intervals as a baby. He developed nervous tics at the age of 3 years. He was extremely nervous in school and made very poor grades.

In 1947, at the age of 17, the patient developed a chronic cough, began losing weight, and suffered from frequent loose stools. He became lethargic and began to run a low grade fever. No definite diagnosis was made, but he was treated with long courses of sulfonamides, penicillin, and streptomycin. The condition progressed and he began passing purulent and hemorrhagic stools. A diagnosis of ulcerative colitis was made in 1949. The patient was sent through two excellent clinics in neighboring medical centers where repeated cultures, acid-fast stains, and animal inoculation revealed no causative organisms. However, it was suspected by physicians at one of the clinics that the cause was a fungus infection. Subsequently the patient developed multiple perianal abscesses and ulcers. These were operated upon but resisted all treatment. Multiple tender subcutaneous nodules appeared in the lower extremities. The patient's weight, normally about 140 pounds, declined to around 90 pounds. In 1950 he was given Aureomycin and improved rapidly. The fever and diarrhea subsided, the perianal ulcers healed, and normal weight was regained. However, the stools remained semisoft and liquid. The patient remained in fairly good health until 1952, when all symptoms re-

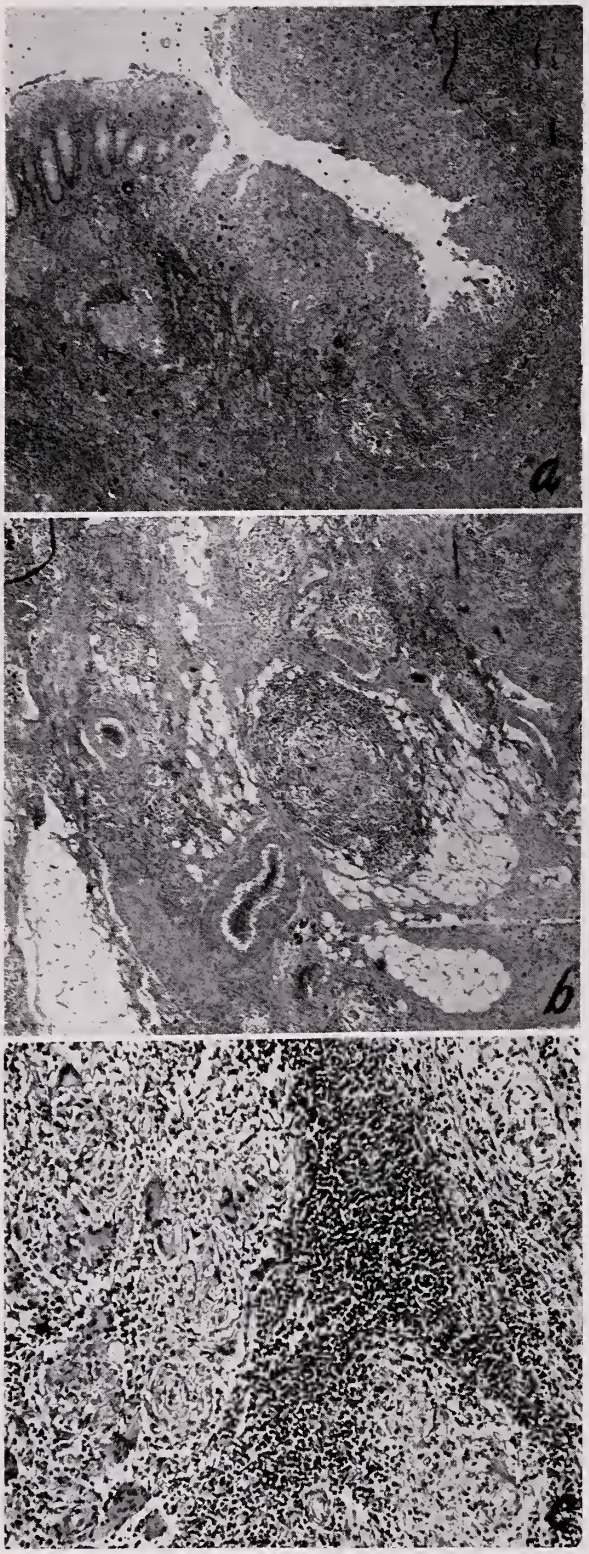

FIG. 1a. Photomicrograph of a section through an ulcerating crypt in a field showing the nonspecific chronic picture usually observed in chronic ulcerative colitis. x 26.

b. Section showing a tuberculoid granulomatous focus occupying an island of adipose tissue and located immediately outside the serosa of the colon. Note the giant cells. x 26.

c. High power view of a granulomatous area similar to *b*. A typical noncaseating tubercle is shown.

turned. Multiple perianal ulcers and abscesses recurred. There was no improvement with Aureomycin or sulfa drugs. Again body weight declined to 90 pounds.

June 21, 1952, a Cattell[2] type of ileostomy was done under light Pentothal and local anesthesia. The postoperative course was stormy and manifested by repeated attacks of gastric dilatation and obstructive symptoms with little drainage through the ileostomy tube. These signs of obstruction were relieved when a colon tube was passed about 20 cm. up the ileum through the ileostomy. The double-barrel ileostomy as described by Cattell creates a pocket between the two loops of the ileum and the anterior abdominal wall through which the ileum can herniate. This complication was thought to be the cause of the obstruction.

The skin for about 12 cm. around the ileostomy was covered with a thick, sticky paste, as advised by Ladd and Gross,[3] which prevented all irritation. The wound healed cleanly, and twelve days postoperatively measurements were taken for a Koenig Rutzen ileostomy bag. This was applied three weeks after ileostomy. If the ileostomy opening projects 1½ inches above the skin, the intestinal contents will be discharged directly into the bag, which is glued to the skin and cannot slip.

The patient felt well and gained about 15 pounds in weight but continued to have diarrhea with passage of a purulent hemorrhagic exudate. There was no evidence of healing of the perianal ulcers.

The patient was rehospitalized and given transfusions. Ten grams of Sulfasuxidine was instilled in the colon through the distal end of the ileum each day for five days prior to colectomy. On January 5, 1953, with spinal anesthesia, through a long left paramedian incision, the distal end of the terminal ileum was excised from the abdominal wall and total colectomy was performed in one stage. A wide incision around the anus was necessary to excise the deep perineal ulcers.

Pathologic Report.—Dr. H. W. Neidhardt, the pathologist who examined the surgical specimen, diagnosed the condition as chronic ulcerative colitis with an unusual superimposed sarcoid-like type of lesion and an appendix showing granulomatous inflammation.

The entire colon showed extensive ulcerations of the mucosa so that in most of the areas there were typical "islands" of mucosa (pseudopolyps). The transverse and descending portion of the colon showed particularly severe involvement with beginning fibrosis of the wall. The cecum showed the least degree of involvement and the small portion of terminal ileum no involvement. The transverse mesocolon showed innumerable enlarged lymph nodes. No areas were suggestive of malignant changes.

Numerous sections taken through the colon microscopically showed extensive ulceration of the mucosa. These ulcers were filled with granulation tissue containing a great many macrophages and newly formed capillaries. There was a dense infiltration with lymphocytes and numerous foreign body type, multinucleated giant cells which are often associated with typical epithelioid noncaseating tubercles such as are seen in sarcoidosis. The granulomatous foci were usually evident in the submucosal part of the colon, but also appeared sometimes as deep as or within the muscularis. The serosa, however, was never involved. Sections through regional lymph nodes suggested sarcoidosis. Sections through the appendix were striking in that the submucosal lymphoid tissue was replete with this same type of tubercle, but without evidence of ulceration. The lesions at the mucocutaneous junction were very severe and the ulcerations unusually deep. Sections through the ileum

showed nothing remarkable. Special stains (periodic-Schiff) were done to demonstrate fungi; however, no fungi were observed. It was postulated that the multiple granulomatous lesions may have been a result of a superimposed fungus infection upon what was otherwise a classical example of chronic ulcerative colitis. The sarcoid-like picture encountered throughout this specimen was difficult to explain. Acid-fast stains were negative.

Postoperative Course.—The postoperative course was smooth. Active peristalsis was noted in the second day with passage of frequent liquid stools. The patient was taking liquid diet on the third day and allowed to be up. The wound healed by primary union. The patient was discharged on the fourteenth postoperative day on a full diet.

Nine months after the colectomy, the patient was doing manual labor, had gained 40 pounds in weight, and had a soft to firm stool once daily.

DISCUSSION

To my knowledge no other cases of chronic ulcerative colitis have displayed this singular pathologic lesion and one may reasonably wonder if the administration of antibiotics over a prolonged period would favor a fungus infection which would account for the granulomatous tissue reaction observed here.

Sommers and others[5] have failed to confirm the contention of some authors[4] that an important histologic alteration in chronic ulcerative colitis is a "basement membrane deficiency" supposedly demonstrated by using the periodic-Schiff reaction.

Since the periodic-Schiff reaction was used in the study of the present case, the sections were reviewed with special attention to basement membrane alteration. No conclusive evidence of such changes could be found.

SUMMARY

A case of chronic ulcerative colitis presenting sarcoid-like lesions in a constitutionally inferior patient was treated by total colectomy. The obstruction from internal herniation which can follow the Cattell type of ileostomy was relieved by high insertion of a colon tube. The Koenig Rutzen bag has robbed ileostomy of its horrors.

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NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, San Antonio, May 3-5, 1954. Dr. George Turner, El Paso, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, San Francisco, June 21-25, 1954. Dr. Edward J. McCormick, Toledo, Ohio, Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, Houston, Feb. 1-3, 1954. Dr. Ben Z. Rappaport, Chicago, Pres.; Dr. Alan G. Cazort, 1425 West 7th St., Little Rock, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice, Cleveland, March 22-25, 1954. Dr. U. R. Bryner, Salt Lake City, Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology. Dr. Robert A. Kimbrough, Jr., Philadelphia, Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Montreal, Canada, May 3-5, 1954. Dr. Emile F. Holman, San Francisco, Pres.; Dr. Paul C. Samson, 2938 McClure St., Oakland 9, Calif., Secy.

American Association of Genito-Urinary Surgeons, Shawnee-on Delaware, Pa., May 26-28, 1954. Dr. Vincent J. O'Conor, Chicago, Pres.; Dr. Norris J. Heckel, 122 S. Michigan Ave., Chicago 3, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 9-11, 1954. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Miami Beach, April 5-10, 1954. Dr. M. Murray Peshkin, New York, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, San Francisco, June 17-20, 1954. Dr. Alvis E. Greer, Houston, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Chicago, April 5-9, 1954. Dr. Leroy H. Sloan, Chicago, Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 5, 1954. Dr. John D. Camp, Los Angeles, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-18, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress of Physical Medicine and Rehabilitation, Washington, D. C., Sept. 6-11, 1954. Dr. William B. Snow, New York, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, White Sulphur Springs, W. Va., April 13-17, 1954. Dr. Louis A. Brunsting, Rochester, Minn., Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, San Francisco, June 18-19, 1954. Dr. J. M. Ruffin, Durham, N. C., Pres.; Dr. H. Marvin Pollard, 1313 E. Ann St., Ann Arbor, Mich., Secy.

American Gynecological Society, Hot Springs, Va., May 20-22, 1954. Dr. Richard W. TeLinde, Baltimore, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, Chicago, April 1-4, 1954. Dr. Robert L. King, Seattle, Pres.; Dr. William H. Bunn, 44 E. 23d St., New York 10, Secy.

American Hospital Association, Chicago, Sept. 13-16, 1954. Mr. Ritz E. Heerman, Los Angeles, Pres.; Mr. George P. Bugbee, 18 E. Division St., Chicago, Executive Secy.

American Laryngological, Rhinological, and Otological Society, Boston, May 25-27, 1954. Dr. LeRoy A. Schall, Boston, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Atlantic City, N. J., June 14-16, 1954. Dr. Roland P. Mackay, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, Glacier Park, Mont., June 16-18, 1954. Dr. William L. Benedict, Rochester, Minn., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, Bretton Woods, N. H., June 6-9, 1954. Dr. A. R. Shands, Jr., Wilmington, Del., Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Buck Hill Falls, Pa., May 3-5, 1954. Dr. Rustin McIntosh, New York, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, Los Angeles, June 2-5, 1954. Dr. Wendell Green, Toledo, Ohio, Pres.; Dr. Stuart T. Ross, 131 Fulton Ave., Hempstead, N. Y., Secy.

American Psychiatric Association, St. Louis, May 3-7, 1954. Dr. Kenneth E. Appel, Philadelphia, Pres.; Dr. R. Finley Gayle, 6300 Three Chopt Rd., Richmond 21, Va., Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Cincinnati, Oct. 25-30, 1954. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Washington, D. C., Sept. 6, 1954. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, Indiana University School of Medicine, Indianapolis, Secy.

American Surgical Association, Cleveland, April, 1954. Dr. Howard C. Naffziger, San Francisco, Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison St., Chicago 3, Secy.

American Urological Association, New York, May 31-June 3, 1954. Dr. J. A. Campbell Colston, Baltimore, Md., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Jackson, Miss., April 1-3, 1954. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1954. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Atlantic City, N. J., May 17-21, 1954. Mr. Mark H. Harrington, Denver, Pres.; Mr. Kemp D. Battle, 1790 Broadway, New York 19, Secy.

Radiological Society of North America. Dr. Ira H. Lockwood, Kansas City, Mo., Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association. Dr. I. A. Bigger, Richmond, Va., Pres.; Dr. John C. Burch, 2112 West End Ave., Nashville 5, Tenn., Secy.

Southwest Allergy Forum, New Orleans, May 9-11, 1954. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, 1954. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Oklahoma City, Sept. 27-29, 1954. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen, Oklahoma City 3, Secy.

Tri-State Medical Assembly, Fall, 1954. Dr. Joe D. Nichols, Atlanta, Pres.; Dr. Broox C. Garrett, 940 Margaret Pl., Shreveport, La., Secy.

United States-Mexico Border Public Health Association, Albuquerque, N. M., April 6-9, 1954. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

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Private Clinics and Hospitals Association of Texas. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice, Galveston, Sept. 9-11, 1954. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris, 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association, San Antonio, May 2-3, 1954. Dr. George L. Gallaher, Harlingen, Pres.; Dr. J. S. Minnett, 2512 Welborn, Dallas, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Waco, Feb. 19-20, 1954. Dr. D. D. Wall, San Angelo, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, San Antonio, May 2, 1954. Dr. Henry H. Hoskins, San Antonio, Pres.; Dr. Walter C. Brown, 1733 S. Brownlee Blvd., Corpus Christi, Secy.

Texas Club of Internists. Dr. Joseph F. McVeigh, Fort Worth, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, San Antonio, May 2, 1954. Dr. Maurice Barnes, Waco, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

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Texas Neuropsychiatric Association, San Antonio, May 2, 1954. Dr. James Blair, San Antonio, Pres.; Dr. John L. Otto, John Sealy Hospital, Galveston, Secy.

Texas Orthopedic Association, San Antonio, May 3, 1954. Dr. Edward T. Smith, Houston, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, October, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society, Houston, Feb. 27, 1954. Dr. Herbert T. Hayes, Houston, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 14-17, 1954. Dr. Roy G. Reed, La Marque, Pres.; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Executive Secy.

Texas Radiological Society, Houston. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, San Antonio, May 3, 1954. Dr. William E. Crump, Wichita Falls, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred H. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Waco, March 4-6, 1954. Mrs. Frank Schoonover, Fort Worth, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 21, Executive Secy.

Texas Society of Anesthesiologists, San Antonio, May 2, 1954. Dr. James B. Robinett, Jr., Houston, Pres.; Dr. C. R. Allen, John Sealy Hospital, Galveston, Secy.

Texas Society of Gastroenterologists and Proctologists, San Antonio, May 3, 1954. Dr. Cecil O. Patterson, Dallas, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, San Antonio, May 3, 1954. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society, Waco, April 5-6, 1954. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Dallas, April 9-10, 1954. Dr. R. G. McCorkle, San Antonio, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Fort Worth, Feb. 22, 1954. Dr. J. Reese Blundell, Houston, Pres.; Dr. Dolphus E. Compere, 1415 Pennsylvania Ave., Fort Worth, Secy.

DISTRICT

First District Society, Pecos, Feb. 12, 1954. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society, Sweetwater, April 15, 1954. Dr. T. D. Young, Sweetwater, Pres.; Dr. Francis Hood, Sweetwater, Secy.

Third District Society, Amarillo, April 13, 1954. Dr. Robert A. Neblett, Canyon, Pres.; Dr. James T. Hall, 1626 Fifteenth St., Lubbock, Secy.

Fourth District Society, San Angelo, Fall, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July, 1954. Dr. Y. C. Smith, Sr., Corpus Christi, Pres.; Dr. Robert J. Sigler, 1126 Third Street, Corpus Christi, Secy.

Seventh District Society, Austin, Feb. 18, 1954. Dr. Benjamin Clary Bates, Austin, Pres.; Dr. William McLean, 4618 Burnet Road, Austin, Secy.

Eighth District Society. Dr. Howard Z. Fretz, Wharton, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society, Brenham, March 25, 1954. Dr. George D. Bruce, Baytown, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. Edmund D. Jones, Beaumont, Pres.; Dr. O. W. Harris, Jr., Liberty, Secy.

Eleventh District Society, Crockett, Spring, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society, Corsicana, July 13, 1954. Dr. Neil Buie, Marlin, Pres.; Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society, Fort Worth, March 24, 1954. Dr. William E. Crump, Wichita Falls, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society, Denton, 1954. Dr. J. W. Atchison, Gainesville, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Longview, April 20, 1954. Dr. Bain Leake, Gladewater, Pres.; Dr. George Tate, Longview, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 15-18, 1954. Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco, April 7, 1954. Dr. Walter B. King, 2320 Columbus Ave., Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 8-11, 1954. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference. Dr. C. H. Wilson, Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, July 19-21, 1954. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls, March 31, 1954. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, June 21-23, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

PERSONALS

"Experiences with the Palmer Open Reduction of Os Calcis Fractures" was the title of a paper presented by *Dr. Jack E. Maxfield* and *Dr. Frederick J. McDermott,* Wichita Falls, at the annual meeting of the American Academy of Orthopedic Surgeons January 23-28 in Chicago.

At the meeting of the American Academy of Obstetrics and Gynecology in Cincinnati on December 14, *Dr. William F. Mengert,* head of the Department of Obstetrics and Gynecology at Southwestern Medical School of the University of Texas, Dallas, was elected president-elect rather than president as reported in the January JOURNAL.

Dr. A. Ford Wolf, Temple, recently was elected secretary-treasurer of the allergy section of the Southern Medical Association.

Dr. William E. Morris was recently selected as the "Outstanding Young Man" in Corpus Christi for 1953.

A dinner was held in Jacksonville to honor *Dr. R. T. Travis* in November, on the eve of the formal open house for the new Nan Travis Memorial Hospital. Dr. Travis was presented with a gold engraved watch and a hat as well as the announcement that the Travis Clinic would sponsor an annual lecture in his honor.

A thirty-year service pin was awarded to *Dr. L. M. Cochran,* Temple, manager of the McCloskey Veterans Administration Center, during the employees' incentive awards program in October. The pin was presented by *Dr. C. R. Miller,* manager of the Veterans Administration Hospital at Marlin and a lifelong friend of Dr. Cochran.

The people of Sanger in November elected as their outstanding citizen for 1953, *Dr. J. M. Sullivan.*

Dr. Martha Helen Hale, Dallas, became a member of the American Academy for Cerebral Palsy at the group's meeting in Fort Worth in November.

Dr. Michael E. DeBakey, Houston, was one of fourteen men throughout the nation named by former President Herbert Hoover to serve on the Hoover Commission's task force on medical services in the federal government, according to an announcement made in November.

Dr. Roger Hanna of Jackson, Mich., became director of tuberculosis hospitals operated by the state of Texas February 1, according to an announcement in the January issue of *Here and There,* official publication of the Texas Tuberculosis Association. Dr. Hanna was superintendent and medical director of the Jackson County Tuberculosis Sanatorium.

Dr. Michael E. DeBakey, professor of surgery at Baylor University College of Medicine, Houston, and *Dr. J. W. Duckett,* professor of clinical surgery, Southwestern Medical School of the University of Texas, Dallas, were two of the three guest speakers for a postgraduate course in surgery offered by the University of Oklahoma School of Medicine, Oklahoma City, early in January.

Dr. Paul Bontley and his family celebrated his parents' fiftieth wedding anniversary with them in Coshocton, Ohio, recently. Dr. Bontley is from Arlington.

Dr. Henry A. Hawkins, New Boston, was elected president of the East Texas Unit of the National Chinchilla Breeders of America at the group's meeting in November in Tyler.

Dr. Thomas J. B. Shanley was honored with a Thanksgiving dinner and presented with a gift by the Plainview Hospital staff before he returned to private practice in El Paso from his position as house physician at the Plainview Hospital and Civic Foundation, Plainview.

Dr. George E. Penny, Laredo, married Mrs. Dorothy L. Morrison in San Antonio, November 1, reports the *South Texas Citizen* of Laredo.

Dr. S. H. Kirkham and Miss Ruby Lea Long, both of Cleveland, were married October 31, according to the Cleveland *Advocate.*

Dallas Southern Clinical Society

Announcement has been made of the honor guests of the Dallas Southern Clinical Society who will participate in the 1954 spring clinical conference March 15-18 in Dallas. The physicians and their specialties are Drs. Willard M. Allen, St. Louis, gynecology; William B. Bean, Iowa City, internal medicine; Edward G. Billings, Denver, psychiatry; William L. Bradford, Rochester, N. Y., pediatrics; Alson E. Braley, Iowa City, ophthalmology; Ormond S. Culp, Rochester, Minn., urology; Clarence Dennis, Brooklyn, surgery; Thomas J. Dry, Rochester, Minn., cardiology; Charles H. Eyermann, St. Louis, allergy; Hugh F. Hare, Los Angeles, radiology; A. C. Hilding, Duluth, otolaryngology; Samuel F. Marshall, Boston, surgery; Paul E. McMaster, Beverly Hills, Calif., orthopedics; George T. Pack, New York, surgery; John Parks, Washington, D. C., obstetrics; Douglas H. Sprunt, Memphis, pathology; C. Dwight Townes, Louisville, ophthalmology; and Walter P. Work, San Francisco, otolaryngology.

This twenty-third annual conference will consist of general assemblies, round-table luncheons, a clinicopathologic conference, lectures, motion pictures, panel discussions, technical and scientific exhibits, and a dinner dance. Registration fee is $25, which may be mailed in advance to the society, Medical Arts Building, Dallas 1. Any member in good standing of a county medical society may attend. Hotel reservations are to be made directly with the hotel of choice.

Study of Man Continues at Dallas Health Museum

In the early eighteenth century Alexander Pope opined that "The proper study of mankind is man." Now in the middle of the twentieth century a good many people still agree with him. Some 200,000 Texans (and a liberal sprinkling of "foreigners") annually agree to the extent that they visit the Dallas Health Museum. Seven days a week, year after year, they file through the halls of this building on the State Fair grounds, studying exhibits on man, the structure of his body, and how to care for it.

Modeling the ribs for a new transparent man is a technician in the Dallas Health Museum workshop (*upper left*). All methods and equipment used in the man's creation were worked out at the shop since they were not obtainable elsewhere. Master minds in his creation were Mrs. Marguerite Hays, museum director, and Vic Klein, architectural designer.

The completed transparent man (*upper right*) replaces the German-made thirty year old man which was featured at the museum for a number of years.

Nurses study one unit of the beginning of life series (*below*). The museum is used regularly by professional groups as well as classes from all grades of public and private schools, and many youth groups such as YMCA, YWCA, Boy Scouts, and Camp Fire Girls.

No. 1 exhibit at the museum is a new transparent man which was recently finished in the museum workshop. This 6-foot replica of the human male has "flesh" of clear plastic through which are revealed brilliantly lighted organs, nervous system, and blood vessels. The "man" revolves slowly while a recorded voice describes the functioning of the body. In making the "man" a total of 10,760 man-hours were consumed. Thirteen different skills were employed. He is insured for $25,000.

Museum personnel believes that the new "man" is superior in many ways to the German-made "Homer," the original transparent man who was on display at the museum for a number of years. Homer has taken up his permanent residence at the American Museum of Natural History in New York City.

Among the newest exhibits at the museum is a long panel presenting a number of phases of good nutrition. Another display called "Common Contagious Diseases" has models of children's faces showing the symptoms of measles, scarlet fever, diphtheria, smallpox, mumps, chickenpox, ringworm of the scalp, and impetigo. Still another of the newest displays is on poliomyelitis.

An entire room at the museum is devoted to a series of handsome exhibits on cancer. The seven warning signals are graphically described. The accepted methods of treating cancer are explained. Visitors are urged to see their physicians when any suspicious irregularity occurs.

Another room is devoted to dental science. A giant illuminated tooth tells at a glance the basic tooth structure. A panel on dental facts and fallacies explodes old wives' tales about the teeth and gives the observer brief, concise answers to many questions relating to his own dental health. A photographic panel shows vividly how cases of malformation can be corrected by orthodontics.

The most popular exhibit in the museum, reports Mrs. Marguerite Hays, director, has always been the birth series. Known as the "Actual Birth of the Baby," it consists of nine statues showing the birth process. It is one unit in a series of exhibits on the beginning of life.

Most valuable of the museum services, according to a number of parents of young children in and around Dallas, are the parentcraft courses which are carried on the year round. Expectant mothers are taught in daytime classes and the fathers at night. Local physicians and a public health nurse give the students information on how to prepare for and care for the baby, and how to enjoy him in the process. They are referred to the classes by their private physicians.

A program on nutrition is just getting under way, sponsored jointly by the museum and the Dallas City Health Department. The first series of weekly classes planned will be on the subject of obesity. They will be open to the public.

Still another museum project which is as yet in the planning stage is a healthmobile. The idea is to equip a mobile unit with replicas of certain of the museum exhibits (even the transparent man). The unit would then travel over the state, stopping on town squares and school yards to open its doors to all comers for a quick lesson in health. This project awaits the necessary funds to be initiated.

Supported by private contributions, the seven year old museum is governed by a twenty-five man board of trustees. Turner B. Baxter, vice-president of the Rio Grande National Life Insurance Co., is president this year. Dr. J. Frank Roark is vice-president; Dr. M. O. Rouse, secretary; and R. L. Thomas, treasurer.

Postgraduate Course at Temple

Dates for the medical and surgical conference to be held at Scott and White Hospitals, Temple, under the auspices of the University of Texas Postgraduate School of Medicine have been changed from March 1-3 to February 22-24. The three-day conference will consist of operative clinics and panels on medicine and surgery. Tuition fee is $25.

Cancer Society Reports Progress

A review of progress in cancer research was presented by five physicians speaking at the annual meeting of the Texas Division of the American Cancer Society in Austin, January 14-16. Drs. Michael B. Shimkin, San Francisco, chief of the Laboratory of Experimental Oncology of the United States Public Health Service; Dr. Charles L. Martin, Dallas, clinical professor of radiology at Southwestern Medical School; Dr. William F. Mengert, Dallas, head of the Department of Obstetrics and Gynecology at Southwestern; Dr. Jack B. Trunnell, Houston, endocrinologist at the M. D. Anderson Hospital for Cancer Research; and Dr. Alfred M. Popma, Boise, Idaho, president of the American Cancer Society, reviewed the progress and prospects in laymen's terms.

A medical session on lesions of the breast featured discussions by Drs. A. C. Broders, Scott and White Clinic, Temple; Clifton D. Howe, M. D. Anderson Hospital, Houston; R. J. White, Fort Worth; Shimkin; and Popma.

John T. Andrews, Lawrence, Kan., general sales manager of the Kansas Public Service Company and chairman of the Kansas Division Cancer Crusade, was the chief speaker for the Crusade session, and Mrs. Harold V. Milligan, New York, director of volunteer recruitment and training for the American Cancer Society, made the principal address at the final luncheon. Dr. Popma was the main speaker at the annual dinner.

Travis T. Wallace, Dallas, was reelected president for the forthcoming year, as were Frank C. Smith, Houston, chairman of the board of directors; Dr. G. V. Brindley, Temple, vice-president for medical activities; Mrs. Joseph M. Perkins, Eastland, vice-president for lay activities; Philip R. Overton, Austin, secretary; and J. Louis Neff, Austin, executive director. Raymond Gee, Fort Worth, was named treasurer. Drs. C. E. Adams, Abilene; Charles T. Ashworth, Fort Worth; Porter Brown, Fort Worth; R. Lee Clark, Houston; Paul North, McKinney; Charles Phillips, Temple; David A. Todd, San Antonio; George Turner, El Paso; and John Dale Weaver, Austin, are among those serving on the executive committee.

The annual report of the executive director pointed out that during the fall and winter of 1953-1954, the cancer society conducted 13 district meetings, largely of a training nature, attended by 363 lay people, with associated scientific sessions drawing 871 physicians. Audiences totaling 277,073 saw motion picture films sponsored by the society; more than 4,000,000 pieces of literature were distributed; and 35,671 women produced 11,560 dozen cancer dressings.

Texas Proctologic Society

The Texas Proctologic Society is holding its third meeting February 27 in Houston, an organizational meeting having taken place in Dallas on September 13, 1952.

Founder members of the organization include Drs. Alvin Baldwin, Jr., Dallas; Hugh Beaton, Fort Worth; Harry B. Burr, Houston; Otho P. Griffin, Fort Worth; C. P. Hardwicke, Austin; J. Wade Harris, Houston; Herbert T. Hayes, Houston; Jack G. Kerr, Dallas; John McGivney, Galveston; Curtice Rosser, Dallas; Robert J. Rowe, Dallas; Tom E. Smith, Dallas; and Victor C. Tucker, San Antonio. Dr. Rosser served as the first president; Dr. McGivney as the first secretary-treasurer. At the 1953 meeting November 7 in Dallas, Dr. Hayes assumed the presidency and Dr. McGivney continued as secretary-treasurer.

The objectives of the society are to facilitate and disseminate knowledge relating to the colon, rectum, and anus; to encourage proctologic research; and to advance the specialty of proctology in Texas. To become a member, a physician must be a graduate of a class A medical school and a member in good standing of his county medical society, must have limited his practice in Texas to proctology for at least three years; must have attended at least one meeting of the society as a guest; and must be invited by the society to join.

Eisenhower's Health Message

On January 18, President Dwight D. Eisenhower sent a special message on his proposed health program to Congress. Briefly, his proposals included (1) "a limited federal reinsurance service to encourage broader health protection to more families," (2) "greater assistance to the states for rehabilitative services," (3) "assistance in the construction of (a) non-profit hospitals for care of chronically ill, (b) non-profit medically supervised nursing and convalescent homes, (c) non-profit rehabilitation facilities for the disabled, (d) non-profit diagnostic or treatment centers for ambulatory patients," and (4) a simplified formula for grant-in-aid "permitting the states to use greater initiative in state programs and take more responsibility" with states being "aided in inverse proportion to their financial capacity."

Four days before, the President had called for changes in the social security laws to provide (a) mandatory coverage of physicians and most other self-employed persons, (b) waiver of old age and survivors' insurance premiums for the disabled, and (c) greater emphasis on the rehabilitation of the physically handicapped, with a close liaison between waiver of premium benefits and the beneficiary's vocational rehabilitation.

Bills to implement most of these proposals have been introduced in Congress. An administration bill providing for reinsurance of health plans was not forthcoming immediately, but a bill previously introduced by Representative Charles Wolverton of New Jersey incorporates the general ideas proposed by President Eisenhower and currently is under consideration in a series of hearings on voluntary health insurance being held by the House Interstate and Foreign Commerce Committee of which Representative Wolverton is chairman. The Wolverton plan calls for a federal health insurance corporation which would underwrite various types of hospital, surgical, and medical insurance programs, permitting individual programs to offer "complete" coverage at low cost with the national corporation paying possibly two-thirds of each subscriber's claim in excess of, say, $500 or $1,000 in any one year. Member plans would contribute a percentage of their gross receipts to keep the national corporation going.

The American Medical Association, officials of which have kept in close touch with developments in Washington, through its Board of Trustees, which held a special meeting January 24 to consider the implications of the Eisenhower health proposals, issued a statement which read in part:

"The Board of Trustees . . . is pleased to find in this message so many of the ideas and principles for which the American Medical Association has striven for so many years.

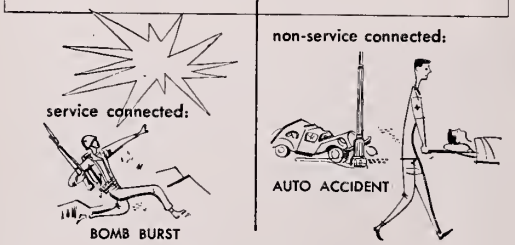
"The Board endorses the general objectives of the President to extend needed facilities, to promote further research, to increase coverage under voluntary health insurance and to rehabilitate the disabled. . . .

"The Administration's federal reinsurance proposal is indefinite. It is not clear whether this is true reinsurance or another form of government subsidy. This whole subject needs careful study and until the plan is spelled out in detail the American Medical Association can make no further comment. . . ."

IN VIEWING THE VA MEDICAL PROGRAM . . .

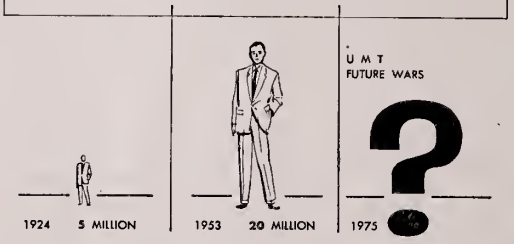
An explanation by the American Medical Association of medicine's attitude toward veteran's care

types of disability



The medical profession fully endorses and supports the medical program of the Veterans Administration through which veterans receive medical care and hospitalization without cost for illnesses or injuries incurred as a result of military service (left). It is felt, however, that the federal government should not assume the responsibility for the medical care of veterans whose disabilities are incurred in civilian life and which hove no relationship to their military service.

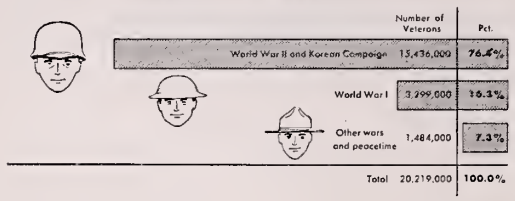
veteran population



The U. S. veteran population now includes about 40% of all adult males. Under existing legislation, the federal government is obliged to provide "free" medical care for many of these veterans, if they request it. The medical profession questions the soundness of providing medical care at federal expense to veterans with non-service-connected disobilities. It is likely that by 1975 the U. S. will truly be o "nation of veterans." If the VA medical program continues to accept responsibility for the care of veterans with service-connected and non-service-connected disabilities alike it is difficult to see how a complete federal health program can be avoided.

analysis of veteran population

PERIOD OF SERVICE



Taxpayers should note that as veterans grow older they require more frequent and increasingly langer periods of hospitalizatian. World War I patients are now hospitalized twice as lang, on the average, as World War II patients with similar disabilities. World War II veterans, relatively young and comprising 76% of the total veteran populatian, present a costly long term responsibility to U. S. taxpayers. The medical profession recammends medical care through the VA for only those veterans with service-incurred disabilities and temporarily for those with tuberculosis or neuropsychiatric conditions of nan-service-connected origin.

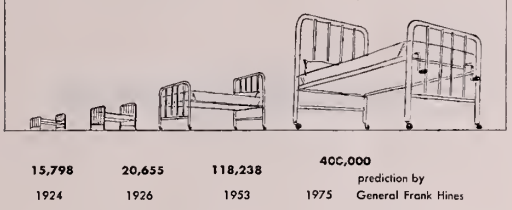
analysis of present veteran population

AGE DISTRIBUTION (Exclusive of those discharged on or after June 27, 1950)

DATE	JAN. 1, 1952	JAN. 1, 1960	JAN. 1, 1970
TOTAL	18,850,000	18,160,000	16,146,000
AGE 22-44	77.2%	62.7%	13.5%
45-64	21.8%	27.4%	73.7%
OVER 65	1.0%	9.9%	12.8%

Older veterans are hospitalized more frequently for civilian-incurred ailments than for service-connected disabilities. By 1970, over 86% of the present veterans will be age 45 or over, more than three times the number in this older age group today. Because of advanced age, they will require more frequent and prolonged hospitalization for illnesses having no relationship to their military service. Responsibility for such medical care should be assumed by the individual or locol government, not by the federal government.

VA hospital beds



15,798	20,655	118,238	400,000 prediction by General Frank Hines
1924	1926	1953	1975

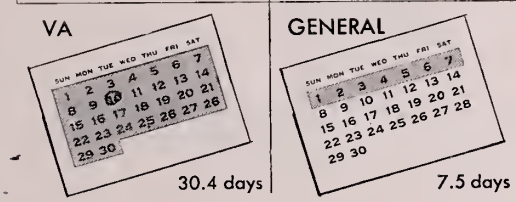
Former VA Administrator Frank Hines estimated that by 1975 under existing VA medical legislation, approximately 400,000 hospital beds will be needed. Yet medical authorities are convinced the VA cannot attract sufficient medical personnel to staff more than 120,000 beds. The VA now maintains three times the number of beds needed for treatment of service-connected cases.

average length of stay in VA hospital

	Average (days)	World War II (days)	World War I & Other (days)
TB	205.8	203.6	210.2
NP	178.3	89.2	430.6
GMS	30.8	23.5	42.5

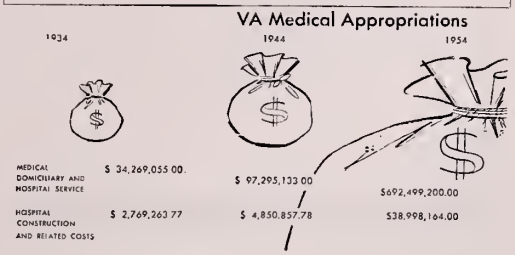
The average length of stay in VA hospitals for World War I veterans is considerably greater than for World War II veterans, which now comprise 76% of the total veteran population. The greatest pressure is yet to be exerted on VA hospitals as World War II veterans grow older and require increased medical care for disabilities unrelated to military service.

comparison of length of stay in VA and general hospitals GM&S



Generol medicol ond surgicol potients in VA hospitols ore confined four times longer thon in non-federol hospitols. VA hospitals odmit potients for exomination, diognosis, ond treotment, much of which is normolly undertoken outside civilion hospitals. Also, VA patients often remoin hospitalized throughout the entire medicol treotment period, whereas non-VA patients ore usuolly treoted ot home during their convolescence. This is o mojor foctor in the tremendous cost of the VA medicol program.

increasing tax burden



In twenty years, the cost of the VA medical program to U. S. taxpayers has increased 1,875%. Yet only 15% of the patients treated in VA hospitals are veterans with disabilities incurred while in uniform. The VA medical program is now second in size and expense only to the nation-wide system of socialized medicine in Great Britain.

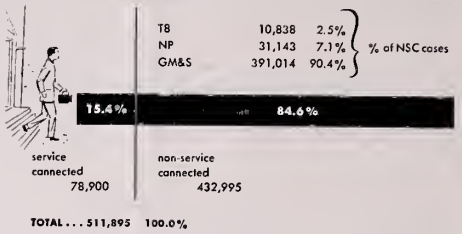
how VA facilities are being used

Patients Discharged During 1951

	TOTAL	SERVICE CONNECTED		NON SERVICE CONNECTED	
TB	21,388	10,550 = 2.1%		10,838 = 2.1%	
NP	47,673	16,530 = 3.2%		31,143 = 6.1%	
GM&S	442,834	51,820 = 10.1%		391,014 = 76.4%	
TOTAL	511,895	78,900	15.4%	432,995	84.6%

The medical profession recommends that VA medical care be maintained for treatment of all service-connected cases and temporarily for all wartime veterans suffering from tuberculosis or neuropsychiatric disorders of non-service-connected origin, within limits of existing VA facilities, if they cannot afford private medical care. General medical and surgical patients with non-service-connected disabilities (now 76.4% of all VA patients) should not be entitled to "free" federal medical care.

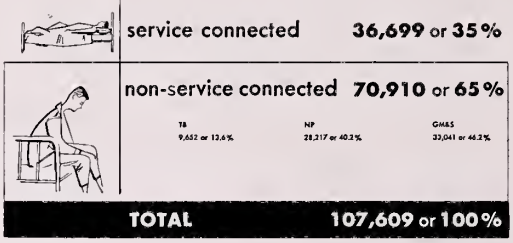
VA patients discharged during 1951



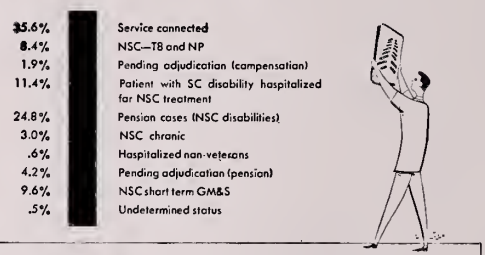
Of 511,895 patients discharged from VA hospitals in 1951, only 15.4% were treated for illnesses or injuries incurred as a result of military service. Physicians believe it is unsound to continue authorization of "free" lifetime medical care for those who suffer no mishap while in uniform, while other citizens with no military background must pay their own way.

VA patient load as of a given day

January 31, 1952



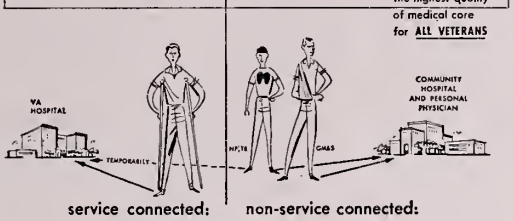
While the VA lists its patient load an a given day as 35% service-connected, anly the lang-range view of admissions and discharges over a year's time gives a truly accurate picture of the service-connected load (only 15.4%). This "discrepancy" appears because the VA's listing of 35% on a daily basis is not affected by the yearly turn-aver af patients—the ratia af VA patients remaining ta those treated and discharged (1 to 5.1). Over a period of a year, 84.6% of VA patients are treated for disabilities incurred after—and having no relationship to—military service.



VA explanation of patient load on a given day

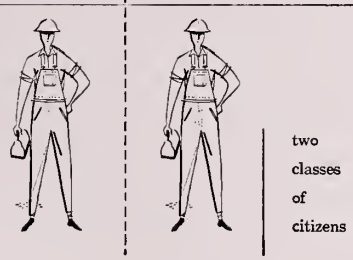
The above classification is presented by the VA as an explanation of the large non-service-connected patient load in its hospitals. The medical profession recommends that only the first categary and thase in the third whose disabilities are determined to be service-connected should be entitled to federal medical care. Non-service-connected TB and NP cases should continue to be treated on a temporary basis until community and state facilities can be readied. The remaining groups obviously have no service-connection and are hospitalized for illnesses or injuries incurred in civilian life.

the medical profession's policy on medical care for veterans



The medical profession stands for the highest quality medical care for all citizens. Veterans, as citizens, should accept the responsibility for their own health needs—unless they became disabled as a result of military service; then it is the responsibility of the Veterans Administration to provide medical care and hospitalization. Because many communities do not as yet have adequate facilities to care for war veterans with non-service-connected tuberculosis or neuropsychiatric disorders, the medical profession recommends that the VA continue—on a temporary basis—to treat these patients.

effects of present veterans medical legislation



It is the belief of the medical profession that it is unsound to authorize free lifetime medical care for veterans who suffered no mishap in uniform, while other citizens with no military background must pay their own way. Althaugh the two men above are identical, they represent "two classes af citizens"—the veteran with na service-connected disability who is granted medical care at federal expense, and the non-veteran wha must personally assume respansibility for his medical care.

what we are talking about...

1. Lack af maral ar legal justificatian in praviding federal medical care far ALL veterans
2. Effect af the VA program on civilian medical training pragrams
3. Current and eventual effects af VA program on civilian health standards
4. Competitian far health persannel and patients
5. Unsaund ecanamics af averlapping federal medical services
6. Expanding tax-burden
7. Veterans' attitude taward VA medical pragram

These seven points are the canclusians af a careful analysis by the medical profession of the current VA medical program. (1) Veterans with no service-incurred disability should assume responsibility for their own medical care on the same basis as other citizens. (2) Medical schaals and hospitals are hard pressed to train enough medical personnel far the benefit of all as long as the federal government siphons off such personnel from civilian programs. This VA practice has caused a duplication of hospital facilities and an unwarranted dispersion of health personnel. (3) The VA is creating an "artificial" shortage of medical personnel at the expense of civilian health programs. (4) Government has placed itself in.competition with civilian medical programs, both for personnel and patients, making it increasingly difficult ta operate civilian hospitals efficiently and economically. (5) Although the federal government is spending millions of dollars under the Hill-Burton act in civilian hospital construction, these haspitals are hard pressed to aperate at reasanable cost while in direct competition with hospitals **wholly** supported by the federal government. (6) The medical profession asks whether a program providing "free" medical care to veterans with na service-incurred disabilities is a justified burden ta impase on the taxpayers af this country. (7) Physicians do not believe that a veteran who served his country wishes to be the recipient of a federal "handout" at the expense of his fellow citizen-taxpayers.

POSTGRADUATE COURSES AT SOUTHWESTERN

A seminar course in bacteriology and chemistry for medical technologists will be given in Dallas February 26 and 27 by Southwestern Medical School of the University of Texas in association with the Postgraduate School of Medicine of the University of Texas.

The bacteriology seminar on February 26 will include such topics as acid-fast bacteria, antibiotic sensitivity tests, virology, leptospiral and rickettsial infections, mycotic diseases, and proper techniques in blood culture. The chemistry seminar on February 27 will include talks on hepatic and renal function tests, newer techniques and standard procedures, preparation of standard solutions and care of scientific instruments, and cholesterol determination and its significance.

Registration fee is $5 and tuition $10 for the bacteriology and chemistry course. Application and check covering the fees should be sent to the office of the dean of Southwestern, 2211 Oak Lawn, Dallas 19.

A postgraduate course in orthopedic surgery was given in Dallas February 15-16 by Southwestern in association with the Dallas Southern Clinical Society and under the auspices of the Postgraduate School of Medicine of the University of Texas, the Texas Medical Association, and the Texas Academy of General Practice.

The program included discussions on such subjects as congenital anomalies of bone, low back problems, knee troubles, common foot problems, basic principles of fracture healing, sprains and dislocations, curvatures and fractures of the spine, fractures of the upper extremity, fractures of the foot and hand, neck-arm syndrome, neuromuscular disorders, infections in bone, bone tumors, fractures of pelvis and hips, and fractures of the knee and tibia. The faculty consisted of full-time and clinical staff members of the medical school.

UNIVERSITY OF TEXAS MEDICAL BRANCH

The new 1,000-bed, thirteen-story John Sealy Hospital, Galveston, became home to more than 300 patients January 20, and tuberculous patients were moved into the new four-story, sixty-bed Ziegler Memorial Hospital shortly afterwards. Patients scheduled to undergo surgery remained in the old hospital until the ten operating rooms in the new building were completely equipped. More than 200 special guests were invited to the exercises.

The American Board of Surgery for the first time has held its oral examination at the Medical Branch. Approximately fifty candidates from the southern and western sections of the United States were in Galveston for the examinations January 15-16.

Dr. Arild E. Hansen, chairman of the Department of Pediatrics at the University of Texas Medical Branch, Galveston, discussed the national duty in regard to the handicapped child and the preventive program for such children at the regional conference of the International Council for Exceptional Children held in Houston the latter part of December. He delivered a paper on vitamin B_6 at the Nutritional Symposium of the American Medical Association in Chicago in November; and in late November and early December he spoke on rheumatic fever at the meeting of the American Academy of General Practice in Colorado Springs and of the American Medical Association in St. Louis.

C. M. Pomerat, Ph. D., professor of cytology and director of the Tissue Culture Laboratory at the Medical Branch, addressed the New York Academy of Science January 15 in New York.

Dr. W. R. Cooke, professor of obstetrics and gynecology at the Medical Branch, was honored recently by the unveiling of an oil portrait of him which is to be placed in the new John Sealy Hospital building.

Molly R. Harrower, Ph. D., clinical psychologist of New York, will conduct special seminars and demonstrate the ways a clinical psychologist may cooperate in current medical problems. For several weeks in February and March of each year, Dr. Harrower will reside in Galveston and lecture at the Medical Branch.

Dr. W. W. Nowinski, director of the Tissue Metabolism Laboratory at the Medical Branch, was visiting lecturer at the Institute of Cardiology, Mexico City, in November and December.

Dr. Robert N. Cooley has recently become professor of radiology and chairman of the Department of Radiology at the Medical Branch. He was previously associated with the Johns Hopkins School of Medicine, Baltimore.

Dr. Hamilton Ford, professor of neuropsychiatry, was elected secretary-treasurer of the Central Neuropsychiatric Association at its October meeting in Indianapolis.

Research grants were given recently to members of the Department of Pediatrics of the Medical Branch by the National Drug Company, $3,000; Sharp and Dohme, Inc., $6,500; United States Public Health Service, $40,896; Bureau of Home Economics and Human Nutrition of the United States Department of Agriculture, $45,000; National Live Stock and Meat Board, $2,000; and Hoffman-LaRoche, Inc., $2,000.

January visitors at the Medical Branch include Dr. M. B. Shimkin, chief of the Laboratory of Experimental Oncology; Hilton Smith, Ph. D., Texas Agricultural and Mechanical College, College Station; and Dr. Leland S. McKittrick, clinical professor of surgery, Harvard Medical School, Boston.

STATE TUMOR CONFERENCE MARCH 31

The State Tumor Conference will be held in Wichita Falls March 31 rather than March 13 as reported in the January JOURNAL. The program, sponsored by the Wichita County Medical Society Tumor Clinic, the American Cancer Society, and the State Department of Health, is approved for credit in formal postgraduate training. There is no registration fee. Scientific discussions will be given by Drs. Shields Warren, Boston; Alton Ochsner, New Orleans; and Jesshill Love, Louisville. Director of the clinic is Dr. Bailey R. Collins.

CORRECTION: WERNER'S SYNDROME

An error appears in the abstract of discussion by Dr. Mavis P. Kelsey, Houston, of the article entitled "Werner's Syndrome; A Study of Adrenocortical and Hepatic Steroidal Metabolism" by Drs. Jere M. Bauer and Jerome W. Conn, Ann Arbor, Mich., which was published in the December, 1953, issue of the TEXAS STATE JOURNAL OF MEDICINE (*49*:882-888). The first sentence of the paragraph beginning at the end of the first column on page 888 should read as follows: "It may be important that several relationships exist between the liver and adrenals, even though superficial evaluation shows no apparent clues to Dr. Bauer's theory."

District Surgical Meeting Held

The Second District of Texas Chapter of the American College of Surgeons held its first annual session November 7 in San Antonio with Dr. Asher R. McComb, San Antonio, president, presiding. Dr. George W. Waldron, Houston, district governor of the college, also was present and participated in the scientific program, which included ward rounds and operative clinics, a panel discussion on the abdomen, and a series of papers by San Antonio surgeons.

LIBRARY SECTION

RECENT PUBLICATIONS BY TEXAS PHYSICIANS

Following is a list of recent articles published by Texas physicians and available at the Memorial Library of the Texas Medical Association. Articles appearing in the TEXAS STATE JOURNAL OF MEDICINE are not included. If a physician who has had a paper printed in the past six months is not named below, the Library would appreciate being notified. Also, the Library would like to have two reprints of each article.

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BOOKS RECEIVED IN JANUARY

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CONTRIBUTIONS TO LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library of the following recent gifts:

Dr. C. H. Brownlee, Austin, 445 journals.
Dr. George E. Clark, Jr., Austin, 4 books, 818 journals.
Dr. Josephine Dunlop, Austin, 12 journals.
Dr. James G. Hamer, Austin, 224 journals.
Dr. Henry L. Hilgartner, Austin, 33 journals.
Dr. J. Warren Jackson, Austin, 23 journals.
Dr. J. Edward Johnson, Austin, 7 books, 22 journals.
Dr. S. N. Key, Jr., Austin, 12 journals.
Dr. N. L. Schiller, Austin, 9 journals.
Dr. Milton Turner, Austin, 5 books, 13 journals.
Dr. R. T. Wilson, Austin, 118 journals.

MOTION PICTURES FOR LOAN

They Also Serve

16 mm., sound, 17 minutes.

This film was designed as an introduction to the organization of medical and health services for disaster and to stimulate study of the role the civilian medical profession must assume in peacetime, to insure the systematic and successful response by medical and other health services in disaster situations, particularly in war. It is an excellent film for all medical groups and hospitals.

Observations of Hepatitis

16 mm., sound, 30 minutes. (Courtesy of Mead Johnson & Company, Evansville, Ind.)

This is a lecture film, with numerous charts used in illustration. The film is largely concerned with an outbreak of infectious hepatitis in a children's camp. Careful studies on the epidemiology of the illness were conducted, and the causative agent was isolated and studied. Source of contamination was determined. This film is suitable for showing to pediatricians, internists, and medical students, as well as general practitioners.

Surgial Treatment for Congenital Pyloric Stenosis

16 mm., silent, color, 15 minutes.

The patient is a 3 week old boy. Preoperative roentgenograms are shown, and the anesthesia is discussed. The procedure consists of removal of a wedge-shaped segment of thickened pyloric musculature down to, but not through, the mucosa. A test for patency of the pylorus is shown. Postoperative views are included.

BOOK NOTICES

[1]Clinical Obstetrics

By Members of the Staff of the Pennsylvania Hospital. Edited by CLIFFORD B. LULL, M. D., *Late Director, Division of Obstetrics and Gynecology, Pennsylvania Hospital, and* ROBERT A. KIMBROUGH, M. D., *Director of the Division of Obstetrics and Gynecology, Pennsylvania Hospital; Professor of Gynecology and Obstetrics, Graduate School of Medicine, University of Pennsylvania. 732 pages. $10. Philadelphia, J. B. Lippincott Company, 1953.*

This book is an unusually good clinical survey of obstetrics. It includes the composite work of numerous coauthors, each of whom contributes a fundamental chapter in its make-up. This gives a nice résumé with the increased value of many opinions pertaining to the same subject.

The chapter on nutrition and nutritional deficiencies with their clinical relation to many of the subjective and objective entities encountered in everyday practice is especially informative and interesting. This approach to the problems of prematurity, toxemias, and many of the distressing if not dangerous symptoms experienced by the obstetric patient will be of value to those interested in good prenatal care. The inclusion of an excellent chapter on fertility and the problems relating to childless couples is properly included in a book of this type. Dr. Hingson has added a chapter on analgesia and anesthesia, which is becoming of increasing interest and importance to physicians doing obstetrics.

Because of the especially good and profuse illustrations and the clinical approach, this book will make a good reference for the student and practitioner.

[2]Chronic Pulmonary Emphysema: Physiopathology and Treatment

MAURICE S. SEGAL, M. D., *Clinical Professor of Medicine, Tufts College Medical School; Director, Department of Inhalational Therapy, Boston City Hospital, and* M. J. DULFANO, M. D., *Resident, Department of Inhalational Therapy, Boston City Hospital; Research Fellow in Medicine, Tufts College Medical School. Modern Medical Monographs. 180 pages. $5.50. New York City, Grune & Stratton, Inc., 1953.*

The monograph prepared by Drs. Segal and Dulfano on chronic pulmonary emphysema is an important addition to medical literature. Chronic pulmonary emphysema is a disabling disease which only recently has been better understood in all of its physiologic and pathologic aspects, chiefly due to recent advances in the fields of pulmonary function tests and respiratory physiology. The treatment of this distressing condition, which at best is only palliative, has been little understood by medical practitioners; as a result patients suffering from this condition have gone from physician to physician and even to medical quacks and to the use of patent medicines in their attempt to find relief.

The monograph opens with the definition of chronic pul-

[1]*Glenn R. Wright, M. D., Cleburne.*
[2]*Robert R. Shaw, M. D., Dallas.*

monary emphysema differentiating it from nonpulmonary emphysema and emphysema of the nonobstructive type. The discussion of the development of this condition is prefaced by an excellent description of the intrathoracic pressure relationships in health. A description of the pathologic course is well illustrated with photographs and microphotographs. The chapter on pulmonary function tests applicable in this condition may prove too technical for the average physician but will delight the student of respiratory physiology. The terminology of pulmonary function tests is carefully defined, and the significance of each test in relation to chronic pulmonary emphysema is pointed out. The chapters of "Clinical Concepts, Pulmonocardiac Complications" and "Therapeutic Management" are easily comprehended by any physician and should give the physician confidence in his ability to treat these patients intelligently. The descriptions of therapeutic measures are complete down to exact details of drugs to be used and dosages employed. The chapter on oxygen therapy is especially valuable since this type of therapy has in the main been badly mismanaged because of the physician's ignorance of the dangers of the administration of 100 per cent oxygen in the hypoxic patient. Detailed descriptions are given of the use of the various types of masks and tents that are commercially available for oxygen therapy. The chapter on mechanical respiration describes the use of the newer intermittent positive pressure mechanisms employing various types of valves. The valve of pneumoperitoneum therapy and breathing exercises are adequately discussed.

This monograph actually has a much wider usefulness than its title would indicate. For the general practitioner, it affords an excellent guide toward proper understanding of the signs, symptoms, and complications of this disease and will help him immeasurably in the management of patients with chronic pulmonary emphysema. For the specialist in the management of cardiorespiratory diseases, the monograph is sufficiently detailed and the conclusions so adequately backed by laboratory proof that it can be used as a reference text and a teaching guide. For the student of respiratory physiology, the chapters on pulmonary function tests and the appendix, in which detailed descriptions of the methodology used are presented, provide an adequate, concise manual that would be valuable in the experimental laboratory.

[3]Short Practice of Surgery

HAMILTON BAILEY, F.R.C.S. *(Eng.)*, F.A.C.S., *Emeritus Surgeon, Royal Northern Hospital, London; Senior Surgeon, St. Vincent's Clinic and the Italian Hospital, and* R. J. MCNEILL LOVE, F.R.C.S. *(Eng.)*, F.A.C.S., *Surgeon, Royal Northern, Mildmay Mission, and Metropolitan Hospitals, London. With pathologic illustrations by* L. C. D. HERMITTE, M. B., Ch. B., *(Edin.). Ninth edition, 1,254 pages. $12.50. Baltimore, Williams and Wilkins Company, 1953.*

This volume of general surgery, now in its ninth edition, is interesting because of its inclusion of material which primarily has been helpful to the authors' practices in the diagnosis and treatment of disease, and for this reason it contains valuable personal touches characteristic of other British texts. The footnotes regarding the contribution of current and historical personalities in surgery are an extremely interesting inclusion.

The outlined material is carefully arranged and ordinarily is widely accepted, an exception being certain views regarding the topical use of the sulfonamides.

Often theory suffers by omission; however, the book enumerates countless office and hospital aids which are not generally found in such completeness. Outstanding are the sections on nerves, the hand, and infectious diseases. Weakest are the chapters on the bile ducts and pancreas.

Although some of the numerous illustrations are of such quality as to be of doubtful assistance, as, for example, several of the black and white photographs, most of them are quite descriptive, particularly the several line drawings.

Despite its semioutline form and its deemphasis on surgical technique, this text deals with the subject of surgery as a whole and should be of great interest to the student and general practitioner because of its comprehensiveness.

[3]*W. R. Whitehouse, M. D., Cleburne.*

[4]Essential Urology

FLETCHER H. COLBY, M. D., *Chief of the Urological Service, Massachusetts General Hospital; Associate Clinical Professor of Genito-Urinary Surgery, Harvard Medical School, Boston. Second edition. 650 pages. $8. Baltimore, Williams and Wilkins Company, 1953.*

A welcome addition to the urologic library is this new book, which, as its title implies, is a presentation of the important facts concerning genitourinary conditions. It does not pretend to be a comprehensive textbook of urology. It gives little attention to the rare conditions. However, it discusses in detail and in a thorough manner the more common problems which are met within this field of medicine.

Particularly worthy are the descriptions of the embryology of the genitourinary organs and the discussion of diseases of the prostate with the various types of surgical management.

The section on the physiology of the kidney is modern and gives a practical understanding of the abnormal functioning of kidneys in disease and following systemic trauma. The chapter on tuberculosis of the genitourinary organs has been revised. This excellent discussion pays particular attention to the modern treatment by surgery and the newer drugs. The chapter on disease of the testes also has been revised, and the discussion on testicular tumors is worth-while reading. This also applies to the subject of urinary calculi. Illustrations throughout the book are abundant and informative.

The author planned this book as a useful aid for students, residents, and general practitioners. However, the experienced urologic surgeon will find it a beneficial addition to his medical library because of the concise and thorough discussion of various urologic problems.

[5]Diagnostic Tests in Neurology

ROBERT WARTENBERG, M. D., *with forewords by* SIR GORDON HOLMES, M. D., F.R.S., *and by* STANLEY TRUMAN, M. D. *200 pages. $4.50. Chicago, Year Book Publishers, 1953.*

This text is an excellent review of diagnostic neurologic tests. Dr. Wartenberg brings out strongly the fact that too much reliance is paid on extensive laboratory work and not enough on careful observation which is available to anyone so inclined. The book has an introduction describing the plan of examination and procedures which are applicable in the office. The book is further divided into seven sections dealing with the tests of cranial nerves, peripheral nerves, pyramidal system, extrapyramidal system, cerebellar system, sensory system, and vasomotor-trophic system.

Dr. Wartenberg, a distinguished neurologist who has studied and taught on two continents, gives the benefit of his many years of observation. The book has many pictures which clearly show the findings in the diagnostic tests which he describes. This adds to its usefulness in further delineating the tests.

The book certainly is to be recommended both to the general practitioner and to the specialist as an excellent text on diagnostic tests in neurology.

[4]*Robert F. Thompson, M. D., El Paso.*
[5]*Robert J. Goodall, M. D., Houston.*

[6]Commotio Cerebri

CYRIL B. COURVILLE, M. D., *Director, Ramon Cajal Laboratory of Neuropathology, Los Angeles County Hospital, Los Angeles. 161 pages. $5.25. Los Angeles, San Lucas Press, 1953.*

Dr. Courville has done an excellent piece of work in compiling and organizing the available medicolegal aspects of cerebral concussion and the postconcussion syndrome. Through the author's involvement in the courtroom aspects of compensation demands following head injuries as well as his experience in the field of neurology and neuropathology, he has set down in one volume a survey which will be a reference source to physicians and attorneys in problems of this type. The author approaches his subject from the historical viewpoint with excellent use of source material. This same approach to the mechanism and the pathology of commotio cerebri and the process of healing permits the reader not only to find valid conclusions within this volume but to expand them by following out the quoted source material. Management of this type of injury is rather well covered although it appears that the author is as often stumped for specific remedies as are many of lesser experience.

This monograph is highly recommended to any physician who becomes involved in the medicolegal aspects of head injuries. I feel that it would be of special value as a preparation for anyone who is called upon to testify in court. This book also will be of use to those of more purely clinical interest as an excellent survey of the entire problem from historic, pathologic, and therapeutic standpoints.

[7]Pain Syndromes and Their Treatment

JAMES M. TARSY, M. D., *Chief, Arthritis Clinic, University (New York Postgraduate) Hospital, New York University-Bellevue Medical Center; Assistant Clinical Professor of Medicine, Postgraduate Medical School, New York University. 592 pages. $12. Springfield, Ill., Charles C Thomas, 1953.*

This book is an exhaustive review of pain syndromes of the upper extremities and trunk. The author gives satisfactory discussions of the pathogenesis, diagnosis, and treatment of these syndromes, and, as he states in his introduction, has compiled much information that has been published previously in articles dealing with individual pain syndromes.

This book would be a worth-while addition to the physician's diagnostic armamentarium.

[8]Basic Bacteriology: Its Biological and Chemical Background

CARL LAMANNA, PH. D., *Associate Professor of Bacteriology, and* M. FRANK MALLETTE, PH. D., *Associate Professor of Biochemistry, Johns Hopkins University School of Hygiene and Public Health. 677 pages. $10. Baltimore, Williams and Wilkins, 1953.*

The material presented in this book is intended for the more advanced student of bacteriology or microbiological biochemistry. The authors have emphasized the theoretic rather than the descriptive aspects of the subject. Several chapters are devoted to the fundamental concepts of physics, chemistry, and biology which are essential for an understanding either of bacteriologic phenomena or of the techniques employed in bacteriology. These chapters include discussions on physical properties of bacteria, theory of microscopy, the physics of light and color, and the chemistry of dyes used in staining. The microbiological biochemist will find the chapters on enzymes, nutrition of bacteria, and bacterial metabolism of especial interest. The use of diagrams rather than tables enables the reader more easily to comprehend the topic under discussion.

The book is a comprehensive and well-written treatise on pure bacteriology; however, it was not designed to present the medical aspect of the subject.

[9]Synovial Fluid Changes in Joint Disease

MARIAN W. ROPES, M. D., *Associate Physician, Massachusetts General Hospital, and Assistant Clinical Professor of Medicine, Harvard Medical School, Boston, and* WALTER BAUER, M. D., *Chief of Medical Services, Massachusetts General Hospital, and Jackson Professor of Clinical Medicine and Director of Robert W. Lovett Memorial Foundation for the Study of Crippling Disease, Harvard Medical School. 149 pages. $4. Cambridge, Mass., Harvard University Press, Commonwealth Fund, 1953.*

There long has been a need for a concise source of information about synovial fluid characteristics which this book answers in a satisfactory manner. Only general descriptions of synovial fluid have been presented heretofore in the texts dealing with arthritides, and this probably has been due to the fact that such studies are extremely difficult. Therefore, the authors of this publication have performed a real service to the profession.

The opportunity to learn more about the synovial fluid is timely since physicians are now doing more aspirations of joints for treatment purposes and can easily secure samples for analysis; the instillation of hydrocortisone, antibiotics, and hyaluronidase in treatment of certain joint diseases as well as during the taking of pneumarthrograms is becoming a much more common procedure.

The accompanying charts are an aid both in diagnosis and prognosis of joint diseases, especially the summarization chart in the back of the book. The distinguishing features between the two large groups of joint diseases are clearly defined along with certain more specific changes indicating, when combined with clinical impressions and roentgen-ray findings, the evidence in favor of individual joint conditions. The changes noted in the chemical and cytologic analyses during treatment offer a valuable adjunct in following a case. In view of the sometimes inconclusive evidence through study of biopsy material, the opportunity to gain information in this manner will be welcomed by most physicians concerned with joint diseases.

It is gratifying, indeed, to find, at last, this much needed description of synovial fluid changes.

[10]The Psychopathic, Delinquent and Criminal

GEORGE N. THOMPSON, M. D., F.A.C.P., *Associate Clinical Professor of Neurology and Psychiatry, School of Medicine, University of Southern California, Los Angeles. 142 pages. $4.50. Springfield, Ill., Charles C Thomas, 1953.*

Organicists will like this treatise.

This book of ten chapters lends support to organic causes of psychopathic delinquencies and psychopathic criminal behaviors.

The author gives evidence for the importance of heredity, trauma, infection, neoplasms, degeneration, and other diverse factors in the causation of these disorders. He plays down the significance of psychogenic factors.

There are discussions of psychopathic personality as an entity and psychopathology of the entity is handled from the author's viewpoint. Cases are presented. Treatment is professed to be a serious and difficult problem.

The book is suggested for specialists and researchers.

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[6]*Clarence S. Hoekstra, M. D., Dallas.*
[7]*R. Vincent Murray, Jr., M. D., Austin.*
[8]*Robert P. Sandman, M. A., Austin.*
[9]*P. L. Day, M. D., San Antonio.*
[10]*Lee F. Scarborough, M. D., Austin.*

[11]The Roentgen Aspects of the Papilla and Ampulla of Vater

MAXWELL H. POPPEL, M. D., F.A.C.R., *Professor of Radiology, New York University Post-Graduate Medical School, and Director of the Roentgen Ray Department, Bellevue Hospital;* HAROLD G. JACOBSON, M. D., F.A.C.R., *Director, Department of Roentgenology, Hospital for Special Surgery, New York; and* ROBERT W. SMITH, M. D., *Senior Resident in Radiology, Veterans Administration Hospital, Bronx, N. Y. 195 pages. $8.50. Springfield, Ill., Charles C Thomas, 1953.*

The monograph is intended by the author to be a "complete presentation of the roentgenologic survey of the anatomy, physiology, and pathological status of the Vaterian region." Though it may fall short of the goal, it is a worth-while effort.

The development, anatomy, and physiology of the papilla and ampulla of Vater and of the sphincter of Oddi are reviewed with a report, illustrations, and tabulation of the authors' anatomico-roentgen studies of 100 specimens.

Malignancy, both primary in the Vaterian segment and extended from adjacent organs, inflammatory and calcerous disease, benign tumors, and biliary dyskinesia are discussed.

There are 106 good figures and several tables. A large proportion of the book is given to differential diagnosis.

A bibliography listing 138 references and an index follow the text.

In general, this book seems to come up to the standards set by the authors. It should be readily available to anyone interested in the diagnosis of gastrointestinal conditions.

[11]*C. H. Frank, M. D., Texarkana.*

Fool's Haven

C. C. CAWLEY. *210 pages. $2.75. Boston, House of Edinboro, 1953.*

The theme of "Fool's Haven" is woven around a young girl and her mother who have been caught in the web of a religious cult, the basic principles of which were not to seek a doctor but to pray. The belief was so great that one life was lost because of a ruptured appendix and a young lover left his career in science to study law in hopes that he could help break up such cults.

"Fool's Haven" is a story that could take place in any neighborhood when cults defying medicine are allowed to operate.

Stedman's Medical Dictionary

Edited by NORMAN BURKE TAYLOR, M. D., F.R.S.C., F.R.C.S. *(Edin.),* F.R.C.P. *(Can.), M.R.C.S. (Lon.), Associated with University of Western Ontario. Eighteenth edition. 1561 pages. $11.50. Baltimore, Williams and Wilkins, 1953.*

This new edition of a favorite reference tool covering medicine and the allied sciences has added many new entries and illustrations. The main entries have been changed from Latin to English. The section on etymology contains a helpful root-word list. The appendix with its tables and charts is still a valuable part of the dictionary.

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION

Rural Health Conference in Dallas

The ninth National Conference on Rural Health is to be held at the Baker Hotel in Dallas, March 4-6. With the theme "Let's Put More 'U' in Comm*Unity*," the conference is sponsored by the American Medical Association's Council on Rural Health, Dr. Carll S. Mundy, Toledo, acting chairman. Speakers and three general discussion panels will stress the importance of organized community efforts in the maintenance of healthful conditions in agricultural areas.

Topics for panel discussions will be what farm areas are doing to solve pressing rural health problems, the role of nutrition in rural health programs, and the various aspects of health insurance. Dr. Everett C. Fox, Dallas, will participate in one of the discussions.

Dr. Edward J. McCormick. Toledo, AMA President, will review the AMA's contributions to rural health. Dr. Joseph I. Greenwell, New Haven, Ky., national General Practitioner of the Year, will discuss the role of the family doctor in small communities. Dr. Chester U. Callan, Rotan, chairman of the Texas Medical Association's Committee on Rural Health, will present a planned approach to doctor distribution. Other speakers will discuss how high school girls formed a club to promote interest in nursing as a career, how a community was able to build and operate a hospital on a budget far below average, how a physician met a community's need for a clinic by building one at his own expense, and how soil is important to nutrition.

Chauncey Leake, Ph. D., Galveston, vice-president of the University of Texas School of Medicine, will be a dinner speaker. Among those who will give greetings will be Mayor Robert L. Thornton, Dallas; Dr. George F. Lull, Chicago, AMA secretary and general manager; Dr. George Turner, El Paso, President of the Texas Medical Association; and Mrs. Leo Schaefer, Salina, Kan., President, Woman's Auxiliary to the AMA.

Presiding over the various sessions will be Dr. Allen T. Stewart, Lubbock; Dr. N. H. Gardner, East Hampton, Conn.; Dr. George F. Bond, Bat Cave, N. C.; Dr. Willard A. Wright, Williston, N. D.; and Dr. Mundy, all of whom are regional directors of the council.

As in the past few years, an informal preconference session will be held on the morning of March 4 for doctors only. This session will be devoted to problems confronting physicians who are members of state rural health committees or committees handling rural health problems. Greetings will be extended by Dr. F. J. L. Blasingame, Wharton, President-Elect of the Texas Medical Association and member of the AMA Board of Trustees, and speakers will include Dr. James Stevenson, Tulsa, treasurer of the Oklahoma Physician's Service; Dr. Henry Randel, Fresno, Calif., chairman of the California Medical Association's Committee on Rural Health; and Dr. Mundy.

TEXAS MEDICAL ASSOCIATION

COUNTY AND STATE OFFICIALS CONFER

The semiannual meeting of the Executive Council of the Texas Medical Association was held in the headquarters building in Austin on January 24 with the President, Dr. George Turner, El Paso, expediting business sufficiently for adjournment before noon. This meeting, at which reports from most councils and committees were submitted, concluded a week-end of activity which included an all-day conference of county medical society presidents and secretaries and numerous committee meetings January 23.

Highlights of the week-end was the afternoon program arranged for county society officers and featuring addresses by Dr. Frank E. Wilson, Washington, D. C., director of the American Medical Association's Washington office; Dr. Everett C. Fox, Dallas, former chairman of the Texas Association's Council on Medical Economics; and Dr. F. J. L. Blasingame, Wharton, member of the AMA Board of Trustees and President-Elect of the Texas organization. These three discussed the medical care policies of the Veterans Administration and the attitude of the medical profession toward them and also the proposals relating to health introduced to Congress earlier in the week by President Dwight D. Eisenhower. The activities of the AMA Washington staff and of the AMA Legislative Committee were described, and the urgency of support by individual physicians, working in their own communities and communicating with their own representatives and senators, was stated.

During the morning, the county officers had an opportunity to become better acquainted with the state organization. Nine councils, boards, and committees were described and their present programs outlined by the respective chairmen: Dr. R. W. Kimbro, Cleburne, Trustees; Dr. R. G. Baker, Fort Worth, Councilors; Dr. Charles L. McGehee, San Antonio, Medical Defense; Dr. G. W. Cleveland, Austin (representing Dr. J. B. Copeland, San Antonio), Medical Jurisprudence; Dr. May Owen, Fort Worth, Scientific Work; Dr. Harvey Renger, Hallettsville, Medical Economics; Dr. M. O. Rouse, Dallas, Medical Education and Hospitals; Dr. Troy A. Shafer, Harlingen, Public Relations; and Dr. Chester U. Callan, Rotan, Rural Health. A question and answer period followed this session as well as the afternoon panel discussion.

Board and council chairmen reported briefly to the Executive Council, calling attention to the satisfactory financial condition of the Association, reporting on studies to determine what action should be taken to approve insurance companies desiring to provide group policies for members of the Association, revealing plans possibly leading toward college courses for doctors' assistants and medical school courses in medical jurisprudence, and outlining the scientific programs being carried on by telephone broadcast and at the annual sessions for the further education of practicing physicians.

The Committee on Library Endowment called attention to the gift of his library to the Memorial Library of the Texas Medical Association by Dr. L. H. Reeves of Fort Worth and commended such action, as well as money gifts to the Library endowment fund, to other members of the Association and their families. The Committee on Public Relations pointed with satisfaction to the Medical Students' Days held partially under its auspices in the three medical schools of the state, the conference for county presidents and secretaries the preceding day, and the twenty-nine special newspaper sections commemorating the hundredth anniversary of organized medicine in Texas which were issued in recent months. The Committee on Doctor Distribution reported not a single request for additional doctors in a pilot survey directed at all communities of more than 800 population in District 7, proof to the committee that physician care in that area is adequate. The Committees on Nursing Care, Blood Banks, Emergency Medical Service, and Rural Health, gave evidence of developing programs in their respective areas in cooperation with other agencies. The Committee on Infringement of the Private Practice of Medicine indicated that the medical school staffs and faculties and the private physicians practicing in the same towns apparently have worked out satisfactorily the problems affecting referral and treatment of patients.

The Executive Council officially designated April 25, 26, and 27 as the dates for the 1955 annual session, scheduled to be held in Fort Worth. It also adopted two resolutions, one recommending to Governor Allan Shivers that the special session of the Legislature which he has called include a consideration of further financial support to the medical and dental branches of the University of Texas and to the state hospitals and special schools and the other approving development of a clearing house for blood by the Texas Association of Blood Banks.

Mrs. E. W. Coyle, San Antonio, President of the Woman's Auxiliary to the Texas Medical Association, addressed the Executive Council by invitation, calling attention to the program which the wives of Texas physicians are carrying on to bolster the aims and objectives of the medical profession. She introduced Mrs. Mark Latimer, Houston, President-Elect of the State Auxiliary, and Mrs. George Turner, El Paso, President-Elect of the AMA Auxiliary.

Doctor Distribution Studied

During the last several years, anyone listing the main public relations problems of the medical profession in Texas would have included the problem of doctor distribution.

There are 254 Texas counties, and although the ratio of doctors to population compares reasonably with the national average (Texas: 1 per 813; United States: 1 per 730), the state's broad reaches and sparsely populated counties lead to misconceptions about "doctor shortages." Many well-meaning friends of medicine in recent years have referred to the "shortage of doctors in Texas."

About a year ago the Texas Medical Association determined to set up a slide rule of facts against which to measure the actual conditions as opposed to supposition and rumor.

The Board of Trustees named a special Committee on Doctor Distribution headed by Dr. Chester U. Callan, Rotan, chairman of the Committee on Rural Health, and consisting also of Dr. Harvey Renger, Hallettsville, chairman of the Council on Medical Economics; Dr. Troy A. Shafer, Harlingen, chairman of the Committee on Public Relations; Dr. J. C. Terrell, Stephenville, past chairman of the Committee on Rural Health; and Dr. Allen T. Stewart, Lubbock, past president of the Texas Medical Association and present member of the American Medical Association's Committee on Rural Health.

Committee objectives were simple: (1) Find out the extent of "doctor shortage" in the eyes of the profession. (2) Find out the extent of "doctor shortage" in the eyes of Texas communities. (3) Where shortages exist, do something about them. This would include showing communities their part of the two-way job.

The committee immediately launched a survey of the profession itself. Questionnaires went to 6,500 doctors. Answers came from 6,000. The committee established to its satisfaction that medicine's viewpoint held that help was needed in the ranks of the general practitioner, particularly in communities under 5,000, and most particularly in the northwest areas of Texas.

Thus armed, the committee faced the problem of asking communities what they think. Realizing that it might be swamped with requests for help—justified or based on misinformation—the committee determined to move slowly. A pattern for statewide survey was applied to the reasonably limited confines of District 7 surrounding Austin.

The same approach which would be used in every county in the state at the proper time was utilized in the ten counties of the district. A printed pamphlet, "Does Your Community Need a Doctor?" was prepared for distribution to

community officials. Dr. J. M. Coleman of Austin, district councilor, wrote letters to each doctor in the district, as well as to county society officers. He explained the intent and the mechanics of the survey about to be launched.

Then Dr. Callan wrote the chamber of commerce secretary, the mayor, or the county judge, as appropriate, in each community with 800 population or more. His letter follows:

"Dear Sir:

"As you doubtless know, many critics of the American Free Enterprise System maintain a running fire of propaganda against the business and professional men to weaken public confidence in our way of life. The medical profession is well acquainted with these tactics.

"One criticism most frequently heard is that there aren't enough doctors to go around. Actual facts show that the ratio of physicians to population in America is much higher than any other nation in the world.

"However, the medical profession of Texas recognizes that problems do exist, primarily in the area of doctor distribution—not of doctor shortage. Our recent statewide survey has established this fact clearly.

"In this respect, we are making a sincere and continuous effort to extend medical service on the broadest possible base. Among many other things being done to place more doctors in rural areas, a special committee on doctor distribution has been created by the Texas Medical Association.

"The function of this committee is to work at the local level with qualified representatives of Texas communities where the facts show that such communities do not have enough doctors of medicine.

"In this connection, we are enclosing a brochure which contains explicit instructions on pages 5, 6, and 8, which, in the event your community needs additional doctors, should be followed carefully, and the results sent to Texas Medical Association, 1801 Lamar Boulevard, Austin. It is our belief, then, that representatives of this committee can meet with representatives of the community and determine definite needs for additional doctors of medicine in your town.

"In the event that we do not hear from you, we shall know that you consider the number of doctors in your community as sufficient.

"Please understand that this is a sincere effort by the more than 6,500 members of the Texas Medical Association to establish the real facts as regards the distribution of medical care and, wherever possible, to do something about existing shortages discovered."

Committee members meeting in Austin in late January reviewed the findings of the survey. They revealed that not one community requested additional help. Conclusions reached by the committee were that either the distribution problem is not nearly so serious as medicine's critics would make it out to be, or the particular district under survey is happily far better off than others throughout the state.

In any event, the wisest course to the committee seemed to be to pursue the pilot survey through portions of three other districts until such time as it may be broached statewide, and materials for this purpose are now ready.

Medical Officer Examination

A new medical officer examination has been announced by the United States Civil Service Commission for filling the positions of rotating intern and resident in training in psychiatry and in neurology at St. Elizabeth's Hospital, Washington, D. C. Further information is available from the commission, Washington 25.

SIDE ATTRACTIONS AT ANNUAL SESSION

Sometimes the sideshow at a circus is as entertaining as the main performance, and the Council on Scientific Work of the Texas Medical Association, cooperating with specialty societies, medical alumni and fraternity groups, and others who have a contribution to make at a physicians' convention, reports a full slate of scientific and social activity to assure a "sideshow" worthy of being on the same bill with the more official program at the Texas Medical Association annual session in May.

At least twelve related specialty organizations will convene Sunday or Monday, May 2 or 3, with scientific presentations open to all members of the Texas Medical Association. The Texas Air-Medics Association, in addition to a round-table discussion of Civil Aeronautics Authority problems participated in by Dr. W. R. Stovall of Washington, D. C., will be taken on a tour of the research laboratories of the School of Aviation Medicine at Randolph Field.

The Texas Chapter of the American College of Chest Physicians promises Dr. William A. Hudson of Detroit, president-elect of the American College of Chest Physicians, to deliver the first annual Hendricks Memorial Address.

The Texas Dermatological Society will offer a series of papers on penicillin, hydrocortisone ointment, vulvar dermatoses, kissing bug bites, swimming pool granuloma, and Letterer-Siwe disease.

Dr. Herbert Pollack, New York, will be guest speaker for the Texas Diabetes Association, speaking on management of diabetic coma and dietary requirements of the diabetic patient. He also will participate in a panel discussion on the newly discovered diabetic.

Cardiography and new treatments, medical and surgical, of heart disorders will be discussed on the Texas Heart Association program, for which Dr. Myron Prinzmetal, Los Angeles, will be special guest.

The Texas Neuropsychiatric Association will present Dr. Tracy J. Putnam, Beverly Hills, Calif., in a paper on the treatment of epilepsy. The title of one of the presentations by Texas psychiatrists is "The Significance of Reciprocal Depressions in Marital Partners."

Eight papers by members of the armed forces and an address by Dr. William T. Green, Boston orthopedist, will be featured on the program of the Texas Orthopedic Association. Dr. Green, orthopedic surgeon-in-chief of the Children's and Peter Bent Brigham Hospitals and clinical professor of orthopedic surgery at Harvard Medical School, will spend several days in Houston touring the Texas Medical Center before going to San Antonio.

A symposium on the management of trauma involving disturbance of cerebral and cardiorespiratory function is scheduled for the Texas Railway and Traumatic Surgical Association meeting.

Dr. Digby Leigh, Vancouver, B. C., Canada, will discuss pediatric anesthesia for the Texas Society of Anesthesiologists.

A survey of 1,000 consecutive gastroscopic examinations and anorectal complications of antibiotics given orally are among the topics to be discussed for the Texas Society of Gastroenterologists and Proctologists.

The Texas Society of Pathologists will discuss basic concepts of response to trauma as well as other problems in pathology.

City and county health officers, in addition to learning more about poliomyelitis, leprosy, and infectious hepatitis, will consider the current problems of air pollution and community disasters. Dr. Gordon W. Grace, Los Angeles, will speak.

A luncheon for life insurance medical directors, a convention of physical therapists, and tentatively an organizational meeting of physicians interested in geriatrics will be held in San Antonio at the time of the Texas Medical Association annual session.

The oldsters among the doctors of Texas have been given a cordial invitation by the Fifty Year Club to attend its breakfast Tuesday morning, May 4. Members of the Texas Medical Association who have been in practice fifty years or more are eligible for membership in this organization, the main purpose of which is to encourage friendship and the sharing of experiences by doctors of medicine who have seen service from horse and buggy days to the present.

The Past Presidents Association has planned its annual luncheon for Monday, May 3.

Eight alumni associations (Texas Medical Branch, Southwestern, Baylor, Tulane, Arkansas, Tennessee, Vanderbilt, and Louisiana State) will hold dinners May 3, and seven medical fraternities are planning parties to precede the entertainment for the President of the Texas Medical Association, Tuesday, May 4. This latter event, although an official part of the annual session program, will be different from most such entertainments, featuring a buffet supper for those who want it and a floor show of Mexican songs and dances in the courtyard of La Villita.

As announced previously, committee meetings will begin Saturday, May 1; the House of Delegates will convene Sunday, May 2; specialty societies will meet Sunday and Monday, May 2 and 3; opening exercises and memorial services of the Texas Medical Association will be held Monday, May 3; and the scientific program of the Association will be held Tuesday and Wednesday, May 4 and 5. The Woman's Auxiliary will meet concurrently. Hotel reservations should be made directly with the hotel of choice in San Antonio.

COUNTY SOCIETIES

Baylor-Knox-Haskell Counties Society

November 10, 1953

The Baylor-Knox-Haskell Counties Medical Society participated in the telephone postgraduate broadcast sponsored by the Texas Medical Association November 10. The group met in the office of Robert L. Newsom, Munday, to hear the discussion on antibiotics.

Brazoria County Society

December 3, 1953

(Reported by Carlos E. Fuste, Jr., Secretary)

Brazoria County Medical Society met December 3 in Freeport for dinner and a business session at which they elected the following officers for 1954: William D. Nicholson, Freeport, president; M. Warren Hardwick, Angleton, vice-president; Carlos E. Fuste, Jr., Alvin, secretary; John S. Caldwell, Jr., Velasco, treasurer; and Joe S. Montgomery, Angleton, retiring president, member of the board of censors.

The society voted to sponsor locally the essay contest of the Association of American Physicians and Surgeons.

January 7, 1954

(Reported by Carlos E. Fuste, Jr., Secretary)

At the January 7 meeting of the Brazoria County Medical Society in Freeport, the following committee chairmen were announced by the president, William D. Nicholson, Freeport: M. Warren Hardwick, Angleton, program; Carlos E. Fuste, Jr., Alvin, medical jurisprudence and public relations; A. O. McCary, Freeport, tuberculosis; John C. O'Leary, Lake Jackson, medical advisory on poliomyelitis; R. M. McCary, Freeport, advisory to state public health and welfare; Ralph E. Gray, Lake Jackson, procurement and assignment; John S. Caldwell, Jr., Velasco, civil defense; and Robert H. Kirkpatrick, Freeport, blood banks.

Cass-Marion Counties Society

November 18, 1953

The Cass-Marion Counties Medical Society met with its woman's auxiliary November 18 at Linden for dinner followed by separate business sessions. Society members heard a discussion of the kidneys by Robert Womack, Shreveport.

Cherokee County Society

November 24, 1953

The annual Thanksgiving dinner meeting of the Cherokee County Medical Society and its woman's auxiliary was held at the Rusk State Hospital on November 24. The dinner and all-patient program were under the direction of the hospital staff. C. L. Jackson, hospital superintendent, acted as toastmaster.

Cooke County Society

November 16, 1953

Recent Problems of Anesthesia—Earl Weir, Dallas.

Following dinner with the local woman's auxiliary, the Cooke County Medical Society convened for a business and scientific session November 16 at Gainesville. Dr. Weir, chief anesthesiologist at Baylor Hospital, discussed the recent problems of anesthesia that have resulted from the development of new drugs.

Dallam-Hartley-Sherman-Moore Counties Society

November 12, 1953

The Dallam-Hartley-Sherman-Moore Counties Medical Society met November 12 in Dalhart. M. E. Jacobson, Amarillo, was guest speaker.

Dallas County Society

December 8, 1953

(Reported by W. W. Fowler, Secretary)

Radical Treatment for Carcinoma of Prostate—Harry M. Spence, Dallas.

Hormonal and Isotope Treatment for Carcinoma of Prostate—Joseph D. Mitchell, Jr., Dallas.

Role of Hyaluronidase in Recurring Renal Calculi—John M. Pace, Dallas.

The Dallas County Medical Society met December 8 in Dallas, elected new officers, and heard Jay Waddell, chairman of the society's medical jurisprudence committee, ask for support of the Bricker Amendment to the United States Constitution.

After the reading of a memorial for those society members who had died during 1953, the following new officers were presented: R. A. Trumbull, president-elect; Harry M. Spence, vice-president; W. W. Fowler, secretary emeritus; Glenn D. Carlson, secretary; Porter K. Mason, treasurer; Earl Loftis, censor; Dale Austin and Haynes Harvill, members of the board of directors; Barton E. Park, Fred W. Horn, Dr. Trumbull, and Edward White, delegates; T. M. Kirksey, L. S. Thompson, Frank H. Kidd, Jr., and Arnott DeLange, alternates; and J. O. S. Holt, Marvin Knight, Robert L. Moore, and Robert J. Rowe, members of the nominating committee.

The scientific program was presented as outlined above.

Dr. Park, chairman of the board of directors, presented a recommendation from the public health committee, which was adopted. The recommendation was that the expense of operating well-child conferences in Dallas be assumed

by the local city and county governments under direction of the city and county health departments, inasmuch as federal funds are no longer available, and that the following regulations apply: (1) Physicians shall be authorized to accept payment from the Health Department for their services at the conference sessions. (2) The conferences shall be limited to 15 patients per physician per session. (3) Only well children under 6 years of age shall be accepted.

Eastland-Callahan-Stephens-Shackelford-Throckmorton Counties Society

November 17, 1953

Management of Obstructive Prostate—E. O. Bradfield, Temple.
Surgical Management of Duodenal Ulcer—R. R. White, Temple.

Members of the Eastland-Callahan-Stephens-Shackelford-Throckmorton Counties Medical Society heard the above talks when the society held its regular meeting November 17 in Eastland.

Hale-Floyd-Briscoe-Swisher Counties Society

January 12, 1954

(Reported by John C. Long, Jr., Secretary)

Medical Induction of Labor—Eugene McCarthy, Plainview.
Discussion—Russell K. Williams, Plainview.

The Hale-Floyd-Briscoe-Swisher Counties Medical Society held its first meeting of 1954 on January 12 in Plainview with Roy R. Roberts, Plainview, president, presiding over the business session which preceded the above scientific program.

Hardeman-Cottle-Foard-Motley Counties Society

December 9, 1953

(Reported by J. M. Taylor, Secretary)

Psychiatric Evaluation of Menopause—Henry Snyderman, Plainview.

After a dinner at the home of A. C. Traweek, Jr., of Matador, on December 9, the Hardeman-Cottle-Foard-Motley Counties Medical Society heard the above scientific paper and elected new officers. They are J. M. George, Quanah, president; C. C. Pate, Paducah, vice-president; J. M. Taylor, Quanah, secretary-treasurer; A. C. Traweek, Sr., Matador, delegate; and R. R. McDaniel, Quanah, alternate. J. F. Hughes, Spur, and P. L. Salkeld and E. A. Vestal, Quanah, were elected to the board of censors.

Harris County Society

November 10, 1953

Charles D. Reece assumed the presidency of the Harris County Medical Society at the group's November 10 meeting in Houston. Louis E. Williford became president-elect; S. G. Ohlhausen, vice-president; William M. Wallis, secretary; and Mavis P. Kelsey, treasurer. Also named were the following board and committee members: James Greenwood, executive; Eugene L. Slataper, censors; Lawrence W. Johnson, Jackson A. Smith, and Mylie E. Durham, Jr., medical jurisprudence and public relations; and Moise D. Levy, Jr., Ralph Liles, and William D. Seybold, adjudication and medical testimony. John K. Glen, C. Forrest Jorns, Denton Kerr, Herbert L. Alexander, J. Stanley Oliver, and Bill Robins are delegates; and William M. Sherrill, Hiram P. Arnold, Hampton C. Robinson, Edward S. Crocker, Wendell H. Hamrick, and John T. Armstrong, alternates.

Hill County Society

November 10, 1953

Emergency Treatment of Chest—G. V. Brindley, Jr., Temple.

The Hill County Medical Society met November 10 in Hillsboro to hear the above scientific paper. The group voted to hold a joint meeting with the local cancer group on December 14 in Hillsboro.

Lubbock-Crosby Counties Society

December 1, 1953

(Reported by Clyde F. Elkins, Acting Secretary)

Following a dinner given by J. A. Chatman at the Chatman Hospital in Lubbock on December 1, an election of officers was held by the Lubbock-Crosby Counties Medical Society. Frank C. Goodwin became president; Sam C. Arnett, vice-president; Richard K. O'Loughlin, secretary; Clyde F. Elkins, treasurer; Ewell L. Hunt, censor for three years; and William H. Gordon, delegate for two years. James T. Hall has two more years to serve as censor; E. E. McClure, one more year. Albert G. Barsh remains a delegate, and Allen T. Stewart and Arthur Jenkins remain alternates. All officers are from Lubbock.

The revised constitution, which had been mailed previously to each member, was unanimously accepted. E. A. Rowley, Amarillo, discussed raising money for the American Medical Education Foundation; Frank Malone, Lubbock, spoke about the Bricker Amendment.

January 5, 1954

(Reported by Richard K. O'Loughlin, Secretary)

Painful Low Back—R. Q. Lewis, Lubbock.
Discussion—Charles Ratcliff, Elbert Loveless, William Cashion, Lubbock.

Before hearing the above discussion on January 5 in Lubbock, the Lubbock-Crosby Counties Medical Society held a business session, presided over by Frank C. Goodwin, new president. Allen T. Stewart explained the procedure for obtaining honorary membership in the Texas Medical Association; O. B. Hull discussed the television programs planned by the society; Roy Riddel announced plans for a banquet and social hour to be held January 12; and Frank Malone made an announcement about the state conference for county society presidents and secretaries scheduled for January 23 at the Association's headquarters building in Austin.

Nueces County Society

December 8, 1953

(Reported by William E. Morris, Secretary)

Hugh A. Kennedy assumed the presidency of the Nueces County Medical Society and conducted an election of officers at the December 8 meeting in Corpus Christi. New officers are William E. Morris, president-elect; C. B. Slabaugh, vice-president; G. S. Ahern, secretary; A. L. Lane, treasurer; L. C. Arnim, F. W. Hartwick, and R. G. Spann, censors; C. P. Yeager and J. F. Pilcher, delegates; H. E. Griffin and L. M. Garrett, alternates; and W. E. Riley and Joseph Alsop, cancer clinic directors.

The society voted to raise the salary of the executive secretary and to have the dues remain $110 for 1954. The diabetic committee reported that 5,723 tests were taken during Diabetic Week, with 16 positive cases reported. M. C. Kendrick gave a resumé of the society's activities for the past year in his president's report.

January 12, 1954

(Reported by Gerald S. Ahern, Secretary)

Pheochromocytoma, Its Diagnosis and Management—Nicholas C. Hightower, Temple.

The Nueces County Medical Society met January 12 in Corpus Christi and heard the above scientific discussion. Ralph Cameron, O. S. Carlson, Stanley Dolch, Jr., and A. F. Kiel were elected to membership. The following medical officers from the Corpus Christi Naval Air Station attended the meeting: D. O. Coffman, B. R. Malpass, William Russell, and A. B. Stephens, Jr.

A resolution from the United Fund, Inc., praising the society for its support of the drive and its contribution to the health and welfare of the community, was read.

Tarrant County Society

November 17, 1953

(Reported by S. W. Wilson, Secretary)

Investments for Professional Man—Paul Hastings, Ph. D.; Mr. F. L. Hargis; and Mr. Roy Stevenson, Fort Worth.

The Tarrant County Medical Society and the Fort Worth District Dental Society held a joint dinner meeting November 17 in Fort Worth. Seventy-eight society members, forty-two dentists, and three guests heard the above panel discussion following the dinner. A resolution presented by T. L. Lauderdale expressing the society's opposition to the Ives Bill (United States S. 1153), which "would actually mean federal subsidization of the voluntary plans, medical education and health facilities," and would "make them a vehicle for the complete socialization of medical care," was adopted.

December 1, 1953

(Reported by S. W. Wilson, Secretary)

New officers were elected December 1 in Fort Worth by the Tarrant County Medical Society. They follow: C. S. E. Touzel, president-elect; J. Franklin Campbell, vice-president; S. W. Wilson, secretary-treasurer; John Wiggins, censor; William Crawford, member of the board of trustees; Mal Rumph, James D. Murphy, and H. T. Jackson, delegates; and Robert C. Stow, J. H. Steger, Drue O. D. Ware, and Fred B. Aurin, alternates.

A motion by Dr. Murphy making the insurance committee permanent and stating its function was passed.

December 15, 1953

(Reported by S. W. Wilson, Secretary, and Joseph F. McVeigh, Chairman, Public Relations Committee)

Gold-Headed Cane: Modern Symbol of Aesculapian Staff—William J. Kerr, near Eureka, Calif.

Two hundred and forty-five members and their wives attended the annual "Gold-Headed Cane" dinner sponsored by the Tarrant County Medical Society December 15 in Fort Worth and saw R. J. White receive the award from May Owen, the 1952 winner.

Dr. Kerr, who is a retired professor of medicine at the University of California and editor of the new edition of the "Gold-Headed Cane," gave the above address and displayed several canes from his collection.

January 5, 1954

(Reported by S. W. Wilson, Secretary)

The Tarrant County Medical Society held its inaugural banquet January 5 in Fort Worth with approximately 300 members and guests in attendance, including officials of the Texas Medical Association and medical officers of the United States Public Health Service Hospital and of Carswell Air Force Base, Fort Worth.

R. J. White was master of ceremonies, and Bishop Thomas K. Gorman of the Fort Worth-Dallas Catholic Diocese was guest speaker. William P. Higgins, Jr., incoming president, was presented with the gavel by William Crawford, outgoing president.

Taylor-Jones Counties Society

November 11, 1953

Local and State Tuberculosis Situation—Travis Smith, Abilene.
Childhood Tuberculosis, Testing and BCG—Dale Johnson, Abilene.
Medical Treatment of Tuberculosis—Frank Carman, Dallas.
Indications for Surgical Treatment of Tuberculosis—Walter Park, San Antonio.

A scientific and business session was held by the Taylor-Jones Counties Medical Society November 11 in Abilene. New officers were elected and the program as outlined above was presented. J. C. Duff, who is mayor of Anson, became president; C. A. McFadden, vice-president; Marshall Turnbull, secretary; Travis Smith, censor; and R. W. Varner, delegate. All officers except Dr. Duff are from Abilene.

Tom Green-Eight County Society

November 2, 1953

Diagnosis of Types of Pneumonia—John Chapman, Dallas.

Dr. Chapman, who is assistant dean of graduate and postgraduate education at Southwestern Medical School of the University of Texas, addressed the Tom Green-Eight County Medical Society at its November 2 meeting in San Angelo and used slides of roentgenograms to illustrate the variety of pneumonias.

R. M. Arledge became president for 1954; T. G. Coleman, president-elect; K. B. Round, vice-president; and Joe L. Cornelison, secretary-treasurer. All officers are from San Angelo.

January 4, 1954

(Reported by Joe L. Cornelison, Secretary)

A program by the Parkland Tumor Clinic panel of Dallas comprised the January 4 meeting of the Tom Green-Eight County Medical Society in San Angelo.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

January, 1954

(Reported by S. E. Thompson, Secretary)

Problems of Industrial Insurance—Mr. Dan W. Jones, Houston.

At the January meeting of the Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society in Richmond, Mr. Jones spoke on the above subject from an insurance company's viewpoint. He is claims manager for Travelers Insurance Company.

Forty-three society and auxiliary members attended.

Wichita County Society

November 10, 1953

Diagnosis, Prognosis, and Treatment of Intracranial Tumors—Albert P. D'Errico, Dallas.

The Wichita County Medical Society heard the above scientific discussion at its November 10 meeting in Wichita Falls. Dr. D'Errico is professor of neurosurgery at Southwestern Medical School.

James T. Lee has been named president of the society; Roger W. Manar, president-elect and vice-president; David Allen, secretary-treasurer; J. D. Hall, delegate; Aubrey Cox, alternate; and L. N. Simmons, censor. All are of Wichita Falls.

DISTRICT SOCIETIES

Twelfth District Society

January 12, 1954

(Reported by Walter B. King, Jr., Secretary)

Extrophy of Bladder—James Hejtmancik, Waco.
Pulmonary Embolus: Its Prevention and Treatment—R. D. Holt, Jr., Meridian.
Survey of Waco Tornado Casualties—R. K. Gassler, Waco.
Can Private Practice Survive?—F. J. L. Blasingame, Wharton.
Emergency Treatment of Fractures of Mandible and Maxilla—Joe Rutherford, D.D.S., Waco.
Value of Blood Volume Determinations in Gastrointestinal Disease—Nathan Cedars, Stephenville.
Vertigo: Etiology, Type, and Treatment—Vance Terrell, Stephenville.

The program outlined above was presented when the Twelfth District Medical Society met January 12 in Waco. Dr. Blasingame, President-Elect of the Texas Medical Asso-

ciation and member of the Board of Trustees of the American Medical Association, was luncheon speaker. Approximately eighty-six doctors and wives attended.

Neil Buie, Marlin, became president; Van D. Goodall, Clifton, was elected president-elect and Paul H. Mitchell, Corsicana, secretary-treasurer.

Thirteenth District Society

March 24, 1954

(Reported by Robert D. Moreton, Secretary)

When the Thirteenth District Medical Society meets at the Fort Worth Academy of Medicine building March 24, special emphasis will be laid on acquainting members with the items of importance which are to come before the House of Delegates of the Texas Medical Association six weeks later. A luncheon panel made up primarily of officials of the Association will be present to explain the reports, resolutions, and recommendations which it is anticipated will create the most interest at the annual session and the adoption of which would have the most far-reaching effects. Those attending the district meeting can go home better prepared to discuss with their colleagues the pending business of the Association and the stand which delegates from the county societies should take.

Physicians from areas adjacent to the Thirteenth District are invited to attend the one day meeting in Fort Worth, which will include panel discussions on diseases of muscles and lesions of the colon. The Woman's Auxiliary is planning entertainment for visiting ladies.

No registration fee will be charged at the district meeting, registration for which will open at 9 a. m., but luncheon tickets will be on sale.

AUXILIARY SECTION

COMMUNITY SERVICE

"Human life," it has been said, "consists in mutual service." The Woman's Auxiliary to the Texas Medical Association pays homage to this point of view in recommending a program of activity which calls for individual as well as group cooperation with other community agencies working for the betterment of health. By contributing their share of time, energy, and knowledge to other organizations which have some of the same ideals as the medical auxiliary, Mrs. E. W. Coyle of San Antonio, President of the State Auxiliary, points out, physicians' wives can achieve greater results than if they worked alone and at the same time can create among those with whom they labor a greater understanding and sympathy for the medical profession and its objectives.

The Constitution of the Woman's Auxiliary to the Texas Medical Association states that the primary object of the organization shall be "to extend the aims of the medical profession, through the wives of the doctors, to other organizations which look to the advancement of health and education." Furnishing a speaker on first aid for home accidents for a local parent-teacher association, rolling bandages for the local cancer society, raising funds to cover the health and character building agencies within the United Fund or Community Chest, taking gifts to an old people's home—all of these and many more similar projects are included in the programs of county medical auxiliaries. They help do a job that needs doing; they also help to develop an awareness of the medical profession and a feeling that it is contributing in a positive way to the welfare of the community.

Civil defense, mental health, and nurse recruitment committees of the medical auxiliary almost automatically find themselves working in cooperation with other groups concerned with the same areas, Mrs. Coyle says. Essay contest, legislative, American Medical Education Foundation, physical examinations, and Today's Health committees have an opportunity to take medicine's message to others, for none of the topics with which they deal is for doctors and doctors' wives alone. Some of the other committees which customarily function in the medical auxiliary likewise are challenged to interpret the point of view of the medical profession while serving the community, and the program and public relations committees are concerned largely with this interplay of community and auxiliary member.

In these days when both the motives and the methods of the medical profession seem to be under fire, perhaps it is right for the Woman's Auxiliary to the Texas Medical Association to think first of the desirable public relations which will be built through cooperation in the community. Nevertheless, Mrs. Coyle reminds, real service for its own sake cannot help but foster the mutual understanding and respect upon which good public relations must be established.

Officers of the Woman's Auxiliary to the Texas Medical Association: President, Mrs. E. W. Coyle, San Antonio; President-Elect, Mrs. Mark H. Latimer, Houston; First Vice-President (Organization), Mrs. John D. Gleckler, Denison; Second Vice-President (Physical Examinations), Mrs. Cecil O. Patterson, Dallas; Third Vice-President (Today's Health), Mrs. Ralph B. Payne, Amarillo; Fourth Vice-President (Program), Mrs. Guy Knolle, Houston; Recording Secretary, Mrs. Paul Brindley, Galveston; Corresponding Secretary, Mrs. Charles L. McGehee, San Antonio; Treasurer, Mrs. Oscar M. Marchman, Jr., Dallas; Publicity Secretary, Mrs. Allen H. Neighbors, Jr., Austin; Parliamentarian, Mrs. H. S. Renshaw, Fort Worth.

COUNTY AUXILIARIES

More than 300 dolls were collected for the Christmas Clearing Bureau's gift baskets by the *Bexar County Auxiliary*. With Mrs. John Parsons as coordinator, publicity was sent to various clubs belonging to the City Federation, and many nursery schools also cooperated. The group honored the doctors December 12 with a dinner dance in San Antonio; Mrs. F. G. Lahourcade was social chairman for the affair.

Sixty couples attended the annual Christmas open house of the *Nueces County Auxiliary* December 6 at the home of the C. D. Dixons, Corpus Christi. Mrs. C. D. Stewart, chairman; Mrs. Sterling Martin, co-chairman; Mrs. Sam Powell, president; and Mrs. Dixon were hostesses.

"Here I Stand," a book by Roland Bainston, was reviewed by Mrs. J. M. Spurlock in observance of Bible Day by the *Hunt-Rockwall-Rains Counties Auxiliary* November 3 in the home of Dr. and Mrs. Grady Bruce, Greenville. Members answered roll call with quotations from the Bible on health. The speaker was presented by Mrs. S. D. Whitten, and Mrs. C. D. Savage, president, presided over the business session.

"Books" was the topic discussed by Mrs. E. W. Grumbles, Atlanta, at the November 18 meeting of the *Cass-Marion Counties Auxiliary* at Linden. The meeting followed a dinner with the society. On January 13 following dinner with the doctors, the auxiliary met at the home of Dr. and Mrs.

T. K. Nichols, Atlanta, to complete final reports for the year's work. A social hour ended the evening.

The annual Thanksgiving dinner of the *Cherokee County Auxiliary* and society held at the Rusk State Hospital November 24 was followed by an all-patient program. Dr. C. L. Jackson, superintendent, acted as toastmaster.

"Personality Development in Children" was discussed by Dr. George Schlenker at the January 11 meeting of the *El Paso County Auxiliary.* Mrs. Clement C. Boehler, mental health chairman, was in charge of the program. The Bricker Amendment was discussed by Mrs. Louis Breck, and copies of "You Can Lose Your Freedom Overnight by Treaty—Protect It by Bricker Amendment," prepared by the auxiliary, were distributed. Poll taxes were sold at the meeting, which was preceded by a luncheon, the chairmen for which were Mrs. Morton Leonard and Mrs. Jack Bernard. The auxiliary honored Dr. and Mrs. George Turner at a dinner dance November 28 at the Hilton Hotel in El Paso as its Doctor's Day celebration; Mrs. Frank Schuster was chairman. Dr. Turner is President of the Texas Medical Association, and Mrs. Turner is President-Elect of the American Medical Association's Woman's Auxiliary.

The *Navarro County Auxiliary* observed Doctor's Day January 8 with a dinner in Corsicana. Dr. Robert Kimbro, Cleburne, chairman of the Board of Trustees of the Texas Medical Association, was speaker. Throughout the day the doctors of Corsicana wore red carnation boutonnieres presented to them by their wives. Mrs. Paul H. Mitchell and Mrs. W. K. Logsdon were hostesses for the dinner. Mrs. Kimbro also attended.

"The Doctor's Wife in Fashion" was the theme of a luncheon-style show given November 4 in Dallas by the *Dallas County Auxiliary.* Mrs. Everett C. Fox was chairman of the program.

Jimmie Angel, business manager of the Kerrville State Home, told the *Kerr-Kendall-Gillespie-Bandera Counties Auxiliary* about "Care of the Aged" at the group's meeting November 6 in Kerrville.

Mrs. Edward W. Coyle, San Antonio, State President, was honor guest at several county auxiliary functions throughout the state recently. The *Tom Green-Eight County Auxiliary* honored her with a luncheon at the home of Dr. and Mrs. M. D. Knight, San Angelo, in the early part of November, as did the *Nolan-Fisher-Mitchell Counties Auxiliary* at Sweetwater, Mrs. T. D. Young presiding. Mrs. Coyle also was guest at a dinner meeting November 10 in Abilene of the *Taylor-Jones Counties Auxiliary,* at which meeting Mrs. T. B. Bass gave the invocation; Mrs. Sol Estes, president, recognized local members who were state officers; and the silver cup won by the group at the 1953 annual session for acquiring the greatest number of new members was displayed. Mrs. Coyle discussed the phases of State Auxiliary work with stress on the field of mental health.

DEATHS

W. E. MARTIN

Dr. Walter Evans Martin, Dallas and Seagoville, Texas, died October 15, 1953, in a Dallas hospital after a stroke.

DR. WALTER E. MARTIN

Born in Deport, August 15, 1897, Dr. Martin attended East Texas State Teachers College, Commerce, and the University of Texas, Austin, and was graduated from Wesley College, Greenville. He taught school in Lamar County, later becoming superintendent of Lamar County public schools, before beginning his medical work. He was graduated from Baylor University College of Medicine, Dallas, in 1931 and practiced medicine in Paris briefly before locating in 1932 in Dallas. Dr. Martin organized a group practice at his offices in Dallas and founded the East Dallas Hospital. Two years ago, he moved to his ranch in Seagoville.

Dr. Martin was a current member of the American Medical Association and Texas Medical Association through Dallas County Medical Society. He was a member and past president of the Dallas County Chapter of the American Academy of General Practice and belonged to the Dallas Southern Clinical Society. For many years, he was a steward in the Methodist Church. He was a Mason and former president of the J. L. Long Dad's Club.

Dr. Martin is survived by his wife; two sons, Oscar W. Martin and Wayne E. Martin, both of Seagoville; a daughter, Dr. Robbie Jo Shires, Dallas; a brother, Lee H. Martin, Tahoka; and six sisters, Mrs. Jessie Reece and Mrs. Belle Griffin, both of Dallas; Mrs. Bessie Barham and Mrs. Alice Westbrook, both of Deport; Mrs. Dora Watkins, Fort Worth; and Mrs. Joe Merrell, Kemp.

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

L. M. REAVES

Dr. Lovett Martin Reaves, Dallas, Texas, died at a local hospital, January 2, 1954, of myeloma.

The son of Mr. and Mrs. B. A. Reaves, Dr. Reaves was born December 17, 1904, in Warren, Ark. He received his preliminary education in Warren public schools and attended Henderson-Brown College, Arkadelphia, Ark. After being graduated in 1929 from the University of Arkansas School of Medicine, Little Rock, he served an internship at St. Paul's Hospital, Dallas. For twenty-three years, he had maintained a private practice of medicine in Dallas.

Dr. Reaves belonged to the American and Texas Medical Associations through Dallas County Medical Society and was a member of the Texas Academy of General Practice, Dallas Southern Clinical Society, and Phi Chi medical fraternity. He was a thirty-second degree Mason and a member of the Shrine, and served on the board of stewards of the Highland Park Methodist Church.

For three years during World War II, he was a captain and later a lieutenant colonel in the Medical Corps, serving in the Asiatic Pacific theater for fifteen months in 1944 and 1945.

His wife, the former Miss Allan Wells, whom he married July 15, 1934, survives, as do two daughters, Carol Reaves and Jane Reaves, Dallas; his mother, Mrs. B. A.

DR. L.. M. REAVES

Reaves, Warren, Ark.; two sisters, Miss Mary C. Reaves, El Dorado, Ark., and Mrs. E. F. Carter, Shreveport, La.; four brothers, Lee Reaves and Hugh Reaves, Warren, Ark.; Glenn Reaves, Houston; and Noel Reaves, Oklahoma City.

R. D. MOORE, JR.

Dr. Rufus Dillard Moore, Jr., died of myocardial infarction November 30, 1953, at his home in Houston, Texas.

The son of Dr. Rufus Dillard and Emily Jessie Moore, Dr. Moore was born in Omaha, Texas, May 25, 1910. He attended Omaha public schools and Lon Morris College, Jacksonville. He received a bachelor of arts degree from Southern Methodist University, Dallas, and bachelor of science and master of arts degrees from East Texas State Teachers College, Commerce. After receiving his medical degree in 1935 from the University of Arkansas School of Medicine, Little Rock, he served an internship at Little Rock City Hospital.

For four years Dr. Moore practiced at Mount Pleasant. He then served from 1941 to 1946 with the Army Medical Corps, completing his tour of duty in executive positions in Chicago and San Francisco and being discharged as a lieutenant colonel. More recently he had been a colonel in the Medical Reserve Corps. In 1946 Dr. Moore returned to Omaha and practiced there for two and a half years before moving to Houston.

A member of the American and Texas Medical Associations through Harris County Medical Society, Dr. Moore was formerly a member of Titus and Morris Counties Medical Societies. He belonged to the Southern Medical Association, American Geriatrics Society, American Academy of General Practice, American Association of Military Sur-

DR. RUFUS D. MOORE, JR.

geons, and Reserve Officers Association. He also was a Scottish Rite and York Rite Mason, a member of the Shrine, and a member of the Eastern Star. He held membership in the Variety Club and belonged to the Methodist Church.

His survivors include his wife, the former Miss Sally Reba Newman, whom he married in Forrest City, Ark., December 31, 1936; his mother, Mrs. R. D. Moore, Sr., Omaha; and a brother, J. Marion Moore, Dallas.

J. T. LAWSON

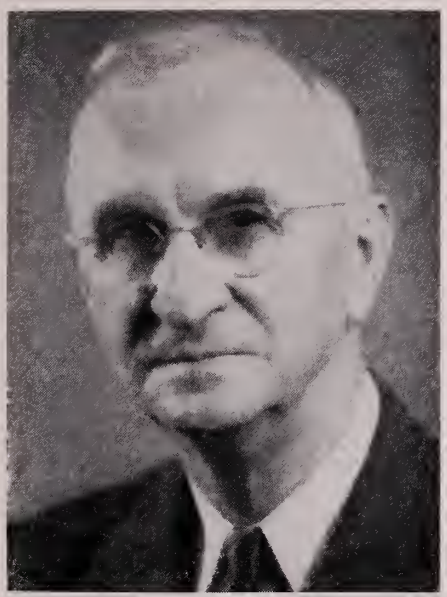
Dr. John Thomas Lawson died December 12, 1953, at his home in Bowie, Texas, after suffering a heart attack.

Dr. Lawson was born November 23, 1876, at Talladega, Ala., the son of Thomas E. and Julia A. Lawson. In 1887, he came to Cleburne with his parents. After being graduated in 1899 from the old Memphis Hospital Medical College, Memphis, Tenn., which was consolidated with the University of Tennessee College of Medicine in 1913, Dr. Lawson located at Files, where he practiced for six years. He then moved to Bowie and did general practice and surgery before taking special work and entering the field of diseases of the eye, ear, nose, and throat. He had taken many postgraduate courses in medicine and surgery at various medical centers in Chicago and St. Louis.

Dr. Lawson was a member of the American Medical Association and Texas Medical Association through Clay-Montague-Wise Counties Medical Society. He served as president of Hill County Medical Society before moving to Bowie, and had served as both president and secretary of Montague County Medical Society before assisting in organizing and becoming first president of the Clay-Montague-Wise Counties society. In 1915, he was president of the Thirteenth District Medical Society. He belonged to the Dallas Academy of Ophthalmology and Otolaryngology. President of the Texas State Board of Medical Examiners

for four years and member of the Board for twelve years, Dr. Lawson was city health officer at Bowie and local surgeon for the Fort Worth and Denver Railroad Company and the Rock Island Lines. He had been a member of the Bowie Clinic and on the staff of the Bowie Clinic Hospital since they were organized. He was a member of the Fifty Year Club.

Dr. Lawson served in the Medical Corps of the United States Army during World War I. A one time director of Texas Agricultural and Mechanical College, he was director and twice president of the Bowie Chamber of Commerce. He served as manager of the Bowie Public Welfare Association during the depression years, was past commander of the local American Legion Post, vice-president of the Security National Bank of Bowie, and past president of the Bowie Rotary Club. Among his other interests were real estate, land, cattle, and oil.



DR. JOHN T. LAWSON

Recently, Dr. Lawson had been honored by the University of Tennessee College of Medicine with the presentation of a Golden "T" award for his services to his school and to his community.

Dr. Lawson married the former Miss Edna McKey at Files in 1900. Their son, Dr. J. Mack Lawson, a Fort Worth surgeon, died in 1951. Surviving Dr. Lawson are his wife; a daughter, Mrs. Lucille Head of Ely, Nev.; five grandchildren; and three great-grandchildren.

A. L. RIDINGS

Dr. Alfred Lafayette Ridings, formerly of Sherman, Texas, died December 16, 1953, in a Washington, D. C., hospital of coronary thrombosis.

Dr. Ridings was born in Ivanhoe, March 7, 1879, the son of Perry Pinckney and Mildred (Davis) Ridings. He received his academic education at Ivanhoe and Bonham public schools, and was graduated an honor student from the University of Louisville School of Medicine, Louisville, Ky., in 1910. He practiced in Dorchester before moving in 1916 to Sherman, where he lived until his retirement in 1949 after suffering a stroke. Dr. Ridings had been living with his daughter in Washington since that time.

A member for many years of the Texas Medical Association, he was elected to honorary membership in 1950. He served as Vice-President of the Association in 1934 and as secretary of the Section on Surgery of the Association's 1937 annual session. Dr. Ridings was a former president of the Grayson County Medical Society and the Fourteenth District Medical Society. He held membership in the Texas Railway and Traumatic Surgical Association and was a fellow of the American College of Surgeons. At the time of his retirement he was on the staff of the Wilson N. Jones Hospital and a member of the Stout (now Medical Arts)

DR. ALFRED L. RIDINGS

Clinic. He belonged to the Sherman Kiwanis Club, Masonic Lodge, and the Baptist Church.

Dr. Ridings was a captain in the United States Army Medical Corps in World War I and served as a member of the medical advisory board to the Selective Service system in World War II. He was awarded a presidential citation and a Selective Service medal in 1945 for his work during World War II.

His wife, the former Miss Grace Dupree, whom he married in Bonham in March, 1900, was a Texas poet and an official in several state and national literary and patriotic groups. She died in 1941.

Surviving Dr. Ridings are his daughter, Mrs. Hope Ridings Miller, magazine writer, of Washington, D. C., and a nephew, Dr. Ridings E. Lee of Dallas.

W. L. ROBINSON

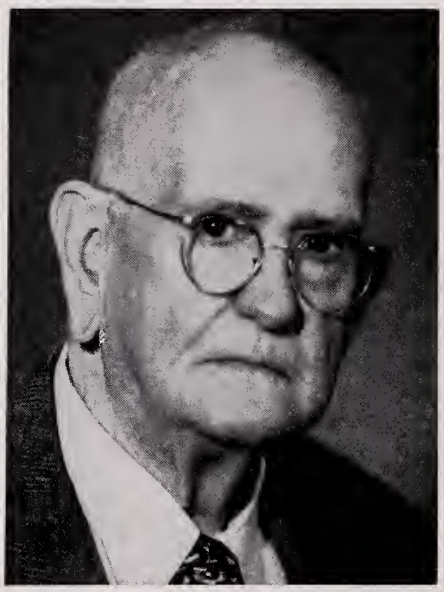
Dr. William Lee Robinson of Texarkana, Texas, died December 22, 1953, of coronary occlusion.

Born the son of William Wirt Bonner and Mary Susan (Irvine) Robinson, August 3, 1876, in Eureka, Navarro County, Texas, Dr. Robinson received his academic education in Eureka, Zions Rest, and Corsicana. He attended Texas Agricultural and Mechanical College, College Station, where he studied engineering, and the University of Texas College of Pharmacy, Galveston. He received his medical degree from the University of Texas School of Medicine, Galveston, in 1903. In 1904, Dr. Robinson was house physician at St. Joseph's Infirmary in Houston. After serving an internship at John Sealy Hospital, Galveston, he practiced in Montgomery, Navarro, and Hill Counties be-

fore moving in 1920 to Dallas. He served for twenty years as visiting physician at Parkland Hospital, Dallas. From 1941 to 1950, he was a physician for Austin State School, Austin. He then returned to Dallas and became superintendent of the County Convalescent Home. Two years later he was resident physician at the Beverly Hills Sanitarium, a post he held until December, 1952, when he moved to Texarkana and served as plant physician for the Lone Star ordnance plant there.

Dr. Robinson belonged to the Texas Medical Association through Dallas County Medical Society. He previously had belonged to Navarro, Hill, and Travis Counties societies. He also was a member of the Southern Medical Association.

Dr. Robinson was in the Spanish-American War, served as a captain with Gen. John J. Pershing in his expedition



DR. WILLIAM LEE ROBINSON

to Mexico in 1915, and was a major in the infantry during World War I.

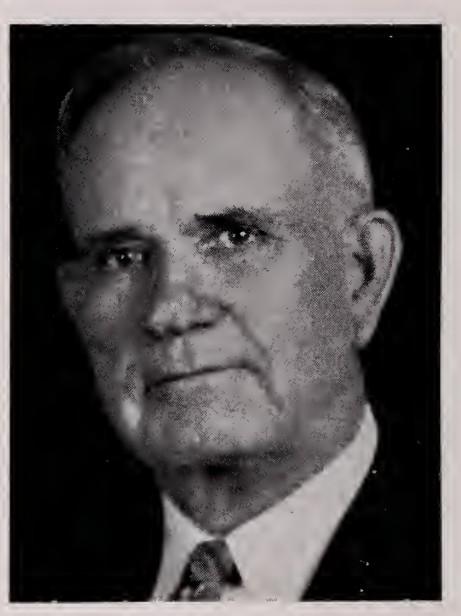
A great-nephew of Confederate Gen. Robert E. Lee, Dr. Robinson was an honor guest when President Franklin D. Roosevelt unveiled the statue of the general in Dallas' Lee Park in the 1930's. He was commander of the Sons of Confederate Veterans. He belonged to the Order of the Green Snake (an organization of Spanish-American War veterans), the American Legion, Veterans of Foreign Wars, and High Noon Club, and served as vice-president for the Sons of the Texas Revolution. He was a thirty-second degree Mason and a member of the Presbyterian Church.

Dr. Robinson is survived by his wife, the former Miss Charlotte Mayfield, Dallas; one son, William Lee Robinson, Jr., Austin; three daughters, Mrs. Roy Nunnally, Hawaii; Mrs. Mayme Sue Murray, Dallas; and Mrs. John B. Matney, San Angelo; two sisters, Mrs. Justin Harrison, Dallas, and Mrs. M. T. Horne, Galveston; two brothers, E. E. Robinson, Dallas, and Dr. H. Reid Robinson, Galveston; four grandchildren; and one great-grandchild.

M. A. FORBES

Dr. Marrell Allen Forbes, San Antonio, Texas, died in that city on January 6, 1954, of coronary occlusion.

A native of Whitehouse, Williamson County, Dr. Forbes was born February 28, 1873, the son of John Alexander and Virginia (Barfield) Forbes. After studying at public schools in Williamson, Burnet, and Tom Green Counties and at the University of Texas Medical Branch, Galveston, Dr. Forbes was graduated in 1901 from Tulane University of Louisiana School of Medicine, New Orleans. He practiced in Beyersville, Kenedy, and Corpus Christi before going to New York for a year as resident at Bellevue Pediatric Clinic. In 1910, he moved to San Antonio, where he spent the remainder of his professional career, and was local surgeon for the San Antonio and Aransas Pass Railway for several years. He was instrumental in the establishment of the first charity children's hospital in San Antonio before the Robert B. Green Hospital was opened in 1916. A member of the State Militia, Dr. Forbes was drillmaster at Camp Mabry, Austin, in 1890-1891, and was a civilian medical examiner in San Antonio for the United States Army during World War I. In honor of the golden anniversary of his graduation, Dr. Forbes along with twenty-eight classmates in 1951 received a "second medical degree" from Tulane and was a guest at a special luncheon in New Orleans.



DR. M. A. FORBES

An honorary member of the Texas Medical Association since 1951 and a member almost continuously since 1904, Dr. Forbes also belonged to the American Medical Association, the Bexar County Medical Society, and the Presbyterian Church. He was a Royal Arch Mason, a thirty-third degree Scottish Rite Mason, and a member of the Shrine. Dr. Forbes was twice master and a life member of the local Masonic Lodge and had served as district deputy grand master of Texas for the thirty-ninth Masonic district and both grand orator and grand visitor of the Grand Lodge of Texas. He was also a member of the board of directors of the Scottish Rite Dormitory at the University of Texas, Austin, from 1943 to 1949 and chairman of the executive committee of the Scottish Rite bodies in San Antonio from 1945 to 1949.

Survivors include his wife, the former Miss Vance Word, whom he married February 4, 1906, at Kenedy; a daughter, Miss Muriel Forbes, San Antonio; two sons, C. A. Forbes, Georgetown, and Dr. M. Allen Forbes, Jr., Austin; and four grandchildren.

President's Page

KNOW YOUR STATE HEALTH DEPARTMENT

Public health is a concern of organized medicine and a working interest should be taken to see that there is coverage in areas lacking it. The function of our public health services is the prevention of disease through the application of sanitary engineering methods, quarantine, vaccination, and case finding. This work is closely related to medical care, particularly in the fields of general practice and industrial medicine. The Texas Medical Association Committee on Public Health works as a coordinating council between the activities of public health workers and practicing physicians. Individual physicians and county medical societies can greatly assist in this worth-while public service by insisting on efficient public health coverage in all communities.

Sixteen separate bureaus and divisions perform the many functions incident to state public health service operations as follows:

The Bureau of Vital Statistics registers all births and deaths in Texas and furnishes certified copies of these records.

The Bureau of Food and Drugs is charged with the enforcement of the Pure Food and Drug Laws of Texas.

The Public Health Education Division prepares and distributes spot announcement radio script and programs to Texas radio stations, prepares and distributes news releases to Texas newspapers, distributes movies, and publishes a monthy magazine.

The Bedding Division enforces the Texas statutes regulating the manufacture, sale, sterilization, and labeling of bedding.

The Bureau of Laboratories tests samples collected by the Bureau of Food and Drugs and the Venereal Disease Control Division, and also types blood donations, prepares and stores blood plasma, and performs other services.

The Bureau of Sanitary Engineering directs the enforcement of laws governing water purification, stream pollution, and sewage disposal. The control of insects and rodents, air pollution, and sanitary consulting services are also functions of this bureau.

The Venereal Disease Control Division is engaged in educational activities and venereal disease case finding, in cooperation with physicians, city and county health units, and local welfare and civic groups.

The Tuberculosis Control Division conducts mass surveys by chest x-ray microfilms in cooperation with local health units, civic clubs, PTA's, churches, and other organizations.

The Local Health Service Division acts as adviser and supervisor to local health units in epidemiology, conducts in-service training for public health personnel, and prepares reports on the status of public health in Texas.

The Maternal and Child Health Division offers educational and advisory service to the general public in pediatrics and obstetrics, and acts as consultant in health programs for the school child.

The School Health Services Division promotes public school education in the control of communicable disease, instruction in nutrition, school sanitation, and adequate physical activities.

The Dental Health Division conducts educational programs in dental health, and in certain localities of the state offers clinical services to underprivileged children and expectant mothers.

The Public Health Nursing Division renders service programs for the control of venereal disease, tuberculosis, cancer, and maternal and infant health; service to crippled children; and help in mental hygiene activities.

The Crippled Children's Division offers free clinical service to underprivileged crippled children and purchases braces, artificial limbs, wheel chairs, and other devices to aid the crippled child.

The Cancer Control Division conducts an educational program in cooperation with the Texas Division of the American Cancer Society, Texas Medical Association, Texas Dental Association, M. D. Anderson Hospital for Cancer Research, and other organizations.

The Mental Health Division promotes a mental health education program and works in cooperation with the State Board for Hospitals and Special Schools.

The Heart Disease Division was organized in 1949 for the purpose of conducting educational programs in this disease. It has remained inactive for the most part because of lack of personnel for this work.

George Tunnell M.D.

TPR
diagnotes

TEXAS HOST TO RURAL HEALTH CONFEREES: American Medical Association's Ninth National Conference on Rural Health saw Texas host to biggest meeting yet. In Dallas, March 4 through 6, the conference drew strong representation from farm, chamber of commerce, and education fields as well as the medical profession from throughout the nation. Dr. Allen T. Stewart, Lubbock, regional director of AMA's Council on Rural Health, presided over opening session, and Dr. Chester Callan, chairman of the Texas Medical Association's Committee on Rural Health, spoke on "A Planned Approach to Doctor Distribution." Texas President, Dr. George Turner, El Paso, brought state greetings. Host arrangements went smoothly through under direction of Dallas County Medical Society. The state Association furnished assistance to AMA staff members in handling press coverage.

Dr. Callan's report summarized detailed study on doctor distribution in Texas as well as pilot survey of District 7 under Dr. J. M. Coleman, Austin, Councilor. Conferees heard that all communities over 800 population in the Central Texas area were asked whether additional doctors were needed and were supplied with information on attracting, as well as holding doctors. Dr. Callan noted that no community requests for help were received, reported that the addition of a competent Texas Medical Association field secretary soon would allow the survey to be extended across the entire state, held out optimistic outlook for results. He told conferees that the work of his special state Committee on Doctor Distribution was trying to accomplish the dual job of dispelling the oft-used misnomer of "doctor shortage" and at the same time of discovering actual areas of improper distribution and doing something about them.

Dr. Callan reported Texas Medical Association's desire to cooperate with local medical-lay groups wishing to establish community rural health committees.

The Association has asked chambers of commerce, local farm bureaus, and other groups properly interested in rural health problems to contact local county medical societies. Material for guidance in planning, establishing, and carrying through such committees will be furnished on request to the Association's central office in Austin. The material parallels work by AMA and by other states in the rural health field.

OTHER DEVELOPMENTS IN TEXAS: First reported county medical society to follow up Association's recently sponsored forum for county presidents and secretaries on the national administration's health program and its implications to medical care has been Harris County. Under the guidance of Dr. Charles D. Reece, president, Houston doctors, February 24, had occasion to listen to as authoritative a panel of speakers as that sponsored by the state Association in January. Dr. Ernest B. Howard, Chicago, Assistant Secretary of AMA, and Dr. F. J. L. Blasingame, Wharton, AMA Trustee, discussed the over-all program, and Dr. Everett C. Fox, Dallas, outlined the problems imposed by V.A. medical care. Attendance: good.

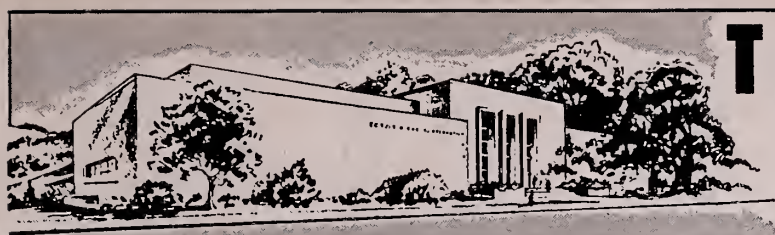
County society officers unable to attend the Presidents and Secretaries Conference in Austin may still obtain complete information kits on V.A. medical care by writing Association central office direct. Other PR aids, such as Presidents' and Secretaries' Handbook, 1954; County Society PR Outline Guide; State Program, Public Relations Committee; as well as many factual pamphlets for society or individual office guidance (see list, P. and S. Handbook, page 15), may be obtained similarly.

ON THE NATIONAL SCENE: A strong socio-economic note from the 867-member Hartford (Conn.) County Medical Association. The association recently amended its by-laws to provide its officers a strong weapon to police association ranks in matters of overcharging, as follows:

> "When a matter in controversy relates to the fee charged by a member of the Association, the Committee (on Medical Ethics and Deportment) shall hold a hearing and by majority vote, determine the fee which it deems fair and proper, after seeking the advice of three physician members who are recognized specialists or practitioners in the field concerned . . . ."

Failure to comply with committee findings may lead, via the association's board of directors, to the Connecticut State Examining Board and result in revocation or suspension of license.

Commented Hartford Times: ". . . another step by the public relations conscious organization to strengthen the position of the profession with the public by imposing shackles on any who might tear down public confidence through gross overcharging."



TEXAS State Journal of Medicine

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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GREEN GRASS INSIDE THE FENCE

Elsewhere in this JOURNAL are details of the 1954 annual session of the Texas Medical Association. The scientific papers and exhibits; information on legislation, economics, and community service; and the renewal and establishment of friendships at this session May 3-5 in San Antonio are samples of the contributions which the Association can make to the life of the Texas physician.

Sometimes the contributions by this parent medical organization of the state are disparaged, and it is well to rethink the position which it holds.

Once upon a time a doctor of medicine treated any disease or injury. He and those like him organized a society in which they could discuss and evaluate methods of diagnosis and treatment, through which they could become better acquainted, and by which they could speak with greater authority to legislators and the public about health problems. The local organization joined with others of like intent to establish a statewide brotherhood, which eventually affiliated nationally with other state associations to perform services no smaller unit could accomplish.

San Antonio's beautifully designed Municipal Auditorium, where scientific sessions will be held and technical and scientific exhibits will be on display during the Texas Medical Association's annual session May 3-5, is usually the scene of symphonies, operas, and concerts by great artists. The registration desk will be housed in the Auditorium beginning May 3.

For a long time, his county, state, and national medical societies offered all of the scientific food for thought, all of the professional fellowship, and the most effective public voice the physician could want.

Then came specialization with its bevy of societies, compulsory hospital staff meet-

ings, regional assemblies where doctors are concentrated. Then came threats to the economic and social ideology upon which American medical practice is built and differences of opinion as to how far men of medicine should go as a group in opposing these threats, with the consequent mushrooming of organizations to reflect varying shades of opinion. Then came a general increased tempo of living with too many meetings and too little time.

Today the county medical society, the Texas Medical Association, and the American Medical Association, strong because of their all-inclusiveness and because of their years of experience in serving the medical profession, at the same time have tended to lose the priority which was theirs before other groups, appealing in their singleness of purpose and with an undeniable raison d'etre, diverted much vigor and zeal to their banners.

The need for all doctors of medicine, whatever their special field, wherever they practice, to recognize the basic reasons for the early organization of a medical society and to understand that they still exist is important. Other medical organizations and activities have their place, but none can substitute for the broad-based, multipurposed federacy of county, state, and national societies of doctors which for so long has been fundamental in the concept of "organized medicine" and which regularly modifies its activities to meet changing needs.

On the state level the Texas Medical Association, which has fought for citizens of the state and their doctors for more than a century, deserves the respect and support of every one of its members—the respect and support which comes with attendance at meetings, participation in committees, attention to publications and correspondence, adherence to society rules, championship of elected officials, prompt payment of dues, and genuine interest in the organization and its progress.

The program of the 1954 annual session has been evolved after long hours of concerted effort based on the expressed desires of many members of the organization. The Texas Medical Association has much to offer, but its members must accept these gifts for themselves—they cannot be forced upon them. Attendance at the annual session, attention to its scientific offerings, interest in the deliberations of the House of Delegates, and enjoyment of the Spanish-flavored entertainment may be a first step back to the rewards of active membership for any physician who has allowed his attention to wander too far afield.

PUBLIC HEALTH, A PERSONAL CONCERN

Public health is in the news in Texas because of a turnover in the position of state health officer after seventeen years. Dr. George W. Cox, often the central figure in controversies which have involved other members of the medical profession and laymen alike, is stepping down voluntarily after having a hand in reducing the prevalence of almost every category of communicable disease in Texas, increasing local health units from 4 to 48, establishing a first class state public health laboratory, constructing a State Department of Health building, organizing the international United States-Mexico Border Public Health Conference, and employing and training dozens of skilled public health craftsmen.

No one, least of all Dr. Cox, could call the job of public health in Texas complete, and it remains for Dr. Henry A. Holle, a native Texan and former practitioner in Brenham who more recently has been medical director for Regions 1 and 2 of the United States Public Health Service with headquarters in New York, to consolidate the advances made under Dr. Cox's administration and progress to still greater achievements. Dr. Holle's background as a practicing physician in his native state and wide experience in public health administration fit him ably for the post of state health officer to which he has been appointed.

Regardless of his personal and professional qualifications, however, no health officer can operate effectively either in a vacuum of indifference or under the pressure of opposition from physicians in private practice. Even though he may have the backing of a well trained corps of health officers, educators, and sanitarians, real public support and a truly effective program are affected tremendously by the attitudes and degree of cooperation of medical doctors in private practice.

Few in this day would argue that public health services have no place—case finding, prevention of disease through immunization and quarantine, and sanitary engineering are areas in which the expenditure of tax funds is conceded to be appropriate and well nigh essential. Nevertheless, there are differences of opinion about how much federal subsidy shall be accepted in a state program, about what patients shall be immunized at public expense, about how much consultation there shall be between the health officer and his colleagues in private practice before a move in the public health field is made. Sometimes these differences grow into open disputes or stubborn stalemates which are harmful to the health of the community and create undeniable ill will against the medical profession.

The chairman of the Texas Medical Association's Council on Medical Jurisprudence is chairman of the State Board of Health which appointed Dr. Holle as state health officer, and the President of the Association is a member of the board. They have assured themselves of his outstanding qualifications for the job and have offered him their support as have other members of the board. The chairman of the Board of Trustees of the Texas Medical Association has pledged his cooperation to the new appointee. It behooves practicing physicians throughout the state to greet Dr. Holle with friendliness, to be ready to discuss objectively plans for improving public health facilities and function, and to offer criticism (if it becomes necessary) in a helpful manner rather than in a deprecatory spirit. The public health official and the private practitioner must complement each other if the best scientific knowledge is to be used in our free society for the betterment of health.

PUBLIC EDUCATION AND THE PHYSICIAN

When Texas broke with Mexico, its Declaration of Independence, signed March 2, 1836, contained this charge:

> [The Mexican government] has failed to establish any public system of education, although possessed of almost boundless resources, [the public domain,] and although it is an axiom in political science, that unless a people are educated and enlightened, it is idle to expect the continuance of civil liberty, or the capacity for self-government.

The Texas Republic, despite the earlier declaration, failed to take concerted action to provide an adequate system of public education, and for almost ten years after its entrance into the United States no statewide system of schools was authorized. In January, 1854, the legislature adopted a measure designed to set up common schools in districts covering the state, each district to receive a per capita share of interest from a special fund and free instruction to be provided for children of paupers. This law had to be revised and implemented, modified and developed, but it laid the foundation for public education, and this year Texas is celebrating the centennial anniversary of its public school system.

The law of 1854 was not intended to lead to the establishment of institutions of higher learning, but eventually it became apparent that the growth of indigenous leadership would require public support of advanced cultural and professional training, and state colleges and universities began to take their place beside church supported and other private institutions. As the years went by, the University of Texas Medical Branch in Galveston was founded, and much more recently the Southwestern Medical

School of the University of Texas in Dallas, the Postgraduate School of Medicine of the University of Texas in Houston with seven divisions elsewhere in the state, and the M. D. Anderson Hospital for Cancer Research in Houston were established. Dental, nursing, pharmacy, and other paramedical educational centers also were instituted under the aegis of the state, bringing this type of training within the financial possibilities of all the sons and daughters of Texas.

Public education and democracy are so closely allied that the necessity for supporting free schools need not be argued. What public education has done for the health of Texas might well be mentioned, however.

Healing by magic and superstition, the legacy of the primitive and unlettered, has given way in large measure to healing based on scientific knowledge. This has come about partly because of the basic knowledge of hygiene which school children are taught and the readiness of educated persons to accept—and even to demand—medical care based on the principles of anatomy, bacteriology, chemistry, and physiology. It has come about partly because of the better educational facilities for the practitioners themselves, facilities which not only make it possible to pass on to students the knowledge already accumulated but also permit experimentation and research to increase the fund of knowledge.

Dr. Dana W. Atchley, professor of clinical medicine at Columbia University, wrote recently:*

. . . In this country, at least, the evolution of the physician has been a reflection of the evolution of medical education, of the medical school. When the medical school ceased being a profitable side line for a group of successful practitioners and became an integral part of the university the physician made the first step toward true dignity. He was respected, useful, and often high-minded before, but he was essentially an artisan. The keen investigative mind had shown itself repeatedly in the recognition of new disease entities and the observation of fresh relationships, but there was little awareness of the experimental method among clinicians and few opportunities for the cultivation of scientific critique. . . .

Modern medical education has helped to fashion a new creature described by Dr. Atchley thus:

. . . the physician of today, at his best, represents a fusion of the healer and the scientist. In his role he analyzes the multiple components presented by a single human being. As healer his intuitive understanding of the personality and environment is amplified by modern psychology; and scientific studies of the many facets of the structure and function of the physical machine inform him as to the existing organic status. The appraisal resulting from an integration of these data leads naturally to the special management appropriate to the particular individual. The introduction of the highest possible standards of scientific precision into clinical medicine is no deterrent to the exhibition of compassion or any of the other generous gifts of the healer. Merging the healer and the scientist combines the best capacities of both and loses nothing by the union.

The type of physician which Dr. Atchley describes is being produced by the schools supported by the people of Texas and is being looked to for medical care by those people. Without detracting from the achievements of privately supported schools and schools in other geographical areas, we can be proud of the steps taken in the past one hundred years in public education in Texas and can join hands for a still better system of schools in the future.

*Healer and Scientist, Saturday Review, Jan. 9, 1954, pp. 7-9 ff.

PLASTIC SURGERY SCHOLARSHIP

Residents in training and plastic surgeons who have been in practice no longer than five years may compete in the fifth annual scholarship contest, junior classification, sponsored by the Foundation of the American Society of Plastic and Reconstructive Surgery. Two scholarships for three months each in plastic surgery study are the main prizes. An award also will be offered for a winning essay in the senior classification, which is for those physicians active in the practice of plastic and reconstructive surgery for more than five years.

Deadline for receiving the 5,000-word essays on some original clinical or experimental research in the field is July 1. The winning essays will be presented at the group's fall meeting. Further information is available from the Award Committee, c/o Dr. Jacques W. Maliniac, 30 Central Park South, New York 19.

ORIGINAL ARTICLES

PUBLIC HEALTH AND THE PRIVATE PHYSICIAN

HENRY A. HOLLE,* M.D., New York, New York

THERE has been a good deal of loose talk about what is meant by the term "public health," and almost everyone seems to have his own definition. The World Health Organization has defined health as "a state of complete physical, mental, and social well being, not merely the absence of disease or infirmity." Regardless of which definition one uses, it is clear that the complexity of living in a modern society makes it necessary for community health to be included in community planning. Optimal health, therefore, is a community responsibility.

BASIC CONCEPTS

It is not within the scope of this discussion to describe public health programs at national, state, or local levels of government. Certain basic facts or concepts seem to merit brief mention in passing, however, in order that there might be a common ground of understanding.

Public health in medicine is a specialty which requires special training comparable with other specialties. It is a full time job which cannot be done properly between professional calls in a busy practice. Public health programs are essential and effective and their results are measurable. They cost money. They should be planned at the community level to fit community needs because no two communities are exactly alike. They will not succeed without community support. Population-wise, the jurisdictions of health departments must not be too small to be economically feasible. These basic concepts as well as several others generally have been accepted in the public health field. I should like to mention one more.

Although the federal government can render valuable advisory and other assistance, it has no jurisdiction within the states. Under our system of government, this is as it should be. One could hardly think of anything more unwieldy, or unwise, than a public health program duplicated in every community and controlled from Washington.

To a lesser degree, it follows that the same general philosophy is appropriate as regards the relationship between state and local governments. The state may have a legal responsibility to provide health protection to its citizens when local government fails to do so, but there is little question that the most effective public health job by far can be done when local autonomy is preserved.

An important part of community support should come from the private physician, and it is obvious to the experienced health officer that without it his problems become almost insuperable. The health officer makes certain, therefore, that both his objectives and his modus operandi are understood by the local profession in the planning stage before the program starts. He knows that opposition from this source will make him vulnerable to the ultimate loss of other vital community support.

The private physician who is familiar with community public health work rarely is unwilling to support any reasonable program. He recognizes the public health physician and his staff as valuable allies and partners who are dedicated to the same good purpose to which he is dedicated, namely, the health and well being of the people. Since the days of Hippocrates, a doctor has not been influenced solely by motive of profit. Though he knows that the practice of improving or preserving community health will reduce sickness and death, he does not consider public health work as being competitive with his own job of restoring and preserving individual health. Rather than being competitive, it is complementary.

PROGRESS

At the turn of the century, life expectancy at birth in the United States was only 49 years. A half century later, the average age at death is more than 67 years. The greatest strides have been made in bringing the infant past his first birthday. We have available greatly improved methods of protecting water, milk, and other food supplies and more effective methods of controlling communicable diseases.

We think of these advances as having occurred in the field of public health. But in my judgment, the impact of the private physician on public health progress is too often underestimated. I say this because in many areas in which organized public health services have been meager or nonexistent, considerable improvement in mortality rates also has occurred. There is evidence here that the family doctor has been practicing public health along with his curative medicine.

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Regional Medical Director, Public Health Service, United States Department of Health, Education, and Welfare, Region II. Recently appointed to become State Health Officer of Texas.

As our population becomes older, it is logical to expect that the incidence of those diseases which are prevalent in the older age group will rise and cause relatively more deaths. This is precisely what has been taking place. The three leading causes of death in the United States in 1900 were tuberculosis, pneumonia, and diarrhea and enteritis.[3] In 1949 they were diseases of the heart, cancer, and vascular lesions affecting the central nervous system.[4] A shift in emphasis is taking place in our public health programs from the acute communicable diseases and sanitation to the chronic diseases.

Unfortunately, the chronic diseases as yet do not lend themselves easily to mass control. We need to think more in terms of the individual instead of principally about his environment. It is my belief, therefore, that the private physician will play a role of increasing importance in health conservation of the future.

ROLE OF FAMILY DOCTOR

The family doctor is the keystone of the arch in American medicine today. He is in a strategic position in large measure to exert the greatest single impact upon the health habits of the American family. How then, one might ask, may the family doctor discharge his responsibilities to society by engaging in good public health practice as well as good medical practice without special public health training? I should like briefly to discuss some answers to this question.

Vital Statistics.—The preparation of birth and death records is of paramount importance. It is irksome and somewhat of a chore to complete a death certificate, especially if it has to be done hurriedly because the mortician cannot obtain a burial permit without it. When the waiting room is full of patients, "senility" and "acute cardiac failure" seem easy to write down. But unless the underlying cause of death is recorded with accuracy, no amount of compilation or tabulation in Washington will reveal the true picture of mortality rates.

In recent years a birth certificate has become one of the necessities of life, and this fact serves as a constant reminder to those who otherwise might forget occasionally to file one.

Reporting of Diseases and Outbreaks.—In addition to reliable birth and death records, the prompt reporting of certain diseases is of great importance to the public health. Unfortunately, morbidity reporting in the past has left a great deal to be desired, and we might as well face it. Good medical records and prompt reporting of diseases to the health department go hand in hand whereas poor reporting usually results from an uncertain memory.

The implications of biologic warfare have alerted public health authorities to outbreaks of disease, especially if the outbreaks are unusual. Here again the private physician is the key figure. A single case may not require reporting while greater numbers of similar cases require prompt epidemiologic investigation and adequate control measures. Unless there is a health department handy in a sizable outbreak of this kind, the doctor and the community may face serious difficulty.

Advice.—The family doctor is the health adviser for the average American family. It is he who is called first for advice in the event of illness in the family. He learns to know the stresses and strains to which this unit of society is exposed, the emotional factors concerned, the economic aspects, and the environment in which its members live. This knowledge offers great advantages in the management of illness. It is usually his responsibility to make the decision as to whether or not a specialist is to be called, and it is he who counsels the family concerning serious and often grave procedures in the modern treatment of disease. These are some of the components of that priceless ingredient which we call the doctor-patient relationship, that ingredient which we believe has made American medicine the finest in the world and which must be preserved at all costs.

This position of confidence and respect which is enjoyed by the family doctor carries with it responsibilities not always recognized or discharged but of vital importance to community health. One of these is a move toward the correction of adverse environmental factors which have their impact not only upon the sick patient but upon the whole family. A word from the physician suggesting that the health officer is the specialist who needs to enter the picture might easily be the ounce of prevention which will keep the remainder of the family on its feet through the elimination of the hazard.

Another responsibility of the private physician is to maintain a high degree of immunity to the preventable diseases especially among his younger patients. It is refreshing to find an occasional family physician who runs through his records[2] to determine what proportion of his patients are immune to diphtheria or to smallpox. A word during a house or office visit or perhaps a card or telephone call from the doctor or his nurse calling attention to this deficiency should be considered an obligation to his patients and not construed as an attempt to solicit business.

I know of no surer method of bringing sex contacts in for examination than through the enlightened patient with syphilis or gonorrhea. In many instances, it is within the power of the doctor to eliminate the necessity of introducing a third party into the already

complicated picture by indoctrinating the patient with the importance of his own obligation in this connection, and a progress report from the patient on the results of his efforts to bring the source of his infection to treatment should not be overlooked at the time of his next visit.

PERIODIC APPRAISAL

Mention has been made of the lengthening span of life. The human "chassis" is being called upon to hold together longer and longer. Unfortunately, replacement of parts is seldom possible. Those who have had experience in the Air Force know about the 100-hour and the 1,000-hour airplane check-ups. All of us know that automobiles and all other mechanical contrivances require at least an annual examination for early signs of deterioration. What about the human machine? What about a 365-day check-up for human beings?

During the past decade almost every physician has been inordinately busy. He has found it difficult to spread himself sufficiently to meet the demands which were made upon his time. But for the most part, he has been busy with repair jobs—with plugging up the leaks, so to speak. He has not found the time to think in terms of appraisals of his patients in the absence of obvious illness. According to a report prepared by the American Academy of Pediatrics,[1] the pediatrician sees more well children than sick ones. This is not true in the case of the general practitioner, who sees more than twice as many sick patients as well ones.

From time to time, community-wide efforts have been made to screen the whole population or a portion of it to uncover cases of communicable or other diseases. We have seen mass testing for syphilis through serology, mass chest surveys for tuberculosis, and more recently the so-called multiphasic screening for chronic diseases. If it were generally practiced, the individual screen or check-up by the family physician on a recurring annual basis, preferably during the month in which the patient's birthday occurs, would, in my judgment, make the greatest single contribution to the early recognition of conditions which are rapidly rising toward the top of the list of the causes of death or disability.

The procedures to be done at various ages could be worked out by national professional groups to provide reasonable uniformity. Obviously, a balance would have to be struck between too much and too little. Concise record systems would make possible quick comparisons with previous examinations.

This type of preventive medicine by the private physician has dynamic possibilities. I should like to suggest that the interest on the part of the average patient to such repeated appraisals of his health status in the absence of obvious disease is far greater than is generally known. It is discouraging for him after little or no examination to be told by his family doctor, "There's nothing wrong with you. Stop worrying and come back when you're sick."

While many routine aspects of the procedures to be followed might reasonably be carried out by ancillary nonmedical personnel, the health check-up should not be so highly mechanized as to leave out its most valuable ingredient for the patient, namely, the medical judgment of the family physician. And in reply to those who contend that the doctor's place is at the patient's bedside, it is submitted that in the early detection of almost any clinical entity lie the richest rewards for the conservation of the patient's health.

SUMMARY

It has been suggested that modern society requires the inclusion of health in community planning. A few basic concepts generally accepted by public health specialists have been enumerated. The strategic importance of the private physician in connection with the changing emphasis of public health programs has been discussed, including his responsibilities to the public health in his day-to-day practice. The opportunities of the family doctor to make a major contribution to the public health through a carefully organized plan of periodic health appraisals of his patients has been discussed briefly.

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ABSTRACT OF DISCUSSION

DR. WILLIAM R. ROSS, Tyler: Dr. Holle has stressed the need for close cooperation between the public health specialist and the private practitioner. I would like to emphasize this point because I feel that it often means the difference between a successful program and a program that is difficult to administer. We should always keep in mind that the private practitioner generally considers his relationship to the patient as one of utmost importance and, therefore, the doctor's attitude may be influenced by the patient. The private practitioner may fail to report a disease since the disease may be considered by the family to be a family stigma; he may feel that the investigation conducted by the health department will interfere with the conduct of his practice; or he may simply feel that public health is an inroad toward socialized medicine.

When the health officer fully realizes the problems he is facing, he may decide better upon the tact and approach to use in overcoming the misunderstanding.

PUBLIC HEALTH AND PHYSICIAN—*Holle—continued*

Dr. Holle has pointed out that public health is a specialty which requires special training comparable with other specialties. I often think how much easier the health officer's job would be if he were in a position to employ well qualified and trained personnel. Often the difficulty with a private practitioner results from the fact that the practitioner has experienced a feeling of interference in his practice on the part of an inexperienced or overenthusiastic public health worker. To fulfill this dream for more qualified personnel, we must have a reservoir of qualified applicants from which to make our selections as well as sufficient funds to enable us to compete for the best.

Dr. Holle has touched upon the fact that both the health officer and the family doctor have responsibilities of vital importance to community health. This responsibility could be better accomplished in all cases if the physician simply would suggest to the family that those in the health department are specialists in the field of preventive medicine and, as such, are needed as consultants to eliminate fully hazards that may exist. When such suggestions are made, the public has much better respect for the practitioner as well as the health department representatives.

In closing, I would like to restate a basic concept of which we must never lose sight and that is that health surveys of any type should not be so highly mechanized as to leave out the most valuable ingredient for the patient, namely, the medical judgment of the family physician.

Alcoholism — A Public Health Problem

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ALCOHOLISM, along with cancer, tuberculosis, and heart disease, is ranked as one of the four major health problems facing us today.

The Metropolitan Life Insurance Company in a recent publication states that there are 50 per cent more sufferers from alcoholism than from tuberculosis; that 65,000,000 people drink alcoholic beverages in varied forms and amounts; and that 4,000,000 people in the United States are either actual or potential alcoholics. The exact number of alcoholics in Texas is not known. However, we do know that alcoholism is prevalent and that the difficulty is spreading.

The ravages of alcoholism are not confined to its actual victims. Members of their families suffer emotional, mental, physical, and economic hardships. In fact, it is probably safe to state that there is hardly a family which has not, at some time or another, been directly concerned with the problem of excessive drinking.

In 1947 *The Journal of the American Medical Association* reported on the findings of a special committee which investigated medical and health conditions in Alaska. Its findings regarding the problem of alcoholism are enlightening: "Alcoholism has assumed the proportion of an important problem in Alaska. In discussing the general over-all health problems of the territory with physicians, truckers, military authorities, and the man on the street, the subject of alcoholism was always spontaneously referred to by them. It accounted for a great deal of human suffering to both victims and their dependents. Indigence, venereal diseases, poor housing, poor nutrition, and general poor health can be attributed directly or indirectly to alcohol."

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In addition, think of the divorces which come as the result of alcoholism, directly or indirectly. Alcoholism has a much wider spectrum than one would ordinarily suspect. It is not only a problem itself but also the source of many, many other difficulties, such as broken homes, mental anguish, and even diseases such as tuberculosis, syphilis, gonorrhea, brain damage (Korsakoff's syndrome), malnutrition, and general poor health.

Another secondary effect which should not go unmentioned is the tremendous number of lost manhours in industry due to alcoholism. Since Texas is now enjoying the most rapid and extensive expansion in industry of any part of the country, the problem of the excessive drinker in our state is assuming even more importance than ever before. Major industries now recognize that alcoholism accounts for approximately 19 per cent of absenteeism. Alcoholism is now depriving industry of the services of skillful and valuable employees in all categories from the common laborer to even the highest echelons.

Another secondary effect has to do with traffic accidents. Homer Garrison, Jr., director of the Texas Department of Public Safety, recently furnished the special Committee on Study of Alcoholism of the Texas Medical Association with data showing that more than 80 per cent of all persons whose licenses were suspended in Texas in 1949 lost them because of driving while intoxicated (DWI) charges. There was a total of 12,726 suspensions of licenses of which 10,255 were on DWI charges. Mr. Garrison also revealed that 838 of the Texas drivers convicted on DWI charges were suspended for a second time or more times for the same offense. His statistics showed that in rural traffic accidents a drinking driver was involved in 42 per cent of all fatal accidents and 21

per cent of the nonfatal accidents. He also showed that 32 per cent of all pedestrians killed had been drinking and 18 per cent of those injured had been drinking.

Dr. William Willentz, medical examiner for Middlesex County, New Jersey, in a recent publication reviewed the problem of alcoholism in violent deaths over a period of nineteen years. He found that alcohol was a contributing or responsible factor in 37 per cent of 1,258 violent deaths investigated.

At this point it might be interesting to conjecture what percentage of those now being booked as driving while intoxicated should be classified instead as driving while drugged, for the use of barbiturates and narcotics with and without alcohol is growing at an alarming rate. This is a problem in itself, but one not far removed from alcoholism. Historians no doubt will label this particular era as "The Age of Sedation" because of the widespread use of sedatives.

DEFINITION

Alcoholism has been discussed as a menace to public health and general welfare, yet nothing has been said about the definition of alcoholism. What then is alcoholism and who is the alcoholic?

Let us first consider all of the wrong definitions of an alcoholic. Everyone has heard the expression, "An alcoholic is an individual who drinks alone." Many a father and mother have given advice to their offspring sounding like this: "Son, never drink alone, and you will never be an alcoholic." Also, many well meaning doctors, psychiatrists, and clergymen have given the same advice. However, the fact is that there are many, many alcoholics who never drink alone. As soon as they start drinking they become gregarious and develop "telephonitis." They do not want to be alone—they want to be with others.

There is another axiom: "The alcoholic is the person who has to take a drink in the morning." Then, as a corollary, this advice is given: "If you don't drink in the morning, you are not an alcoholic." There are many alcoholics laboring under this misinformation. Think of those who refuse to consider themselves alcoholics because they fight off the jitters all morning with aspirins, BC's, and Bromo-seltzers, until at 12 noon they resume their drinking.

Another common misconception about alcoholism is the old idea that by staying within two or three drinks no one becomes an alcoholic. The trouble with this moralizing is that despite everything, an alcoholic cannot possibly stay within such a limit. The truth is that for an alcoholic, "One drink is too many and a thousand are not enough."

Perhaps the most classic advice given by well meaning doctors, parents, clergymen, and educators is "Stick with beer—the light stuff—and you'll never be an alcoholic." Anyone dealing with alcoholics knows the fallacies in this statement. There are many alcoholics who drink nothing but the so-called light stuff such as beer and, more particularly, wine.

Another common error regarding alcoholism is the recommendation, "Never drink every day and you'll not be an alcoholic." We all are familiar with the "periodic binge" type of drinker who may go for weeks, months, and even years without touching a drop and then go on a real spree. It makes no difference whether an alcoholic is a periodic drunkard or a drunkard period.

What then is alcoholism and who is the alcoholic? Alcoholism is a symptom—yes, a symptom of an underlying illness. An alcoholic is an over-the-line drinker whose drinking definitely interferes with his everyday living. He is one who, having taken one drink, cannot guarantee his behavior. He is a person who, after taking the first drink, cannot tell when he is going to stop.

CAUSE

What is the cause of alcoholism? Much has been learned during the past few years regarding the cause or rather causes of alcoholism. First, one must consider that there are many contributory factors which are not in reality the etiologic agents but merely circumstances which aggravate the underlying cause. For example, pain, environment, illness, economic problems, and marital difficulties all are listed as causes. Actually they are not causes but occasions. All of us have heard the remark: "Well, I can't blame So-and-So for getting drunk. If I had to put up with his wife, I'd be drunk all of the time, too." What is not realized in such an instance is that the wife is not the cause of the man's drinking (although many times she might be the exciting factor) and even if she were removed from the man's life, he still would continue to get drunk if he were an alcoholic.

Despite the tremendous amount of research and study of the problem of alcoholism, the primary cause, if there is one, is unknown. Instead it is thought that there is no single cause, but a combination of factors that creates an excessive drinker.

Dr. Edward Strecker, chairman of the Department of Psychiatry, University of Pennsylvania Medical School, defines the cause of alcoholism as "momism mixed with alcohol." He means that the average alcoholic was either much pampered or much neglected and rejected by his mother when he was a child. In the case of the pampered child, the person grows to adult life but tends to retreat because the demands and responsibilities of everyday living are too much for him. Most of us tend to want to retreat, but in the case of the alcoholic it is pathologic and obvious.

Because of his stunted emotional growth and therefore inability to cope with everyday problems, he develops pathologic insecurity and fear. If this is mixed with the highball or cocktail, the element of fear is released and dominates the personality. This is also true in the case of the neglected or rejected child. The common denominator, then, is pathologic fear. It is this aspect which becomes so trying and is least understood by those closest to the alcoholic.

The alcoholic's fears are of the commonplace and trivial rather than of the big things which we erroneously consider as the mark of the brave. He fears social errors; he fears the dark; he fears breaches of etiquette. For example, when an alcoholic is drinking, he is afraid of the dark and as night falls his fear increases. At the same time should an emergency such as the Texas City disaster arise, he will be the first to offer his services (if he is able). In fact, there have been many alcoholics decorated for acts of bravery beyond the call of duty.

This fear is responsible for the four basic traits found in alcoholics: sensitivity, childishness, egocentricity, and grandiosity. These are usually operative in the subconscious. However, they may be expressed or manifested consciously by such symptoms as irritability, loneliness, depression, resentments, defiance, pouting, elation, obstinance, aggressiveness, determination, dishonesty, nervousness, restlessness, frustration, and selfishness.

Because all of these attributes of an alcoholic's personality are based on the element of abnormal or pathologic fear, this element of fear must not be increased. Instead, fear must be offset or counterbalanced by faith, hope, and self-confidence. It is also the reason why condemning, criticizing, making fun of, or frightening an alcoholic only accentuates his difficulty. A so-called normal person who pouts does so because he is hurt—an alcoholic does so because he is frightened.

In the light of these findings it is no wonder that physicians, psychiatrists, and the clergy have had such poor success in solving the problem of alcoholism in the past. The physician, if he attempts to treat an alcoholic, usually does so by telling him that if he does not quit drinking he will die of heart trouble or some other disorder. What does this do? It generates even more fear; thus the patient, emotionally speaking, is right back where he started. Then consider what the psychiatrist usually says to such a patient: "If you don't stop drinking, you'll wind up in an insane asylum." That is exactly what the patient is afraid of, and if his fears are further confirmed and extended by a so-called expert, the vicious cycle begins again. Perhaps he has made a visit or two to the asylum, and to make insanity more bearable, he reaches for another fifth.

In all these cases the condition that was causing the excessive drinking becomes accentuated. The condition becomes worse, and the alcoholic becomes more fearful than ever. Therefore, he drinks more.

There are, of course, other causes for excessive drinking. Alcoholism has been thought of as an allergic disease or as a condition of hypersensitivity. Recent studies have focused attention on hormonal imbalance—particularly with respect to the anterior pituitary–adrenocortical carbohydrate system.

TREATMENT

Prevention.—Alcoholism cannot be prevented or controlled by legal punitive measures, no more than can tuberculosis, syphilis, or poliomyelitis. Its prevention lies in stimulation and providing a more healthy childhood—a childhood wherein a person is fully accepted and shown approval and affection. This calls for a more closely knit family life. This means more education of the public in an attempt to pass on a more profound comprehension of the difficulty.

Chemotherapy and Psychotherapy.—Active treatment of the problem drinker may be divided into two parts. The first phase has to do with the immediate effort to obtain the patient's sobriety. The second phase is concerned with treating his personality so as to help him maintain his sobriety.

For sobering up purposes, hospitalization is always desirable. All alcoholic beverages should be withdrawn immediately or at least within twenty-four hours. Ten cc. of aqueous adrenal cortical extract (ACE) should be administered intravenously every six to eight hours for twenty-four hours; then every twelve hours for the next twenty-four to forty-eight hours; then once a day for two or three days; then 5 cc. intramuscularly biweekly for four weeks; then 5 cc. intramuscularly weekly for four weeks or longer.

Adrenocorticotrophic hormone (ACTH) also may be utilized, and it effects dramatic results especially in delirium tremens. The dosage is 25 mg. intramuscularly every four to six hours for twenty-four to forty-eight hours. Of course, the usual precautions are taken regarding the administration of ACTH. The body weight and blood pressure must be measured at frequent intervals to guard against any disturbance in the electrolyte and water balance.

Fluids in the order of 1,000 cc. of 5 per cent glucose in saline solution containing 20 cc. of ACE may be given intravenously to severely dehydrated or anorexic patients once or twice daily for one to three days.

A low carbohydrate, high fat, and high protein

diet cannot be overlooked. Caffeine and sweet carbonated beverages should be omitted.

Benadryl solution may be administered in dosages ranging between 2 and 5 cc. intravenously along with ACE every twelve to twenty-four hours for marked excitability and distressing nervous or gastrointestinal symptoms.

Tolserol in 1 to 2 Gm. doses four times daily is helpful in reducing muscular tension.

Vitamins should be administered both orally and parenterally.

Sedatives, barbiturates, and narcotics should be used judiciously and sparingly. They should not be allowed to serve as a substitute for alcohol.

Antabuse is tetraethylthiuram disulfide, which when combined with alcohol yields acetylacetic acid, a highly toxic substance which may cause death. It must not be given until after the patient has been alcohol-free for seven days. Its dangers must be explained carefully to the patient, and he must have a full and commanding knowledge of the drug before taking it. It should be administered only as a crutch to help him maintain his sobriety until he is on solid emotional footing once more.

The second phase of treatment is largely psychologic, and it involves not only the patient but his family and friends. They must be told the true nature of the difficulty and then must be made to realize that it can be arrested—that there is hope. In this connection there is referral to Alcoholics Anonymous, which is the answer for most alcoholics. This program has a threefold approach to the problem. Alcoholism is considered a physical, mental, and spiritual sickness, and it is maintained that unless there is an adjustment of the personality on all three levels, there will be no permanent sobriety.

The Alcoholics Anonymous program revives the alcoholic's confidence in himself because he is approached by another alcoholic. The axiom that it takes an alcoholic to treat an alcoholic possesses a great deal of merit. Members of Alcoholics Anonymous insist that the ability to establish this contact of confidence is a gift of the Almighty to all recovered alcoholics. Fear is replaced here with faith and confidence. They have a deep conviction, "Once an alcoholic, always an alcoholic." This points up the fact that, at the present, alcoholism may be arrested but cannot be cured. They place their ultimate security and sobriety upon the only true source of security —Almighty God. Finally they use the time-valued plan of group therapy. This affords the alcoholic an opportunity to work through many of his personality defects.

The core of the Alcoholics Anonymous program consists of twelve steps, simple and solid; its meat is the practicing of the conviction that only an alcoholic can fully understand another alcoholic.

It is something like the story of the boy at the puppy sale who hesitatingly edged up to the seller and said, "Please, mister, I'd like to buy a puppy. How much do they cost?"

"They're $10."

The child's face fell. "I've only got $1.63. I heard you had one with a bad leg. How much is he?"

"But that one will never walk perfectly. You wouldn't want him."

Hiking up his pants leg, the little boy showed a brace. "I don't walk so good either, mister, and I reckon that's just the puppy I want. He'll need some understanding for a long time, till he gets used to it. I did."

Today many more than 100,000 men and women have sobriety because someone understood their problem.

COMMUNITY ASPECT

The skid rows of America are nothing but a black memorial to the mishandling of the problem drinker.

It ill behooves any community to have great and expensive edifices built for the protection of the public's health and then allow the squalor of skid row to mar the community. It does not take elaborate buildings and great expenditure of money to improve this problem. The instruments for this operation are the things that money cannot pay for. It takes the basic kindness that one human should have for another. It takes tolerance and sympathy and understanding and an enlightened approach.

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ABSTRACT OF DISCUSSION

DR. ANDREW S. TOMB, Victoria: Of course we are thankful for the advances made in the use of hormones. We are appreciative of a more generally enlightened attitude concerning this disease. By far the greatest improvement in therapy in our generation, however, is that we can now tell the alcoholic patient with certainty that he is a sick man instead of just a "never-do-well." The quicker we forget the misnomer "will power" in controlling drinking the better off we will be. This man is a victim of compulsion and will power has nothing to do with it. Many alcoholics

have used more sheer nerve and will power in getting up off a sick bed to find another drink than others have used in establishing a business empire.

In spite of all of the education and all of the cooperation of the press and radio, we still have thousands of problem drinkers who do not understand their plight, and they do not know that there is a way out of their dilemma.

Dr. Constant's paper sounds a definite note of optimism which is refreshing to find in the average psychiatrist's approach. It is time to forget the negativistic approach toward the problem drinker. In many instances the public health physicians are our front line of education and they should remember this note of optimism in their thinking of this disease.

All public health physicians have recognized the classic story of Typhoid Mary in the spread of disease. Alcoholism likewise is the carrier of many and other public health problems whether it be directly or contributory. Since education is the first step in improvement it likewise follows that education must begin with the physician.

PREVENTIVE PSYCHIATRY IN PUBLIC HEALTH

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THE public health expert has chalked up so many successes in areas of human suffering that there is much reason to hope that in time he will change the unfortunate fact that psychiatric disorder is now our country's number one public health problem. A psychiatrist can tell something about the nature and extent of the problem and about administrative measures and programs now in the field, but he is less sanguine concerning an operating program which with certainty would mitigate the problem. He often is not even sure as to where prevention stops and clinical psychiatry begins. In some states intensive treatment is being given with the idea of preventing chronic institutionalization. The psychiatrist has been so busy treating the sick that he has had little time or energy for studying the larger aspects of the situation. He is certainly in need of the interest, techniques, and collaborative efforts of those in not only public health but also government, education, religion, sociology, and several other fields.

Although the exact nature and extent of psychiatric disorder in our society is not known, there is enough information to indicate that no other public health problem is of greater magnitude. In the main, psychiatric disorder can be equated with emotional disorder although it must include certain organic conditions such as general paresis, cerebral arteriosclerosis, senile deterioration, convulsive disorder, and some fraction of mental deficiency. Emotional disorder manifests itself in a considerable variety of social morbidity such as delinquency, vagrancy, crime, divorce, dependency, illegitimacy, prostitution, suicide, alcoholism, and drug addiction. At present 1,750,000 serious crimes are committed each year in the United States; at least 50,000 people are addicted to narcotics; there are 3,800,000 problem drinkers of whom 950,000 are severe, chronic alcoholics; 17,000 persons commit suicide each year; 265,000 children are brought into the juvenile courts yearly; and for every 4 marriages there is 1 divorce.[4] Emotional disorder also contributes to physical illnesses which bring patients to physicians in all branches of medicine to the degree that it is estimated that 30 per cent of all patients in general hospitals and 50 per cent of all patients of general practitioners are suffering from personality disturbances or physical illnesses associated with personality disturbance.[4] In assessing the problem, one must also include many persons with psychosomatic disorders such as asthma, peptic ulcer, hypertension, colitis, migraine, and atrophic arthritis. A recent study indicates that 78.5 per cent of 200 routine admissions to a dermatology clinic were for psychosomatic reasons.[3]

In addition, there are 1,500,000 people in our country who are suffering from serious mental illness; of these, 650,000 are in hospital beds, constituting 47 per cent of all the patients in all hospitals in the United States. Each year more than 250,000 new patients are admitted to mental hospitals and another 100,000 are readmitted. One out of every 12 children born each year will sometime during his life suffer a mental illness severe enough to require hospital care.[4] A recent survey by Roth and Luton showed that for 1,000 persons in a community, 123 were to some degree in need of help for emotional disorder.[5] Of this 123, only 2 were hospitalized, indicating that for every patient who gets into a hospital there are at least 60 others who need help.

As I remember, the public health expert judges water by the number of Bacillus coli in it. Although there is no such handy device in psychiatry, there is the survey. A recent one secured interesting figures concerning sex education from parents in those who later became students of nursing and medicine. Of 55 affiliate nursing students from four different

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schools in Texas, only 3 had received any type of sexual education from their parents during their years of growth. Of 160 freshmen medical students from all parts of the state, 25 had received any education in sexual matters from their parents.[6] One would not have to be a psychiatrist to suspect from this that the great majority of our youngsters are growing up in families where the capabilities or attitudes of the parents leave much to be desired. If we are to have healthier population, we somehow must grow healthier people who in due time will be better parents than their own.

PRESENT CARE

The great bulk of present psychiatric activities is concerned with the care of people who are already ill. It is likely that a fraction of chronicity is due to the inadequate care which is almost universal. At present no public mental hospital in the nation meets the minimum standards for personnel of the American Psychiatric Association. In 1950, there were 1,228 service locations throughout the United States where psychiatric clinic service was available. Three-fourths of these clinics were operated by public agencies. At present about $4.15 per year is available for research per hospital psychiatric patient as compared with $28.20 for infantile paralysis, $26.80 for tuberculosis, and $27.70 for cancer. For several years the federal government has included about $10,000,000 per year for the work of the National Institute of Mental Health, including research, training grants, and development of new clinical facilities. With these funds many states have organized bureaus of mental health in their health departments. In general, these bureaus have subsidized clinics for adults and children and have sponsored educational activities through courses, movies, and literature. Some states have matched the federal funds, and some have not. Undoubtedly, this federal program has been useful in developing new facilities, securing more trained workers, bringing clinical service to many, and acquainting many others with facts. States like New York and California have extensive service programs which include traveling teams which through demonstration bring case finding, superficial therapy, and education into many communities which have no other facilities. Hawaii has a program by which branch offices, with a resident psychiatric social worker, conduct educational, consultation, and case finding work. In some states, mental hospitals are actively conducting community programs in the area from which they receive patients.

It should be noted, however, that almost all of what is being done is concerned with individual service which is needed after the fact of emotional disorder has been established. The concept of applying public health measures in this field is so new that the schools of public health in the United States maintaining a division of mental hygiene can be counted on one hand.

EXPERIMENTS

Because of the realization that the basic vulnerability to mental disorder is acquired in childhood, some experiments aimed at influencing the emotional development of the students in a healthy manner are going on in the schools. In some ways the demands and complexities of modern life seem to exceed the capacities of many families to bring forth emotionally healthy persons unaided. Since every child goes to school for a number of years, the experiment in positively influencing emotional development during this time would seem to be wise. One of these enterprises, originated by Col. H. Edmund Bullis of Delaware, has been in operation for a number of years and is now so refined and impressive as to be in use in classrooms totaling more than 200,000 students in different states all over the country.[2] The materials are in a form which makes them usable by any teached who will follow the directions and devote one hour per week to them.

There are other experiments which go much further. In a suburb of Toronto, the entire operation of the schools is organized around mental health principles with the idea that when some final satisfactory techniques and practices are developed, they then can be applied throughout a large area.[2] Some efforts are being made here and there at providing professional students in education, religion, nursing, law, and other fields with a knowledge of human development, functioning, and needs.

Although the advent of psychodynamic psychiatry markedly complicates the task of studying and understanding the emotional development and functioning of a person, it for the first time makes it possible to deal with human problems etiologically. From the intensive study of individual failures of adjustment, we have learned about numerous important normal developmental needs and problems, and also we have learned methods of management which will lead to healthy growth. We also know about common methods of mismanagement which contribute to the vulnerability in the structure of the adult which renders him incapable of handling life situations successfully. For instance, we know that emotional damage can be done to children by allowing them to sleep in the parents' bedroom until an advanced age, that circumcision in boys between 3 and 7 years old is so emotionally hazardous it should be avoided if at all possible, and that permitting outlets for hos-

tility is far better than total suppression. Sickness, surgery, marriage, separation, discord, an absent parent, death, moving, and other family occurrences carry with them real emotional impact on children. Unless these internal situations are understood, they are not apt to be managed constructively.

Some new terms are appearing in the medical literature. These include "psychosomatic medicine," "social medicine," "total medicine," "environmental medicine," "integrated teaching," and "vertical curriculum." A number of experiments are being conducted in the organization of the medical curriculum.[1] One goal of these experiments is to prepare better all medical graduates to understand the environmental, social, family, interpersonal, and emotional aspects of medical practice. The physician can be a key person in demonstrating and teaching methods contributing to healthy growth.

PROGRAM

The physician may wonder what program can best serve mental health needs and what role the public health worker can fill. This paper lacks material concerning an integrated administrative organization of activity in lay and professional education, prevention, case finding, research, and clinical services in psychiatry. Unfortunately, the difficulty is not with me but with the fact that half a dozen different state supported activities operate independently in the field with no over-all planning or coordination. A concerted effort upon this huge problem should start with a coordinated program including the public health and psychiatric departments of the state medical schools; the Bureaus of Maternal and Infant Health, Public Health Nursing, and Mental Hygiene of the State Health Department; the Department of Public Welfare; the State Youth Development Council; the juvenile courts; and the educators of the state on the elementary, secondary, and college levels. Such an approach would make a comprehensive program possible.

The public health instructor at the medical school should be one of the most important members of this operation, not only in educating qualified personnel and in introducing preventive psychiatry to students of medicine and nursing but also in initiating and conducting basic research into the epidemiology of emotional disorder. This is a matter about which little is known. At long last it has been learned that psychiatric disturbances are not inherited just as it was learned some seventy years ago that although tuberculosis runs in families, it is not inherited, but the healthy child is infected by the sick parent. It may be that epidemiologic research would identify some of the geographic, social, cultural, occupational, educational, religious, family, age, and sex factors which would help single out particularly vulnerable situations and individuals. It is hoped that the public health researcher will be able to provide the techniques necessary in devising and evaluating the results of experiments growing out of research surveys.

The department of psychiatry of the schools of medicine should offer the state an outstanding example of the best present day knowledge and practice in the field and should be continually experimenting with various methods of education, community service, and therapy. It also should assume responsibility for providing the mental health agencies and the communities of the state with an adequate number of properly trained persons in the field. It could well supply many of the workers necessary for the research, demonstration, and service programs in several of the other state agencies and simultaneously better prepare its students for a type of practice far above a concern only for the 1 person in 60 ill who gets into the hospital and for the 1 in 10 in the total population who is obviously in need of medical help. Important as the treatment of the sick is, any improvement in the total public health problem of psychiatric illness will come not from the treatment of individual patients but from preventive work with the whole population. It is the proper concern of the medical schools to be training psychiatrists and physicians who are able to fit into such a program.

The State Health Department has numerous opportunities to do research, educate, and prevent disorder through its well baby clinics, its contacts with the newly married or those about to marry, its widespread associations through public health nurses and its Bureau of Mental Hygiene.

There are many opportunities for the state hospitals to improve internal operations and to become area leaders through the development of research, outpatient follow-up, and educational activities. Some states have found it wise to provide university level psychopathic hospitals in different areas of the state for all those who need psychiatric hospital care. With good modern practices these hospitals can return as many as 75 per cent of the patients to the community. A great deal of money thus can be saved by preventing admissions which cost the taxpayer $6,000 per average case.

It is well known that many individual families that come to the attention of any welfare agency are far more in need of clinical service than of money. The same can be said of the young people who find themselves in juvenile courts and state reformatories.

One of the major opportunities in our society to bring healthy factors into the development of children is in the schools, not only through the general

organization and facilities but also through the teacher-student relationship and through the occasion the school has to know about disturbed families and to participate in bringing them help. An over-all preventive psychiatric program certainly would include many experiments in the selection and preparation of teachers, in administrative and curriculum practice, and especially in activities aimed at identifying the areas of emotional difficulty in students and helping them with their problems.

Although outside the field of medicine, every advance in the general standard of living, in the provision of active recreational programs for all, in race relations, in adult education, in improved housing, and in greater leisure can contribute much in preventive mental hygiene.

Democracy ideally operates on a local level. The possibilities of putting the best preventive measures we know and the research which should be done into operation must depend somewhat upon individual communities. State and national agencies can offer suggestions, give advice, conduct demonstrations, and assist in area-wide bookkeeping procedures by which the effectiveness of preventive activities in a given community can be measured.

In conclusion, it is my hope that the interest in preventive psychiatry will persist and expand and that eventually, by working together, we can diminish emotional disorder and add to the usefulness, utility, and joy of life for all.

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ABSTRACT OF DISCUSSION

DR. HARRY M. LITTLE, Houston: The main burden of devising and carrying on a program of promoting mental health and of preventing mental illness must fall on public health workers. More than any other single professional group their training and experience qualifies them for this task. They have the skills in epidemiologic research, in coordinating the efforts of workers in various professional fields, and in organizing at national, state, and community levels the joint efforts of lay and professional persons and groups to solve a common problem.

The field of competence of psychiatrists as a group is chiefly limited to the diagnosis and treatment of persons who have already developed some form of emotional disorder and to research into its nature and causation.

The question arises as to just what is meant by preventive psychiatry. I recall hearing Dr. Stevenson of the United States Public Health Service make the distinction between the fields of mental hygiene and psychiatry. He stated that the former had to do with promoting mental health and preventing the development of mental disorder and at the point that mental disorder develops, the case ceases to be a mental hygiene problem and becomes a psychiatric problem.

In this sense, relatively few psychiatrists are doing preventive work. Even those who work in child guidance clinics and who undertake a certain amount of lay education and other activities that could be considered preventive, nevertheless see their main function as the diagnosis and treatment of children with behavior and emotional problems.

On the other hand, if we take a broader definition of preventive psychiatry—including in the definition basic research in cause and treatment, the accumulation of knowledge about personality structure and development and the positive and negative factors that influence this development, the early diagnosis and proper treatment of children and adults with behavior and emotional problems to avoid the development of more serious disorders—then we may say that a considerable amount of preventive psychiatry is done in this country.

But the combined efforts of psychiatrists and public health specialists will not be equal to the tremendous task of preventing and controlling mental illness. I cannot stress too forcefully the point Dr. Shanahan has made in this connection. There also is needed collaboration of psychologists, sociologists, cultural anthropologists, and all other professions and groups in the community engaged in teaching, counseling, and otherwise seeking to help people solve their own problems. Neither must we overlook the importance of lay participation and support in this program, which, to be successful, must reach into all phases and aspects of family and community life.

Dr. Shanahan has spoken of the necessity for more epidemiologic studies and has referred to several community surveys that have been made. It is heartening to know that at present there are major interdisciplinary projects under way in Onondaga County, N. Y.; New York City; Nova Scotia; and New Haven, Conn. I understand that in the proceedings of the 1952 Round Table on Mental Health of the Milbank Memorial Fund's twenty-ninth annual conference, there will appear brief descriptions of nine such research projects now being carried on.

As an example of significant findings coming out of epidemiologic research are the facts resulting from a project conducted by Community Research Associates in St. Paul, Minn. For instance, in a group of 5,211 families there were found 79.4 per cent of the reported cases of psychiatrically diagnosed emotional disorders (other than those reported only by the state hospitals), 69.2 per cent of reported mental deficiency, and 52.9 per cent of officially reported antisocial behavior.

These figures not only point out the influence of family living on personality development but also strongly suggest that community-wide knowledge and preventive plans should be set in a family framework.

The last point in Dr. Shanahan's paper upon which I will comment is his statement to the effect that in the last analysis the success of a program of prevention and control

PREVENTIVE PSYCHIATRY—*Shanahan—continued*

of mental disorder must depend upon the local community. To my mind, this is the only way these programs really can be made to work. Just as the individual patient must have the desire for help and a willingness to invest energy and perhaps money in an effort to solve his own problems if he is to be helped by the psychiatrist, so it is with the local community that is faced with the problem of mental disorder. The interest and active participation of a sizable segment of the lay and professional people in the community must be obtained if a preventive program is to be effective and if state and national agencies in the field of mental health are to be helpful.

PSITTACOSIS (ORNITHOSIS)

Infection by Fleeting Contact with a Parakeet

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IT IS not necessary to have prolonged or intimate contact with birds to become infected with the psittacine (ornithosis) virus. As will be presented in this case, "fleeting" exposure may be sufficient. Recognition of this will lead to greater diagnostic accuracy in many cases of primary atypical pneumonia. If a history of even transient exposure is obtained, one should be alerted to perform complement-fixation studies for ornithosis. Smadel, in 1943, discovered positive complement-fixation tests in 10 of 45 cases of primary atypical pneumonia, and 4 had definite history of pigeon contact.

ETIOLOGY

The etiologic agent in ornithosis is the Miyagawanella psittaci virus, which is intermediate in size between Rickettsiae and true viruses. By staining with basic dyes, one can visualize, under ordinary microscopic magnification, the elementary coccoid inclusion bodies in reticuloendothelial cells of infected tissues—the Macchiavello bodies. The virus is a relatively hardy one, but may be inactivated by .1 per cent formalin and .5 per cent phenol in twenty-four hours.

SOURCES OF INFECTION

There has been a steadily increasing number of bird reservoirs recognized as sources of human ornithosis infection. Since 1945, more than 500 human cases of this disease have been discovered in the United States and Canada. In this series, the psittacine group of birds (parrots, parakeets, cockatoos, and budgerigars) has been responsible for less than one-third of the cases. Canaries, finches, fulmars, doves, pigeons, Pekin ducks,[12] turkeys,[3], pheasants,[11] and chickens,[7] have now been recognized as potential sources of exposure to the infection.

The virus is present in droppings, in nasal discharges, and in the saliva of the birds. Infection is contracted usually by inhalation and rarely from bites, and the bird need not be sick or dead to infect.[1]

A serious source of infection is the "human to human" spread. This may occur by transmission from the patient to members of the immediate family, to transient visitors, or to attendants or, rarely, from carrier sources. There have been 23 reported instances of "human to human" spread involving 30 nurses. In these cases, contact with birds was definitely excluded.[8, 12] Eaton, Beck, and Pearson reported a fatal case in which the patient infected 3 nurses, of whom 2 died. Two laboratory workers assigned to this case also developed ornithosis, but recovered. Apparently, massive elimination of the infectious agent occurs during the acute illness, and, therefore, most "human to human" contacts occur among hospital and laboratory workers.

Gerlach found the virus of ornithosis in the sputum of 5 patients without clinical evidence of disease,[12] thus suggesting the potentials of a human carrier state. Meyer and Eddy[9] isolated the virus of ornithosis from respiratory discharges of a patient eight years after a severe acute attack. Since the wife of this carrier neither contracted the disease nor developed positive complement-fixation titers, it may be concluded that there must be a low rate of contagiousness in a carrier.

PATHOLOGY

The principal pathologic findings are in the lungs and spleen. Bronchopneumonia starts at the hilus and extends to the periphery. The cells in the alveolar exudate are largely monocytes showing phagocytosis with intracytoplasmic inclusion bodies. The spleen is invariably enlarged, with engorged sinuses filled with phagocytic cells, and the smaller vessels show hyalin degeneration.[4]

CLINICAL FEATURES

In man, the incubation period of ornithosis is seven to fourteen days, rarely thirty. Initially, there is an influenza-like picture, typical symptoms being fever, severe frontal headache, photophobia, and

chilly sensations with profuse sweating. At the onset, the temperature is 100 F. to 102 F. gradually rising to 104 F. Early, there is a dry harsh cough with scanty mucoid sputum, later becoming productive. There is a relative bradycardia, a normal leukocyte and differential count, and on rare occasions, a rose spot skin rash simulating typhoid fever.

The course may last three to four weeks, with defervescence by lysis. Relapses are characteristic, and convalescence is frequently prolonged for several months. Death is usually due to pulmonary insufficiency, secondary to massive pneumonia. Roentgenograms reveal patchy pneumonitis, starting near the hilus and extending peripherally. Serial films show slow resolution. As the hilar involvement of the lung occurs first, the peripheral signs occur later, and the roentgenogram is frequently positive before the auscultatory changes and usually shows a greater degree of pathologic involvement than is anticipated.

The physical findings are primarily those involving the lung and spleen. The spleen becomes characteristically enlarged from the tenth to the eighteenth day of the disease, and may be missed unless

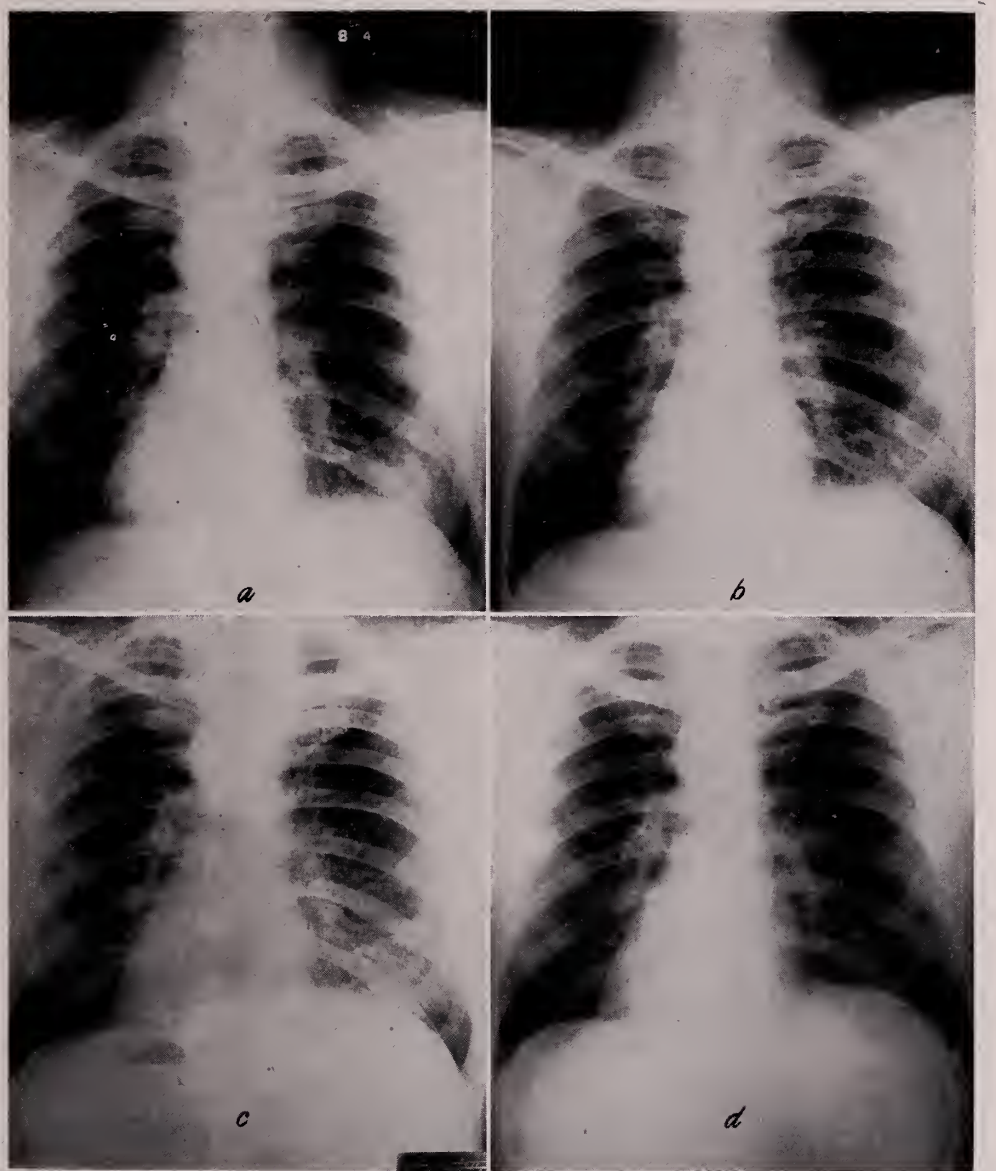

Fig. 1a. Roentgenogram taken August 4, 1953, showing an area of mottled, irregular, poorly defined density involving the right hilar region and lower lobe of the right lung. Primary atypical pneumonia is suggested.

b. In a film taken August 17, the diffuse density persists. Unresolved pneumonitis seems evident.

c. August 24 the diffuse mottling is more widespread in the lower lobe of the right lung. The pneumonitis is unresolved.

d. By September 10 a roentgenogram shows the lower lobe of the right lung to be almost completely clear. The pneumonitis is resolving.

carefully sought. In 3 cases of primary atypical pneumonia, the finding of an enlarged spleen suggested testing for ornithosis. In each instance, the complement-fixation tests were positive.[5]

Since the disease is a nonspecific pneumonitis, in all cases of primary atypical pneumonia one should carefully question for a history of bird contact—"fleeting" or intimate, and if the spleen is enlarged, obtain a complement-fixation test for ornithosis.

The importance of the finding of an enlarged spleen is well emphasized by MacLachlan, who noted that in uncomplicated pneumococcic pneumonia, it is rare to find splenic hyperplasia; that in the influenza epidemic of 1918, an enlarged spleen at autopsy was rare; and finally, that in experimental animal infection, as well as in the natural disease of birds, splenic enlargement is characteristic of ornithosis.

The severity of the illness is milder in the young, who appear to be less susceptible, and most serious in the aged. The disease has a greater incidence in women, since they are most often engaged in the care of birds.

Favour[2] classified ornithosis into the following three groups: mild, with influenzal illness and a short course; moderate, with typhoidal state and pneumonia, lasting approximately four weeks; and severe, with marked toxic manifestations, widespread pneumonia, and a course lasting several months, occurring especially in older people with underlying disease.

Mortality has been reduced from 40 to 10 per cent with present-day antibiotics. In 1950, Hurst, of England, working with experimental animals, demonstrated the ornithosis virus to be decreasingly sensitive to Terramycin, Aureomycin, Chloromycetin, and penicillin,[10] with sulfonamides showing little or no effect.[1] More recently, erythromycin has demonstrated activity against the virus.[6]

In the differential diagnosis of ornithosis, one must consider influenza, typhoid, and primary atypical pneumonia. A negative Widal reaction and stool culture will help eliminate typhoid. Absence of cold agglutinins and agglutinins for Streptococcus MG eliminate primary atypical pneumonia. Absolutely to rule out influenza, negative complement-fixation tests and failure to isolate the influenza virus would be necessary.

For positive laboratory confirmation of ornithosis, one can isolate the virus from the blood, throat washings, vomitus, or sputum, and inoculate this material into white mice. After incubation, the Macchiavello bodies may be identified in the spleen and other reticuloendothelial tissues.

Working with the virus directly is dangerous because of the high element of contagiousness. A safer procedure is complement-fixation testing. This may be accomplished with the use of either Squibb's Lygranum as the lymphogranuloma venereum (LGV) antigen or Lederle's psittacosis antigen.

At the end of the first week of the disease, there is a positive complement-fixation in a 1:16 dilution. Specimens taken from the fourth to the eighth week of illness will show a positive reaction with steadily rising dilutions, usually to a 1:64 titer. Several months after convalescence, there is a fall in the complement-fixation level, and unless a carrier state develops or there is constant reexposure, it usually becomes negative by the eighth month.

In carriers, the complement-fixation level may remain stable for years. Persons constantly exposed (for example, aviary owners) show, as a rule, complement-fixation titers of from 1:8 to 1:32, and their immunity decreases unless they experience constant reexposure. Rasmussen and Meyer, reporting on proved second attacks, demonstrated that immunity is not absolute. Members of the family of a patient with ornithosis have been known to develop positive complement-fixation titers without clinical evidence of the disease, secondary to their exposure.

CONTROL MEASURES

Because of the contagiousness of this disease, it is recommended that there be rigorous isolation during the febrile period, and since antibiotics which produce rapid lysis are used, the isolation should be continued for three weeks. Vomitus, sputum, and feces should be disinfected with either phenol or formalin. It is suggested that all cases be reported. There should be investigation of the source, with all suspect birds destroyed and premises disinfected. Inasmuch as Meyer failed to cure experimental parakeet ornithosis carriers with Aureomycin, it should be recognized that imported birds "cured" with antibiotics may possibly cause the spread of the disease.

CASE REPORT

Mr. L. B., a 42 year old male luggage salesman in a large San Antonio variety store, dated the onset of his illness to July 17, 1953. His initial complaints were fever, frontal headaches, photophobia, generalized muscular aching, chills, and insomnia. There was excessive perspiration and dry cough. Physical examination was essentially negative, except for the 102 F. temperature, injected pharynx, and erythematous nasal mucous membranes. A complete blood count and urinalysis were normal. He was treated at home by another physician with 600,000 units of penicillin for two days. Antipyretics and analgesics effected gradual subsidence of symptoms, so that within ten days he was able to return to work. However, he still had a dry cough and an irritated pharynx, and complained of weakness.

On August 3, he went swimming and noticed unusual

fatigue. This was followed in twenty-four hours by a recurrence of his previous symptoms of frontal headaches, photophobia, chilling, fever, and malaise. He was dyspneic and again had a nonproductive cough. He was referred to my office at this time. Physical examination showed a well developed white man, moderately ill, perspiring freely, with a constant hacking cough. All mucous membranes were injected. His temperature was 102.2 F., pulse 100, blood pressure 112 systolic and 72 diastolic. There were a few coarse bronchial rales in the right side of the chest, and some scattered crepitant rales in the region of the lower lobe of the right lung. There was no adenopathy, enlargement of the spleen, or skin rash. The patient denied any contact with rabbits, cattle, birds, polluted water, or insect bites.

The sedimentation rate was 18 mm. in one hour. The white blood cell count was 8,200, with stabs 1 per cent, segmented cells 70 per cent, lymphocytes 28 per cent, and eosinophils 1 per cent. A nasal smear revealed pus cells and was negative for eosinophils. Roentgenograms of the sinuses were negative.

A roentgenogram of the chest showed a normal heart and left lung field, but revealed a definite widespread hazy infiltration of the lower lobe of the right lung, suggesting a pneumonitis. This was considerably more involvement than was anticipated from the sparse physical findings. A diagnosis of primary atypical pneumonia was made, and the patient was started on Terramycin. On August 11, a checkup disclosed residual lung findings both by roentgen ray and physical examination. On August 18, after Terramycin had been discontinued for several days, there was a relapse with a recurrence of the entire syndrome.

The patient was then hospitalized and during the first few days of his course continued to be moderately ill. The fever, frontal headache, and photophobia persisted. There were several episodes of profuse perspiration, and the previous dry cough became productive. Serum was sent to Austin, Texas, for complement-fixation studies for ornithosis. Sputum was studied for bacteria, fungi, and acid fast organisms. Terramycin treatment was again reinstituted on admission of the patient to the hospital and continued for eight days after discharge on August 26. The temperature on admission was 102.2 F. with gradual lysis to normal on the fourth hospital day.

The physical findings in the lung increased, and on the fourth day of hospitalization, the tip of the spleen was palpable but not tender. Because of the persistence of the pulmonary findings in this male patient, and while awaiting the reports of the complement-fixation tests for ornithosis, bronchoscopic examination was performed August 24, with negative findings, including Papanicolaou stains, smear, and culture for the tuberculosis Bacillus and fungus.

The laboratory studies were as follows: August 18, red blood cell count and hemoglobin normal; white blood cells 11,100; stabs 8 per cent; lymphocytes 24 per cent; monocytes 2 per cent; eosinophils 1 per cent. Wassermann negative. Cold agglutinations, August 19 and 24, both negative. Sedimentation rate 85 mm. per one hour (Westergren method—normal 0-18). Agglutinations for typhoid, paratyphoid, Pasteurella tularensis, Brucella, and Proteus 0X19, all negative in twenty-four hours.

Sputum smears for acid fast bacteria and fungi, direct and two month cultures, all were negative. Skin tests for histoplasmin and coccidioidin 1:100 were negative and purified protein derivative (tuberculin) first strength were positive in twenty-four hours.

On August 24, the sedimentation rate was 48 mm. in one hour and the patient was free of fever.

The first serum collected for complement-fixation tests for ornithosis was reported positive with a psittacosis titer of 2 plus at a 1:16 dilution and LGV titer of 2 plus at 1:16. Two weeks later, while the patient was convalescing, a repeat titer of 2 plus was obtained at a 1:32 dilution for psittacosis antigen and 4 plus at 1:32 with LGV. Seven weeks later, approximately fourteen weeks after onset, the titers were 3 plus for psittacosis at 1:32 and 3 plus for LGV at 1:64. The final testing on December 10 (twenty weeks after onset) was 3 plus for psittacosis at 1:64; the LGV reaction was not tested.

The patient had a prolonged convalescence, and it was several months before he was able to perform his work normally. Roentgenograms of the chest showed slow resolution, requiring several months to clear.

After the first positive complement-fixation report was obtained, the patient was questioned again for possible bird contact, but without success. When the second serum showed a rise in titer, and the clinical findings and roentgen-ray changes were even more compatible with ornithosis, I requestioned the patient, this time in the presence of his wife, who distinctly recalled an incident of bird exposure two weeks before the onset of his illness.

A parakeet had escaped from the bird department, three floors below the patient's luggage department, and momentarily alighted upon the luggage display, soiling it with its droppings. The bird was recaptured by the aviary attendant and returned to its cage in the basement. The patient immediately dusted and rearranged his luggage display, thus apparently inhaling the virus in its pulverized form. Follow-up studies disclosed the presence of the virus in the aviary from which this bird escaped.

SUMMARY

Although the virus was not isolated from the patient, the known exposure to a parakeet fourteen days before the onset of the illness, the typical clinical course with characteristic relapses, the pneumonitis, the typical roentgen-ray findings, the enlarged spleen, and the serologic changes with rising titers during convalescence establish the diagnosis of ornithosis in this case.

Whereas it is generally believed that ornithosis need be considered a disease only of birds or of human beings who have prolonged and intimate contact with birds or with infectious patients, more and more cases are appearing in the literature describing patients who have developed the disease as a result of "fleeting" contact with either infected human beings or birds, as in this instance.

I would like to thank J. V. Irons, Sc.D., Director of Laboratories, Texas State Department of Health, Austin, for his interest and help in the serologic studies in this case.

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POTENTIAL HEALTH HAZARDS OF ORGANIC INSECTICIDES

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FEW fields of research have shown advances parallel to those which have occurred in the development of insecticides during the past decade. Although a fairly large number of insecticidal preparations were available prior to World War II, a definite demand for more and better insecticides existed. This demand was given greater impetus with the entry of the United States into the war. As a result of this demand, phenomenal advances have been made in the development of new economic poisons for the control of insects. For example, in California alone, the number of registered pesticides has doubled in the past ten years so that approximately 10,000 products are now registered in that state. More than 800 new pesticide registrations were listed by the Texas Department of Agriculture for the 1951-1952 fiscal year.[17]

By far the greatest strides have been made in the development of synthetic organic compounds which are effective against a variety of household and agricultural pests. Intensive research in this country and abroad has uncovered a series of chlorinated hydrocarbon compounds ushered in by DDT. Not only are these chemical compounds lethal to insects, ticks, and mites but also they possess remarkable residual properties so that a single application of the material to a surface may continue to be insecticidal for weeks and even months. The more commonly used insecticides in this group are DDT, TDE, methoxychlor, chlordane, toxaphene, benzene hexachloride, lindane (the gamma isomer of benzene hexachloride), aldrin, and dieldrin. These compounds are commercially available in the form of dusts, wettable powders, emulsions, solutions, and aerosols under a variety of trade names.[7] Athough some of these insecticides are used rather extensively in agriculture, the vast majority of people come in contact with them through their availability as household insecticides.

The other major group of newer synthetic insecticides is the organic phosphate compounds which were developed in Germany during World War II. These chemicals are among the most toxic materials used for the control of insect pests. They are employed against aphids, mites, and other agricultural pests but are not marketed for use against household insects. Hexaethyl tetraphosphate (HETP), tetraethylpyrophosphate (TEPP), and parathion have been the most commonly used organic phosphate compounds in this country. They are mixed with other materials to make dusts, wettable powders, emulsifiable concentrates, and aerosols. Although these agents are highly toxic to mammals as well as insects, they do not possess the long lasting residual properties characteristic of the chlorinated hydrocarbon insecticides. For this reason they are highly desirable for the control of insects on fruit and vegetable crops since residues which remain on treated plants do not present the danger of food contamination that is inherent in the chlorinated compounds.[20]

It is inevitable that as more powerful insecticides are developed, these chemicals likewise will be more toxic to man. This may present a particular problem in Texas and other southern states where insect control in some areas must be actively engaged in, either agriculturally or domestically, most of the year. Under such conditions, a great deal of insecticide is used and consequently it seems likely that more accidents involving these toxic materials may occur. The history of accidental poisoning with any of the newer economic poisons, however, is usually a history of

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carelessness, where the person concerned has failed to follow either written or verbal instructions as to how he may protect himself from harmful exposure. That insecticides can be handled with comparative safety is borne out by the fact that the processing of highly concentrated materials in industrial plants over a period of years has resulted in a relatively low incidence of insecticide poisoning. In fact, Princi and Spurbeck[21] were unable to find evidence of harmful effects in 34 workers engaged in the manufacture of chlordane, aldrin, and dieldrin. McGee and others[16] reported that there were no cases of toxaphene poisoning during a five year period in a large group of workers involved in the manufacture of toxaphene. Furthermore, certain of these toxic compounds have undergone wide scale use with apparent safety. Aldrin, for example, was used extensively in the form of an oil solution to control locusts in Persia with no reports of casualties.[3] These findings, however, emphasize the fact that persons engaged in the manufacture or other professional aspects of insecticides are taught how to obtain maximum personal protection against their potentially toxic effects, whereas people in general are largely unaware of the nature of the materials used in their homes.

To protect the public in the use of economic poisons, the Federal Insecticide, Fungicide, and Rodenticide Act was enacted in 1947. This law regulates the marketing of insecticides, fungicides, rodenticides, and herbicides in interstate commerce. Products subject to the act must be registered with the United States Department of Agriculture prior to introduction into interstate commerce. In order that the users of insecticides and other economic poisons may employ them safely and effectively, the label on each product must contain certain essential information. Among other things, the name and percentage of each active ingredient must be given as well as directions for use. A warning or caution statement must be included, when necessary, to prevent injury to man, animals, vegetation, and useful invertebrate animals. If the product is highly toxic, it must contain the word poison in red, the skull and crossbones, and a statement of an antidote. Still further protection is afforded the public by state laws which require registration of pesticides before they are offered for sale in that state.[10]

Despite these important safeguards, some persons are careless in the handling of insecticidal preparations and never bother to read the directions on the label. Others may discontinue observing the suggested precautionary procedures because they become convinced that the insecticide is safe. Since these persons may become patients, it is important for physicians to be able to recognize symptoms of both acute and chronic poisoning by the newer synthetic organic insecticides and to know how to treat such cases. It is with this idea in mind that the following material is presented.

CASE REPORTS

The following reports represent 2 instances of illness which probably were due to accidental poisoning by chlordane solution:

CASE 1.—A 3 year old Negro girl swallowed an undetermined amount, probably about 15 to 20 milliliters, of a commercial insecticide containing 2 per cent chlordane. This solution had been left in a drinking glass on the kitchen table. According to the mother, the child became nauseated and vomited shortly after swallowing the material. The patient was taken to the hospital emergency room about an hour later and upon arrival was noted to have a generalized convulsive seizure. Gastric lavage was begun immediately and was continued until the washings were clear and free of insecticide odor. The convulsions were controlled successfully with phenobarbital. After a period of further observation the patient was allowed to return home. Although she was reported to have spent an extremely restless night, recovery appeared to be complete the following morning.

The past history revealed that the child previously had been in good health and never had exhibited any neurologic symptoms.

CASE 2.—A white boy, aged 10 months, was sprayed with an insecticide solution on the head, face, neck, and trunk by his 3 year old brother. The commercial preparation involved contained 2 per cent chlordane and was sprayed on the child with an ordinary insect spray gun. When the child's mother became aware of the incident a few minutes later, she examined the child and found that his hair and skin in the above mentioned area were wet with the material. The child was wearing only a diaper at the time the spraying occurred. The mother immediately washed his hair and face as well as the other contaminated areas with soap and water. Within an hour after this episode occurred, the child became hyperirritable and cried hysterically for at least thirty minutes. At this time it was noted that his eyes were extremely inflamed and swollen. A physician was called and the mother was advised to wash the child's eyes with a cool boric acid solution. The following day conjunctivitis was the only remaining symptom although the skin still smelled of insecticide. The odor remained in the hair for three days.

The past history revealed that the child had developed normally and was in good health.

Few cases of insecticide poisoning from formulations of chlordane have been reported. Recently, Lemmon[14] reported a case of chlordane intoxication in a woman which he attributed to inhalation of fumes from a 1 or 2 per cent chlordane solution. About the same time Lensky and Evans[15] reported a case of chlordane poisoning in a young girl who accidentally swallowed a small quantity of a suspension of the material. Their findings add important information to existing knowledge of symptomatology of insecticide poisoning in man inasmuch as

their case was one of insecticide poisoning per se without an accompanying solvent to confuse the issue. Although a 2 per cent chlordane solution was involved in both cases presented in the present report, the material was accidentally swallowed by the patient in the first instance whereas absorption through the skin apparently occurred in the other patient. The possible effects of the solvent cannot be excluded: however, the symptoms presented were those which one would expect to see in persons poisoned with a chlorinated hydrocarbon. The comparatively mild reaction exhibited by the patient in the second case when exposed to a solution of chlordane most likely can be attributed to the promptness with which the material was washed off the skin.

SYMPTOMATOLOGY

Although a considerable amount of valuable information has been obtained from human cases of insecticide poisoning, accidental and otherwise, the bulk of our knowledge of the comparative pharmacology, toxicology, and symptomatology of the synthetic organic insecticides necessarily has been derived from animal investigation. The data obtained from these studies cannot be transposed always to fit man, and yet it is the most reliable and practical method available for estimating the relative toxicities of these insecticides for man. Table 1 presents Lehman's[11] interpretation of the predominant symptoms which may be produced in man by some of the more common chlorinated hydrocarbon insecticides. In general, it can be seen that this group of compounds primarily affects the central nervous system. The estimated fatal dose varies from as little as 7 Gm. for toxaphene to 450 Gm. for methoxychlor. The degree of toxicity of an insecticide, however, depends in a large measure upon the concentration, the formulation or type of material with which it is mixed, and the route of exposure. Absorption occurs from the alimentary tract, respiratory tract, and skin. The fact that these compounds are insoluble in water makes it necessary to use a petroleum solvent. Although wettable powders and dusts are poorly absorbed through the skin, Lehman[12] has found that multiple exposure of the skin to insecticides in solution constitutes a real hazard. His data, which are given in table 2, clearly indicate that whereas a single massive dermal exposure to an insecticide may not cause serious consequences, repeated exposure to small quantities of the material may cause marked intoxication. For example, more than 1,880 mg. of benzene hexachloride per kilogram of body weight are required to produce a medial lethal dose in rabbits with a single acute exposure, whereas less than 200 mg. per kilogram of body weight in repeated daily doses are sufficient for a medial lethal dose. In this connection, it is important to note that the solvent may contribute largely to the over-all toxicity of an insecticide, and even the solvent alone may produce in man intoxication, the symptoms of which closely simulate those due to a chlorinated hydrocarbon insecticide.[18] Differential diagnosis lies in the fact that symptoms of solvent poisoning occur promptly, whereas there generally seems to be a delay of an hour or more following exposure to an insecticide.

The symptoms of insecticide poisoning may be divided into two categories, acute and chronic. The acutely ill patient is easy enough to recognize since he usually presents such symptoms as nausea, vomiting, hyperirritability, and lack of muscular coordina-

TABLE 1.—*Summary of Major Toxic Actions of Insecticides Interpreted in Terms of Human Toxicology.*

Compound	Local Effect	Predominant Symptoms	Estimated Fatal Dose (Gm.)	Period
DDT	None	Giddiness, nervous tension, involuntary muscular tremors, convulsions, depression, respiratory failure, death	30	2-24 hr.
Methoxychlor	Slight irritation	Questionable tremors, depression	450	2-4 days
TDE	Slight irritation	Lethargy	300	1-4 days
Chlordane	Irritation	Convulsions, depression repeated several times, deep depression, death	5-60	1-4 days
Toxaphene		Epileptiform convulsions and death	7	4-24 hr.
Benzene hexachloride	Irritation	Hyperirritability to outside stimulus, occasionally convulsions, depression, death	30	1-5 days

Adapted from Lehman, A. J.: Pharmacological Considerations of Insecticides, Assoc. Food and Drug Officials U. S. Quart. Bull. *13*:65-70, 1949.

TABLE 2.—*Dermal Toxicity of Chlorinated Insecticides to Rabbits.*

Insecticide	Skin Irritation	Approximate LD_{50} (mg./kg.) Single Exposure*	Multiple Exposure†
DDT	None	> 2,820	150
TDE	Moderate	1,200	200-400
Methoxychlor	Slight	> 2,820	600
Benzene hexachloride	Moderate	> 1,880	< 200
Lindane	None	> 188	20-50
Toxaphene	Moderate	< 780	40
Chlordane	Severe	< 780	20-40
Aldrin	None	< 150	< 5
Dieldrin	None	< 150	< 5

Adapted from Lehman, A. J.: Chemicals in Foods: Report to Association of Food and Drug Officials on Current Developments; Part 2, Pesticides; Section 2, Dermal Toxicity, Assoc. Food and Drug Officials Quart. Bull. *16*:3-9 (Jan.) 1952.

*These animals received a single acute (24 hour) exposure to a solution of the insecticide in dimethylphthalate, an innocuous solvent.

†The results are based on 90 day exposure periods, except for a 21 day exposure period for lindane and 4 to 14 doses of benzene hexachloride, aldrin, and dieldrin.

tion, all of which may or may not precede convulsions and death. The detection of chronic poisoning, however, may be somewhat more difficult unless a careful history is taken. The history of such patient should reveal frequent multiple exposures which may or may not be of fairly long standing. This patient may complain of a headache, general malaise, loss of appetite, and loss of weight. The severity and type of symptoms depend to some degree upon the extent to which a given insecticide is stored in the body, specifically in the adipose tissue.[9] Chlordane, aldrin, and dieldrin, for example, are stored in fatty tissue and likewise are known to have a high order of chronic toxicity.[1, 9] On the other hand, toxaphene and methoxychlor evidently are not stored in the fat in significant amounts apparently because they are metabolized.[13] The diagnosis should be based on a record of exposure along with the characteristic neurologic manifestations.

Toxicologically, the organic phosphate insecticides differ markedly from the chlorinated compounds and therefore must be considered separately from the standpoint of symptomatology.[6, 20] HETP, TEPP, parathion, and other members of the organic phosphate group are specific enzyme inhibitors which exert their toxic effects by inactivating the plasma and red blood cell enzyme, cholinesterase. This action leads to an accumulation of acetylcholine in the tissues. The resulting symptoms therefore resemble those produced by excessive stimulation of the parasympathetic nervous system. Depending upon the extent of exposure to any one of these insecticides, anorexia, nausea, vomiting, abdominal cramps, sweating, salivation, restlessness, and anxiety may be the prominent symptoms. More extensive exposure may produce diarrhea, pinpoint nonreactive pupils, blurred vision, respiratory embarrassment, and death. Grob[20] has pointed out the important fact that when symptoms begin there actually may be little warning as to the seriousness of the toxic effects, since the margin between the pharmacologic effect and doses that are lethal seems small. The reduction in blood cholinesterase and accumulation of acetylcholine may be a reversible process up to a point beyond which death inevitably occurs. The average time interval between the onset of symptoms and death has been given as nine hours.[20]

Tissue storage of HETP and TEPP apparently does not occur as with certain chlorinated insecticides because these materials are detoxified rapidly by hydrolysis in the body. Parathion, however, is detoxified at a slower rate and it has been shown by animal experimentation that repeated exposure to this material may result in subacute intoxication. Since inflammatory changes in the skin are not produced by the organic phosphates, it is possible that absorption by this particular route may go unnoticed completely until recognizable symptoms appear.

TREATMENT AND PREVENTION

There is no specific antidote for poisoning from any of the chlorinated hydrocarbon insecticides and treatment, therefore, is symptomatic.[18, 19, 23] If the material has been ingested, treatment should be directed toward removing it from the stomach and intestinal tract by gastric lavage followed by a saline cathartic. It is particularly important to determine, if possible, the constituents of the material swallowed, since such information serves as a guide for more specific treatment. It should be noted that oil cathartics are definitely contraindicated since absorption of the insecticide is enhanced thereby. Central nervous system manifestations such as tremors and convulsive seizures can be controlled by barbiturates, phenobarbital being the drug of choice. Pentobarbital sodium is indicated to control violent convulsions. Epinephrine should be avoided since it may produce fatal ventricular fibrillation. Once the patient has recovered from the acute stages of poisoning, it is advisable to keep him on a fat free or at least a low fat diet, and he should be treated for liver damage if indicated. The same symptomatic treatment is recommended for persons poisoned by absorption of insecticide solutions or emulsions through the skin.

Symptoms of poisoning from any organic phosphate insecticide are treated with atropine.[20] This procedure should be supplemented with gastric lavage or, if the material gets into the eyes, ocular irrigation. The recommended dose of atropine is 2 mg. intramuscularly at hourly intervals or more frequently if necessary until the patient has become atropinized. Morphine is contraindicated inasmuch as it depresses respiration. The administration of oxygen and artificial respiration also may be necessary auxiliary measures.

If insecticides are to be used safely, there are certain precautionary measures which must be adhered to strictly. Persons employing insecticides in the form of dusts, sprays, mists, and aerosols must avoid excessive inhalation of the material. Operators engaged in the large scale application of any of these formulations should wear respirators and other protective devices. Measures should be taken to keep the materials out of the eyes and mouth. When solutions or emulsions are used, particularly concentrates, every effort should be made to prevent them from contacting the skin. Material which is spilled on the skin should be washed off immediately with soap and water. When solutions or emulsions are spilled on the clothing, the garments should be changed.

Workers involved in the mixing of these materials, particularly concentrates, should wear respirators, goggles, and solvent resistant gloves, aprons, and boots. This work should be done in a well ventilated room, and fire precautions should be taken with inflammable solvents. Personnel such as pilots who are working with or engaged in the routine application of organic phosphate compounds should wear full face masks as well as respirators. Furthermore, they should undergo periodic tests to determine cholinesterase levels. If cholinesterase activity is reduced significantly, these persons should be removed from further exposure until such time as this enzyme resumes a normal level.

Insecticides employed against household pests should be used according to the directions given on the label. Exposed food and cooking and eating utensils should be covered when the kitchen or dining room is being sprayed. Care should be taken to avoid contact of insecticide with children's toys, cribs, and play pens. It is advisable to apply solutions with a paint brush where possible since inhalation of the spray or mist thereby is avoided. When aerosol bombs are used in a closed space, the area should be well ventilated before occupancy.

In July, 1949, the United States Public Health Service initiated a program wherein economic poisons are investigated from the standpoint of relative toxicities, mode of action, and applicable antidotes.[22] This work is conducted in the toxicology laboratory of the Technical Development Branch of the Communicable Disease Center in Savannah, Ga. This agency likewise prepares clinical memorandums[4] on each of the more important economic poisons to guide the physician in the diagnosis and treatment of persons who have been exposed to toxic amounts of the material.

About this same time, the Council on Pharmacy and Chemistry of the American Medical Association was becoming more aware of the need for integration of the existing information on pesticides so that it might be readily available to physicians. Consequently, in 1950, the council authorized the formation of a Committee on Pesticides,[5] the purpose of which is to promote better coordination of effort between medical and other activities concerned with pesticides as well as to assist the physician when confronted with the medical aspects of the problem. Accordingly, this committee has published a series of carefully prepared reports[8, 18, 19, 20, 23] which integrate and interpret the available data on various insecticides as to their pharmacology, toxicology, and symptomatology as well as the treatment of human cases of insecticide poisoning. These reports will be supplemented with information on additional insecticides as they are developed. In this connection, physicians are in a position to offer helpful assistance not only in the prompt recognition and treatment of patients with insecticide intoxication but also in reporting such cases. For the past several years the Laboratory of Medical Entomology of the University of Texas Medical Branch, Galveston, has been assisting physicians of the state in the evaluation of suspected cases of poisoning from insecticides, and the staff welcomes the opportunity to cooperate in such cases.

Unquestionably, there is a definite need for potent insecticides with which to combat the more than 85,000 kinds of insects, ticks, and mites which are known to cause extensive injury to plants, animals, and man in this country.[10] This is emphasized by the staggering losses as a result of insects which in the United States average about $4,000,000,000 per year. It also is clear that untold numbers of people, including members of our armed forces overseas, have been protected by insecticides from disabling and sometimes fatal insect-borne diseases such as malaria, filariasis, and typhus. The benefits derived from the use of the newer economic poisons far outweigh the dangers, which in the final analysis are largely inherent in the improper handling of insecticidal materials. The problem which confronts public health workers, therefore, is not whether the use of the newer synthetic organic insecticides should be discontinued because of their potentially hazardous nature; rather, it is a matter of educating the public so that it is aware of the toxic nature of the materials so commonly employed in the constant battle against insects. As stated by Justus C. Ward,[24] chief of the Pharmacological and Rodenticide Section, Insecticide Division, United States Department of Agriculture, "Much has yet to be learned about the actual danger from pesticides to the person who uses them only occasionally and in acceptable dilutions. This is particularly true in the household-spray field. It is here where the least experienced individual handles and stores poisons. It is important that the householder be taught that such products must be handled in accordance with directions to be safe."

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ABSTRACT OF DISCUSSION

DR. PAUL LENSKY, Houston: Dr. Micks has emphasized the large number of newly discovered insecticides and the resulting number of commercially available pesticides. Each pesticide is formulated somewhat differently by the many distributors, and consequently there are thousands of varying formulas on the market in many forms.

More recently most of these products have been labeled by law as poisonous, and instructions for their use are on the labels. This is true of all preparations sold through interstate commerce but not necessarily of locally packaged pesticides. Therefore, most cases of poisoning will result from carelessness, as Dr. Micks pointed out, or through ignorance. Even professionals are still guilty of mishandling these toxic substances.

Only a few weeks ago our office laboratory technician had her apartment sprayed with 10 per cent chlordane. The company handling this procedure is a large concern, yet the exterminator used no self-protective equipment in spraying this closed dwelling. As our technician is aware of the potential dangers of chlordane, she questioned the man about any precautions and found that he had no realization of the danger; he had been told nothing by his employers. I am certain that he performs similar sprayings many times a day and many days a week, thus inhaling chlordane and other insecticides over a long period. These multiple skin exposures are a hazard even if the doses ate small each time.

As was pointed out, acute poisoning is easy to recognize, but chronic poisoning is often difficult to diagnose. A careful history must be taken, especially including the occupation and avocations of the patient. Symptoms may be only malaise, loss of weight, headache, and others of a nonspecific nature. It is difficult to prove these cases, except to see improvement after withdrawal of the insecticide, as no tests can be done except in the case of the organic phosphates in which the cholinesterase level may be determined.

It should be emphasized that patients with acute organic phosphate poisoning must be recognized and treated early as death occurs in a matter of hours. The chlorinated hydrocarbons usually do not prove fatal for several days. Fortunately, there is a specific antidote for the organic phosphates—atropine. There is no antidote for the chlorinated compounds.

Compared on a body weight basis, fatal doses of insecticides are almost the same in insects as in warm blooded animals. The least toxic of insecticides actually may not be the safest since larger quantities of the poison must be used to insure effective insect control.

Dr. Micks' first case is almost a duplicate of a case reported by Dr. Evans and me. Our experience pointed out the lack of information which was available as the 50 per cent chlordane powder came in a single cardboard ice cream box labelled "50% Chlordane" with instructions to use one tablespoonful to a quart of water in mixing. There was no indication that the chlordane was a poison. Luckily, we used magnesium sulfate as a lavage material rather than any other substance which might have enhanced the chlordane's absorption. Our patient was probably sicker because of the longer time before lavage was performed.

Since most insecticides will be handled by inexperienced persons and householders, it is important that emphasis be placed on the potential dangers involved in the use of these new agents. Education for safe handling should be universal.

Schering Award Subjects Announced

Medical students are invited by the Schering Corporation, 2 Broad Street, Bloomfield, N. J., to submit manuscripts on "The Use of Androgen Therapy in the Female," "The Prophylactic and Therapeutic Uses of Parenteral Antihistamines," or "Modern Treatment of Infections and Allergic Disorders of the Eye" in a contest to win $500 first prize and $250 second prize for the best papers on each subject. Manuscripts, which may be by individuals or teams, must be submitted by October 1, but entry forms specifying the chosen title must be in by July 1.

"Unless our national civil defense program receives our immediate attention, we are going to have a defense system which is entirely out of balance.... The finest military forces in the world could not operate long if the enemy smashes its home base behind it. It is the people and production of this country that make our most feared weapons. But it will be the people and production that are wide open to death and disaster on a staggering scale—if we do not have a civil defense program ready when attack comes."—U. S. Congressman Gordon Canfield.

Surgically Significant Anomalies of Biliary Passages

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"TO DO good many times is not enough; evil once is too much," might well apply to the surgeon's dilemma following an operative complication resulting from a moment of carelessness or neglect. Too often the region of the gallbladder is dissected casually without adequate concern for the anatomic variations possible. *Perhaps even more than one of ten operations on the gallbladder will reveal one or more anomalies.* These distortions of "textbook normals" are important causes for tragic complications which carry a high morbidity and mortality. Hence the following outline and series of drawings.

I. Purpose.

A. To recount

1. That operations upon the gallbladder and its ducts are increasingly frequent among elective and emergency procedures, because of patient education, efficient diagnostic procedures, expanded indications, and the often pseudosecurity of advanced drug therapy.
2. That complications related to gallbladder surgery are found in increasing numbers and present some of the most formidable problems to be faced in surgery.
3. That many operators are unaware of the potential pitfalls in anatomic variants found in from 10 to 20 per cent of gallbladder operations.

B. To present the collected anomalies from the literature as well as the theoretical anomalies which may occur and dramatically affect surgical morbidity and mortality.

C. To outline the specific complications related to careless gallbladder surgery, showing by composite diagrams how these may occur all too easily, and to indicate accepted technical essentials in prevention of these disasters.

II. Complications related to gallbladder surgery.

A. Hemorrhage.

B. Peritonitis.

1. Bile.
2. Bacterial.

C. Hepatic insufficiency.

D. Duct fistulas.

E. Obstructive jaundice—stones.

F. Duct and vascular stricture.

III. Technical essentials in preventing complications.

A. *Knowledge of normal and anomalous anatomy.*

B. Adequate exposure.

C. Good lighting.

D. Careful dissection of ducts and vessels.

E. Identification of structures with careful clamping and separate ligation, without common duct damage.

F. Doubtful dissections begun at the fundus downward.

G. Careful control of hemorrhage by compression and ligation.

H. Ligation of severed accessory bile ducts to avoid bile abscesses.

IV. Comment.

A. It is realized that pediatric surgery of the gall ducts will reveal agenesis and numerous other anomalies, upon which only 25 per cent will permit a definite surgical procedure. These cases in newborn infants have been largely excluded from this presentation and space given instead to adult findings.

B. One has only to examine the anatomy of the area around the junction of the cystic and common ducts to see how easily a forceps may be misapplied and how segments of ducts or vessels may be destroyed, mistakenly ligated, or otherwise injured.

V. Conclusion.

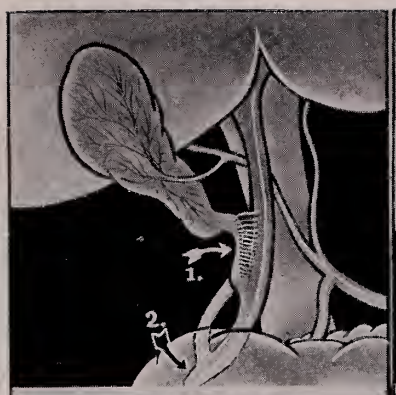
A. The surgeon's possible lack of information regarding anomalies and variations in normal anatomy of the biliary passages (10 to 20 per cent of cases) coupled with careless technique, is a definite problem in surgery.

B. Composite diagrams to reveal all of the reported anomalies are presented on successive pages, and listed are technical guides designed to prevent surgical disaster.

C. The major factor involved is an adequate knowledge of the variety of anatomic arrangements; then only is intelligent action possible.

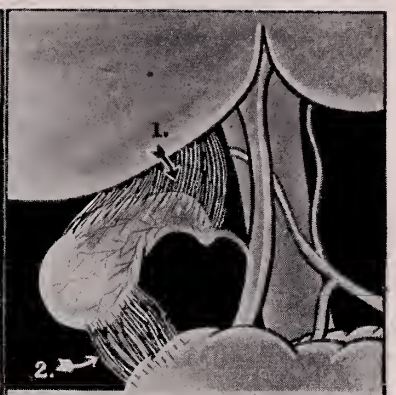
Presented as a scientific exhibit, Texas Medical Association, Annual Session, Houston, April 27-29, 1953. Winner of honorable mention.

Kimbro Clinic.



1. ENSHEATHED OR FUSED PARALLEL JUNCTION OF CYSTIC AND COMMON DUCTS (14-27%).
2. SHORT COMMON DUCT (VARIABLE LENGTH 2-12 CM.) WITH RETRODUODENAL JUNCTION OF CYSTIC AND COMMON DUCTS

PENDULOUS HARTMAN'S POUCH CONGENITALLY ADHERED TO DUODENUM, PERHAPS ADHERED TO THE COLON, STOMACH OR MESENTERY.



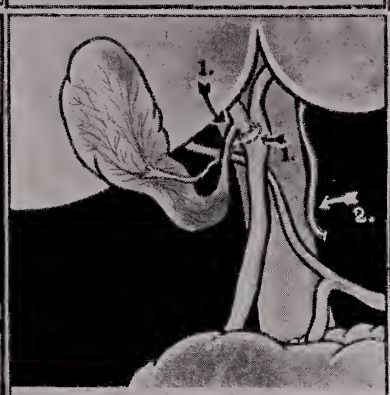
1. GALL BLADDER AND/OR CYSTIC DUCT SUSPENDED BY MESENTERY (TORSION MAY OCCUR)
2. BANDS TO DUODENUM AND/OR STOMACH, COLON, OMENTUM.

1. GALL BLADDER LOCATED RETRO-DUODENAL AND RETRO-PERITONEAL[1a]
2. ANTERIOR POSITION OF THE GASTRO-DUODENAL ARTERY ON THE COMMON DUCT (10%)

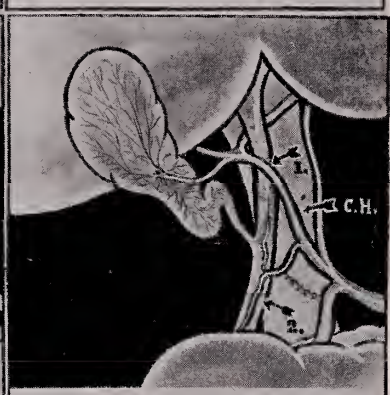
1. CYSTIC DUCT PARTLY ENSHEATHED WITH THE RIGHT HEPATIC DUCT (17%)
2. CONGENITAL STENOSIS OF SPHINCTOR ODDI OR OF THE PANCREATIC AND COMMON DUCT JUNCTION.

ANTERIOR SPIRAL JUNCTION OF CYSTIC AND HEPATIC DUCTS (10%) (JUNCTION MAY BE POSTERIOR, OR RIGHT OR LEFT LATERAL)

1. CYSTIC DUCT TERMINATING IN THE STOMACH
2. ANTERIOR OR POSTERIOR DUODENAL INSERTION OF THE CYSTIC DUCT



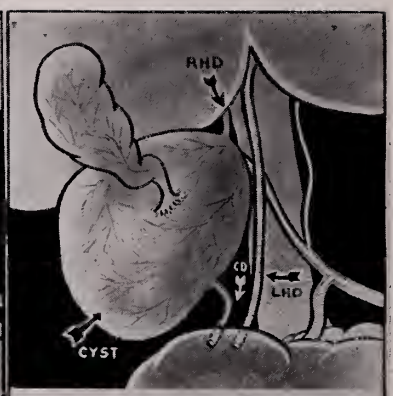
1. CYSTIC DUCT ENTERING RIGHT HEPATIC DUCT ANTERIORLY OR AT AN AMPULARY ENLARGEMENT OF THE HEPATIC DUCT JUNCTION. (EXTRA-HEPATIC JUNCTION OF THE RIGHT AND LEFT HEPATIC DUCTS)
2. ANOMALOUS OR ABERRANT (REPLACING) LEFT HEPATIC ARTERY FROM THE LEFT GASTRIC ARTERY



1. ANTERIOR CROSSING OF THE COMMON HEPATIC DUCT BY THE COMMON HEPATIC ARTERY (15%) (RIGHT HEPATIC ARTERY 3%)
2. THE SUPRA-DUODENAL ARTERY, A BRANCH OF HEPATIC OR GASTRODUODENAL ARTERY LOCATED IN THE ANTERIOR WALL OF THE COMMON DUCT. (30-50%)

1. DOUBLE CYSTIC ARTERIES (15%) AND (NOTE ONE ANTERIOR TO THE COMMON HEPATIC DUCT) CYSTIC AND ACCESSORY CYSTIC ARTERIES MAY ARISE FROM THE RIGHT, LEFT, OR COMMON HEPATIC ARTERIES OR GASTRODUODENAL ARTERY
2. BRANCH OF THE COMMON HEPATIC ARTERY OR GASTRODUODENAL ARTERY IN THE ANTERIOR WALL OF THE COMMON DUCT (30-50%)

1. RIGHT HEPATIC DUCT TERMINATING IN THE CYSTIC DUCT
2. HEPATIC ARTERY PASSING ANTERIOR TO THE COMMON DUCT (12%)
3. SUPERIOR PANCREATICO-DUODENAL ARTERY, A BRANCH OF THE HEPATIC ARTERY.



CONGENITAL CYST OF THE COMMON DUCT
ABSENCE OF THE COMMON HEPATIC DUCT

CYST OF THE COMMON DUCT LOCATED WITHIN THE GASTRO HEPATIC LIGAMENT.

1. DIVERTICULUM OF THE GALL BLADDER — (SIZE AND LOCATION VARIABLE)
2. REDUPLICATION OF THE CYSTIC DUCT

1. PHRYGIAN CAP (FOLDED FUNDUS)
2. MOBILE COMMON DUCT WITH POORLY DEFINED CYSTIC DUCT JUNCTION

1. CYST OF THE COMMON HEPATIC DUCT PARTIALLY EMBEDDED IN LIVER
2. CYSTIC ARTERY ARISING FROM THE COMMON HEPATIC ARTERY.

DOUBLE GALL BLADDER WITH CYSTIC DUCTS CROSSED (GALL BLADDERS AND DUCTS MAY BE FUSED)

1. GALL BLADDER LOCATED WITHIN THE LIVER SUBSTANCE
2. GALL BLADDER SITUATED ON THE LEFT SIDE OR UNDER THE LEFT LOBE OF THE LIVER (MAY BE IN THE VERTICAL POSITION OR LOCATED HORIZONTALLY IN THE TRANSVERSE FISSURE)

1. THE REPLACING RIGHT HEPATIC ARTERY ARISING FROM INFERIOR OR SUPERIOR MESENTERIC, GASTRIC, RENAL OR AORTIC ARTERIES. TWO HEPATIC ARTERIES MAY OCCUR ANTERIOR OR POSTERIOR TO THE COMMON HEPATIC DUCT. (ACCESSORY HEPATIC ARTERIAL BRANCHES MAY BE FROM THE RIGHT GASTRIC, SUPERIOR MESENTERIC OR AORTIC ARTERIES.)
2. DOUBLE GALL BLADDER WITH SINGLE CYSTIC DUCT

1. DOUBLE GALL BLADDER, ONE TERMINATING IN THE HEPATIC SUBSTANCE
2. ANOMALOUS HEPATIC BRANCH OF THE CYSTIC ARTERY (ABNORMAL ORIGIN FROM THE HEPATIC ARTERY.)

1. ACCESSORY GALL BLADDER IN THE GASTRO HEPATIC LIGAMENT COMMUNICATING WITH THE LEFT HEPATIC DUCT.
2. SMALL RUDIMENTARY GALL BLADDER (MAY BE ENTIRELY ABSENT)

1. PARTITIONED GALL BLADDER AND A DECEPTIVELY SHORT BUT LARGE CYSTIC DUCT
2. CYSTIC ARTERY ARISES FROM THE MIDDLE HEPATIC ARTERY AND CROSSES ANTERIOR TO HEPATIC DUCT

1. ABERRANTLY PLACED RIGHT HEPATIC ARTERY PARALLEL AND NEAR THE CYSTIC DUCT (20%)
2. SHORT CYSTIC ARTERY WITH ANTERIOR AND POSTERIOR BRANCHES, FROM THE RIGHT HEPATIC ARTERY.

1. MULTIPLE HEPATIC DUCTS (4 TO 30%), ONE CURVING POSTERIOR TO THE CYSTIC ARTERY.
2. TORTUOUS COMMON HEPATIC DUCT IN CLOSE RELATION TO THE CYSTIC DUCT.

1. PERSISTENT HEPATO-CYSTIC DUCTS (16%), (HEPATO-HEPATIC DUCT AND HEPATO-COMMON HEPATIC DUCT)
2. STRICTURE OF THE CYSTIC DUCT
3. GASTRIC TERMINATION OF THE COMMON DUCT

ABSENT OR SHORT CYSTIC DUCT OR STRICTURE OF THE HEPATIC DUCT OR STRICTURE OF THE COMMON DUCT (REDUPLICATION OF HEPATIC AND COMMON DUCTS MAY APPEAR)

1. VARICOSE VEINS OF THE GALL BLADDER
2. RIGHT HEPATIC DUCT TERMINATING IN THE COMMON DUCT OR GALL BLADDER

CASE REPORTS

DELAYED DEATH FOLLOWING DISK SURGERY

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THE syndrome of the low lumbar herniated nucleus pulposus is widely recognized and well understood.

A case in which death occurred two years after surgery for herniated disk, and apparently as a result of that surgery, is sufficiently unusual and the diagnosis could so easily be missed, that in my opinion such a case must be reported. A search of the literature failed to reveal a reference to this type of case.

The results to be expected when disk surgery is done by competent surgeons are widely recorded. Good results as reported in the literature occur in from 60 to 85 per cent of all patients operated upon. It is also noted that about 5 to 7 per cent will have recurrence of the disk herniation.

The fact that death will occasionally result from even the most minor of surgical procedures is a disconcerting but well known fact. Death resulting from surgery for herniated nucleus pulposus is extremely rare, well below .5 per cent of all cases in which operation is performed. The cause of such death, if the death is a direct result of the surgery, is usually a wound infection with resulting immediate meningitis. Another fatal complication is rupture of the aorta or inferior vena cava. This latter occurs as a surgical accident when a surgeon is so unfortunate as to insert the punch used in removing disks anteriorly into the retroperitoneal space and traumatize one of these large vessels.

CASE REPORT

M. F. L. was first admitted to the Veterans Administration Hospital, McKinney, Texas, in March, 1949. He was an extremely well developed man of 41 years. He gave a history of intermittent low back and left sciatic pain of five years' duration. The patient presented himself for definitive treatment because the syndrome had become completely disabling during the preceding two months. The physical examination and history were typical of herniated nucleus pulposus at the fourth lumbar interspace. A myelogram was interpreted as showing a herniated disk on the left side at the fourth lumbar interspace. Inasmuch as the man was completely incapacitated with pain and had suffered numerous attacks, it was decided to explore this disk. At operation a classic herniated nucleus pulposus was found and handled in the usual manner without difficulty. The pain was relieved, and the patient was discharged on April 6, 1949.

The second admission to the hospital occurred one year later on April 14, 1950. The man had experienced complete pain relief until a few weeks prior to admission, when he had slipped on the ice and had a sudden recurrence of the low back and left sciatic pain. This pain was exactly similar in all respects to that of which he had complained before the first operation. There was absolutely no relief on prolonged bed rest. The physical examination was practically identical with that observed on the first admission. Again a myelogram indicated the presence of a herniated disk at the fourth lumbar interspace on the left.

The neurosurgeon decided that this interspace should again be explored. The orthopedic department thought that in view of the recurrence of this herniated disk a fusion should be done from the fourth lumbar vertebra to the sacrum. This surgery was performed May 5, 1950. A few small fragments of cartilage were found jammed beneath the fifth lumbar nerve root at the fourth lumbar interspace on the left side and were removed with no difficulty. The orthopedists then performed a type of fusion routine in this institution. Screws were placed bilaterally through the facettes joining the fifth lumbar vertebra and the sacrum and through those joining the fourth and fifth lumbar vertebrae. Bone was taken from the iliac crest and a fusion accomplished without unusual difficulty and in a completely routine manner. Eleven days later an elevation of the patient's temperature to 101 F. occurred, and it was noted that the upper end of the wound was fluctuant. This area was aspirated, serosanguinous fluid obtained, and Staphylococcus aureus was cultured. Open drainage and antibiotic therapy were instituted and the wound promptly healed. The man was ambulatory by the first of June. Roentgenograms on June 16 showed a slight area of destruction around the upper of the two screws on the right side. (It is to be remembered the disk had been removed on the left.) Removal of this screw was considered, but in view of the fact that the patient was completely asymptomatic it was decided not to do so.

The patient was reexamined on February 15, 1951. He had had occasional mild and fleeting attacks of back pain, but on the whole he considered his surgery to be highly successful. Complete roentgen-ray studies on this occasion were interpreted as indicating that a solid fusion existed, and no signs of osteomyelitis were recognized.

The final admission of the patient was to the orthopedic service on November 8, 1952, or approximately thirty months after the final surgery in 1950. The history at this time indicated that one week prior to admission this patient began to have some mild low back pain and within a day or so observed a sensation of numbness in his right thigh. He also mentioned that the entire right side of his body felt slightly numb. On the evening prior to admission the patient had experienced a mild chilly sensation, was thought to have had a mild fever, and complained of increased back pain. His physician gave Demerol for the pain and advised readmission to the Veterans Administration Hospital. The man had a comfortable night and came to the hospital the next morning.

Examination on admission revealed nothing particularly unusual. There was slight tenderness over the operative site, the pulse was 80, the temperature 97 F., and the patient was not considered to be seriously ill. Thirty hours after admission he complained of abdominal distension and was given an enema. Three hours later he became disoriented and his

temperature was found to be 102 F. He had an extremely stiff neck plus the other clinical signs of meningitis. A spinal tap at the second lumbar interspace yielded spinal fluid with the consistency and color of milk. This fluid contained 173,000 white blood cells with 95 per cent polymorphonuclears, and the smear contained many bacteria which were thought at the time to be pneumococci.

Immediate medical consultation was obtained. Because of the type of organisms seen in the spinal fluid and the fact that the internist suspected early pneumonia, a tentative diagnosis of pneumococcic meningitis was made. The patient was transferred to the medical service. During the night he became much worse. The temperature rose to 105 F. and the pulse to 160, and the man became extremely maniacal. The following morning a medical consultant described early choking of the optic disks, and asked the neurosurgeon to see the patient. The neurosurgeon requested and obtained roentgenograms of the low lumbar spine, even though the examination had to be done under light Pentothal anesthesia. These roentgenograms demonstrated osteomyelitis, particularly on the right side around the area of the fourth and fifth lumbar vertebrae. This infection involved the fusion mass. The upper of the two screws on the right side had migrated backward and was within 15 mm. of the skin surface. By this time the patient was deeply comatose, the pulse was still 160, and his temperature was 104.8 F. Cultures of the spinal fluid had proved that the meningitis was due to staphylococcus, and the blood culture indicated a Staphylococcus aureus septicemia. Sensitivity tests showed that the organism was sensitive to Aureomycin and penicillin, with only the slightest sensitivity to sulfadiazine. Since being transferred to the medical service, the patient had received 8,000,000 units of penicillin and 2 Gm. of Aureomycin.

It was decided to operate immediately on the presumptive diagnosis of osteomyelitis, epidural abscess, and secondary meningitis, for the purpose of draining the epidural area.

This surgery was performed twenty hours after the first meningeal signs were noted. It was found that the upper of the two screws on the right, that between the fourth and fifth vertebrae, was completely loose. This screw was inadvertently pushed back into the original drill hole while opening the wound. The fourth and fifth lamina on the right side were almost destroyed by osteomyelitis. There was a large gap, or pseudoarthrosis, in the fusion mass at the same level. The surrounding bone was obviously grossly infected, and an epidural granulation tissue mass extended backward through and posterior to the pseudoarthrosis. When this granulomatous mass was entered at a level posterior to the fusion, a large quantity of milky fluid escaped. This at first appeared to be pus, but was later recognized as milky spinal fluid. The screws were removed and a rather wide area of bone removed from over the dura. There was a hole .5 cm. in diameter through the dura under the center of the mass of granulation tissue. After a sufficiently wide laminectomy had been performed, the entire wound was irrigated with penicillin and the wound loosely packed open.

The neurosurgeon interpreted the findings as representing epidural granulation tissue and abscess accompanying osteomyelitis of the fusion mass and surrounding lamina, and a fistula between the epidural abscess and the subarachnoid space.

Microscopic examination of the tissue showed changes consistent with an osteomyelitis and acute cellulitis. Around the periphery of the granulation tissue the pathologist reported infected collagenous tissue which would indicate some chronicity of this process.

The patient remained unconscious after operation, but his temperature rapidly came down to 100 F., the pulse slowed to 100, and his general condition improved. On the third day a minor left sided convulsion occurred, and on the fourth day after surgery a left hemiplegia was noted. The patient had several more convulsions. Huge doses of penicillin and Aureomycin were given at short intervals. The patient had several transfusions, and his fluid balance was accurately controlled. The convulsions ceased after Luminal sodium was given, and on the fifth postoperative day the patient became conscious. Although not completely oriented, he was able to recognize and talk to hospital personnel. On the sixth day he abruptly lost consciousness again, his temperature rose, and he died.

Autopsy.—The autopsy showed that the fluid in the spinal subarachnoid space and the ventricles was clear. There was osteomyelitis of the fusion and bone surrounding the fourth and fifth lumbar area. The dural fistula had sealed with filmy adhesions. The leptomeninges of the spinal cord were thickened and covered with a yellowish exudate which histologically contained many polymorphonuclear cells. Staphylococcus aureus could still be cultured from this exudate. There was a thick tenacious exudate throughout the basal cisterns including the chiasmatic cistern. Over the convexity of the right cerebrum an even thicker exudate was found. It developed on sectioning the brain that the veins over this area were thrombosed, as was the sagittal sinus. The abdomen contained 500 cc. of fluid and there was a large perforated duodenal ulcer, the edges of which microscopically showed almost no recognizable reaction. There were several other unruptured hyperacute ulcers of the duodenum and upper jejunum.

DISCUSSION

In the opinion of the neurosurgeon who had final charge of this patient, the following set of events occurred. The patient had a wound infection following the surgery in 1950. He probably developed low grade, perhaps minor, staphylococcic osteomyelitis. For thirty months this infectious process remained indolent or very slowly progressive, and for some reason just prior to admission this infection became much more active. It is possible, although improbable, that the patient had meningitis at the time of his final admission to the hospital. It seems more likely that the symptoms of backache and leg numbness were due to cauda equina or nerve root pressure incident to the growth of the epidural granulation and abscess mass. The meningitis probably developed suddenly in the hospital following an enema, at which time the epidural abscess ruptured into the subarachnoid space, giving a fulminating staphylococcic meningitis and septicemia.

Since surgery and the antibiotics apparently had controlled the septicemia, the final complications appear to have been due to more or less mechanical factors inherent in the heavy exudate over the brain surface and the resulting thrombosis of cerebral veins. The final episode was obviously perforation of an unsuspected duodenal ulcer, of the type described by Cushing as complicating hypothalamic injury.

Certain points are glaringly obvious in this case.

The most outstanding concerns the fact that delayed serious infection, in this case delayed thirty months, can and does occur following surgery performed in proximity to the central nervous system. If this possibility had been given earlier consideration, it is entirely possible that this man might now still be alive.

Another point to be seriously considered is whether or not a foreign body, in this case a screw used in the fusion, may be responsible for the continuation of the immediate postoperative infection. In this particular instance the neurosurgeon regards this screw as an important element, although his orthopedic colleagues do not concur. The latter agree with the remainder of the rationale here presented.

CONCLUSION

A case of osteomyelitis, epidural abscess, and fatal fulminating meningitis occurring thirty months after disk removal and spinal fusion has been presented.

It is probable that the operation was directly responsible for this sequence of events.

The question is raised as to the wisdom of using metallic means of fixation in fusions of this type. This can be answered only by future experience.

Veterans Administration Hospital.

Retrovesical Sarcoma: A Case Report

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PRIMARY malignant tumors of the retrovesical area are rare. Lazarus, in an extensive review of the literature, found only 3 cases of sarcoma of the retrovesical region involving the seminal vesicle. We wish to report such a case.

CASE REPORT

D. R., a 70 year old white man, was seen at Mercy Hospital April 4, 1952, because of inability to urinate of one day's duration. Hesitancy, small urinary stream, frequency, and nocturia had been present for several years prior to the present illness.

The patient appeared chronically ill and in acute pain. Temperature was 102 F.; blood pressure, 160/100. The bladder was distended to the umbilicus. On rectal examination a hard fixed nodular mass extending from the urogenital diaphragm to as high as the examining finger could reach was palpable anteriorly. The remainder of the physical examination was essentially negative. An indwelling urethral catheter was inserted and a liter of urine obtained.

Urinalysis was normal. Results of a complete blood count were as follows: red blood cells 3,360,000, hemoglobin 7.1 Gm., white blood cells 16,850 per cubic millimeter, neutrophils 97 per cent, lymphocytes 3 per cent. A serologic examination was negative. Blood urea nitrogen was 66.5 mg. and creatinine 5.8 mg. per 100 cc. of blood. Alkaline phosphatase was 1.75 units, acid phosphatase 0.95 units. A flat plate roentgenogram of the abdomen showed a large mottled area of calcification measuring 7.5 by 6.5 cm. overlying the bladder region. Intravenous urography disclosed no function of either kidney even on a one hour film.

A diagnosis of a large vesical calculus which had eroded into the prostate was made. Cystoscopy was deemed unnecessary. Because of the poor renal function, it was considered advisable to continue drainage by catheter for an extended period; the patient was discharged with the urethral catheter in situ.

One month later the patient, having improved remarkably, refused to keep the catheter in place or to undergo surgery. The catheter was removed. Eight days afterward the patient was readmitted to the hospital with chronic urinary retention and uremia. Blood urea nitrogen was 106 mg. and creatinine 10.4 mg. per 100 cc. of blood. The patient again improved with catheter drainage.

On readmission for surgery, a flat plate roentgenogram of the abdomen demonstrated no change in the calcified mass previously seen. The electrocardiogram was within normal limits. Blood urea nitrogen was 13.3 mg. and creatinine 4.9 mg. per 100 cc.

A suprapubic cystotomy was done July 14, 1952, under general anesthesia. When the bladder was opened, a large trilobar prostate was seen but no vesical calculus was present. The prostate was easily enucleated. Posterior to the prostatic capsule, a large hard mass was palpable. The prostatic capsule and trigone were incised in the midline. The tumor mass was encapsulated and lay between the rectum, bladder, and prostatic capsule. The tumor was freed by blunt dissection. Because of its large size, it could not be delivered intact through the posterior bladder incision; however, finally it was removed in its entirety. A large vaginal pack was inserted into both the retrovesical cavity and the prostatic fossa. The bladder was closed around a Pezzer catheter.

Pathology.—Gross: Two specimens were received, the prostate and a separate tumor, both in several pieces. When the parts of the tumor were rejoined, it was seen to have an irregular rounded shape. It was slightly flattened on two surfaces, having a diameter of 7.5 cm. and a thickness of 4 cm., and was hard and calcified. The outer surface was irregularly lobulated. Lobules varied between 3 mm. and 1.5 cm., some calcified and yellow, others fleshy pink. Calcified areas were in the majority. The surface was partially covered by strips of what appeared to be a capsule, through which portions of the tumor protruded. In cross section there seemed to be a cord of pink papillary and lobulated soft tissue, around which was formed a layer of calcium. The calcified portion varied between a few millimeters and 3 cm. in thickness. The calcium was in the form of spicules which were easily broken apart. Gray tissue like that of the central cord protruded along the calcium fragments, separating clusters of them. The soft portion of the tumor reached the outer surface of the tumor.

From The Medical and Surgical Clinic.

FIG. 1. A case of retrovesical sarcoma.
Left. Preoperative roentgenogram revealing a large mottled calcified mass in the vesical region.
Right. Flat film made one year postoperatively disclosing no evidence of calcification in the vesical region. On rectal palpation, however, recurrence was noted.

The prostate was large, rubbery, firm, and irregularly formed. Most of the surfaces were covered with a transparent capsule. On section the cut surfaces were moist, milky, and rather irregularly lobulated.

Microscopic: The tumor was a spindle cell growth. The cells were arranged in swirling, interlacing bundles; they were numerous in some areas, and in others were replaced by their cytoplasmic secretion. The secretion began as vacuolation in the cell. Material, first amorphous, then granular or myxomatous, was deposited. It became fibrillar in some areas, but never collagenous. In most places calcium was deposited in the secretion in dense, granular masses. Osteoblasts, presumably differentiating from the tumor cells, were numerous. Bone formation occurred in only a few places. Mitoses in the spindle cells were present. They were few and attested to the malignant nature of the tumor.

Diagnosis.—Calcifying spindle cell sarcoma. Benign nodular hyperplasia of prostate. (Dr. William J. Emerson.)

The patient was discharged July 25, 1952. A course of deep roentgen therapy was given. Seven months later he complained of dull pain in the right groin. Rectal examination revealed a hard area the size of a pigeon's egg on the right. Additional roentgen therapy was recommended.

One year after surgery the inguinal pain was still dull but bilateral. The lesion was beginning to encircle the rectum, was softer, and was not calcified. No residual urine was present. Further roentgen therapy was being given.

DISCUSSION

Tumors of the retrovesical region may arise either from the seminal vesicles; vestigial remnants such as the Mullerian ducts; or the fibrous tissue, muscle, nerves, and vessels between the bladder and the rectum. By the time a growth in this area produces symptoms, it usually has involved the seminal vesicles, prostate, and surrounding tissue. Therefore, the exact point of origin often remains in doubt.

Symptoms in these cases are first referable to the urinary bladder. In our patient the associated benign prostatic hypertrophy probably was the primary cause of the acute urinary retention. Despite recurrence of the growth, the patient has remained almost asymptomatic. Response to deep roentgen therapy has been negligible.

SUMMARY

A case of retrovesical sarcoma and associated benign prostatic hypertrophy is reported.

REFERENCES

1. Lazarus, J. A.: Primary Malignant Tumors of Retrovesical Region with Special Reference to Malignant Tumors of Seminal Vesicles; Report of Case of Retrovesical Sarcoma, J. Urol. *55*:190-205 (Feb.) 1946.

2. Young, H. H., and Davis, D. M.: Young's Practice of Urology, Philadelphia, W. B. Saunders Co., vol. 1, pp. 558-559, 1926.

Dr. Warres, The Thompson-Brumm-Knepper Clinic, St. Joseph, Mo.
Dr. King, The Medical and Surgical Clinic, Laredo.

POSTDOCTORAL FELLOWSHIPS

Fellowships for one or more years at an approved school of public health and one to three years postdoctoral clinical fellowships at training centers approved for residencies in physical medicine and rehabilitation are being offered by the National Foundation for Infantile Paralysis. Selection of candidates will be on a competitive basis, and stipends will be based on individual need.

Short-term fellowships are also available for physicians who wish to become better acquainted with physical medicine and rehabilitation as it relates to their particular specialties.

Complete information may be obtained from the foundation's Division of Professional Education, 120 Broadway, New York 5.

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, San Antonio, May 3-5, 1954. Dr. George Turner, El Paso, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, San Francisco, June 21-25, 1954. Dr. Edward J. McCormick, Toledo, Ohio, Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton, Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice, Cleveland, March 22-25, 1954 Dr. U. R. Bryner, Salt Lake City, Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Cincinnati, Dec. 14-16, 1954. Dr. Robert A. Kimbrough, Jr., Philadelphia, Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Montreal, Canada, May 3-5, 1954. Dr. Emile F. Holman, San Francisco, Pres.; Dr. Paul C. Samson, 2938 McClure St., Oakland 9, Calif., Secy.

American Association of Genito-Urinary Surgeons, Shawnee-on Delaware, Pa., May 26-28, 1954. Dr. Vincent J. O'Conor, Chicago, Pres.; Dr. Norris J. Heckel, 122 S. Michigan Ave., Chicago 3, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 9-11, 1954. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Miami Beach, April 5-10, 1954. Dr. M. Murray Peshkin, New York, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, San Francisco, June 17-20, 1954. Dr. Alvis E. Greer, Houston, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Chicago, April 5-9, 1954. Dr. Leroy H. Sloan, Chicago, Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 4, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-18, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress of Physical Medicine and Rehabilitation, Washington, D. C., Sept. 6-11, 1954. Dr. William B. Snow, New York, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, White Sulphur Springs, W. Va., April 13-17, 1954. Dr. Louis A. Brunsting, Rochester, Minn., Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, San Francisco, June 18-19, 1954. Dr. J. M. Ruffin, Durham, N. C., Pres.; Dr. H. Marvin Pollard, 1313 E. Ann St., Ann Arbor, Mich., Secy.

American Gynecological Society, Hot Springs, Va., May 20-22, 1954. Dr. Richard W. TeLinde, Baltimore, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, Chicago, April 1-4, 1954. Dr. Robert L. King, Seattle, Pres.; Dr. William H. Bunn, 44 E. 23d St., New York 10, Secy.

American Hospital Association, Chicago, Sept. 13-16, 1954. Mr. Ritz E. Heerman, Los Angeles, Pres.; Mr. George P. Bugbee, 18 E. Division St., Chicago, Executive Secy.

American Laryngological, Rhinological, and Otological Society, Boston, May 25-27, 1954. Dr. LeRoy A. Schall, Boston, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Atlantic City, N. J., June 14-16, 1954. Dr. Roland P. Mackay, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, Glacier Park, Mont., June 16-18, 1954. Dr. William L. Benedict, Rochester, Minn., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, Bretton Woods, N. H., June 6-9, 1954. Dr. A. R. Shands, Jr., Wilmington, Del., Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Buck Hill Falls, Pa., May 3-5, 1954. Dr. Rustin McIntosh, New York, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, Los Angeles, June 2-5, 1954. Dr. Wendell Green, Toledo, Ohio, Pres.; Dr. Stuart T. Ross, 131 Fulton Ave., Hempstead, N. Y., Secy.

American Psychiatric Association, St. Louis, May 3-7, 1954. Dr. Kenneth E. Appel, Philadelphia, Pres.; Dr. R. Finley Gayle, 6300 Three Chopt Rd., Richmond 21, Va., Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Cincinnati, Oct. 25-30, 1954. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Washington, D. C., Sept. 6, 1954. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Cleveland, April 28-30, 1954. Dr. Howard C. Naffziger, San Francisco, Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison St., Chicago 3, Secy.

American Urological Association, New York, May 31-June 3, 1954. Dr. J. A. Campbell Colston, Baltimore, Md., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Jackson, Miss., April 1-3, 1954. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1954. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Atlantic City, N. J., May 17-21, 1954. Mr. Mark H. Harrington, Denver, Pres.; Mr. Kemp D. Battle, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nashville, Pres.; Dr. George G. Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum, New Orleans, May 9-11, 1954. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, 1954. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Oklahoma City, Sept. 27-29, 1954. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secy.

Tri-State Medical Assembly, Fall, 1954. Dr. Joe D. Nichols, Atlanta, Pres.; Dr. Broox C. Garrett, 940 Margaret Pl., Shreveport, La., Secy.

United States-Mexico Border Public Health Association, Albuquerque, N. M., April 6-9, 1954. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice, Galveston, Sept. 9-11, 1954. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris, 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association, San Antonio, May 2-3, 1954. Dr. George L. Gallaher, Harlingen, Pres.; Dr. J. S. Minnett, 2512 Welborn, Dallas, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas. Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, San Antonio, May 2, 1954. Dr. Henry H. Hoskins, San Antonio, Pres.; Dr. Walter C. Brown, 1733 S. Brownlee Blvd., Corpus Christi, Secy.

Texas Club of Internists. Dr. Joseph F. McVeigh, Fort Worth, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, San Antonio, May 2, 1954. Dr. Maurice Barnes, Waco, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, San Antonio, May 2, 1954. Dr. Raymond L. Gregory, Galveston, Pres.; Dr. Edmond K. Doak, 501 Hermann Professional Bldg., Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas, Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Heart Association, San Antonio, May 3, 1954. Dr. Joseph McVeigh, Fort Worth, Pres.; Miss Roberta Miller, 412 Fidelity Union Life Bldg., 1511 Bryan St., Dallas, Executive Secy.

Texas Hospital Association, Houston, May 18-20, 1954. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, San Antonio, May 2, 1954. Dr. James Blair, San Antonio, Pres.; Dr. John L. Otto, John Sealy Hospital, Galveston, Secy.

Texas Orthopedic Association, San Antonio, May 3, 1954. Dr. Edward T. Smith, Houston, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, October, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society. Dr. Herbert T. Hayes, Houston, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association. Dr. Roy G. Reed, La Marque, Pres.; Mr. Earle W. Sudderth, Dallas County Health Department, Court House, Dallas, Executive Secy.

Texas Radiological Society, Houston. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, San Antonio, May 3, 1954. Dr. William E. Crump, Wichita Falls, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred H. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Waco, March 4-6, 1954. Mrs. Frank Schoonover, Fort Worth, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 21, Executive Secy.

Texas Society of Anesthesiologists, San Antonio, May 2, 1954. Dr. James B. Robinett, Jr., Houston, Pres.; Dr. C. R. Allen, John Sealy Hospital, Galveston, Secy.

Texas Society of Gastroenterologists and Proctologists, San Antonio, May 3, 1954. Dr. Cecil O. Patterson, Dallas, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gadin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, San Antonio, May 3, 1954. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society, Waco, April 5-6, 1954. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Dallas, April 9-10, 1954. Dr. R. G. McCorkle, San Antonio, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Corpus Christi, 1954. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg, Corpus Christi, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society, Sweetwater, April 15, 1954. Dr. T. D. Young. Sweetwater, Pres.; Dr. Francis Hood, Sweetwater, Secy.

Third District Society, Amarillo, April 13, 1954. Dr. Robert A. Neblett, Canyon, Pres.; Dr. James T. Hall, 1626 Fifteenth St., Lubbock, Secy.

Fourth District Society, San Angelo, Fall, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July, 1954. Dr. Y. C. Smith, Sr., Corpus Christi, Pres.; Dr. Robert J. Sigler, 1126 Third Street, Corpus Christi, Secy.

Seventh District Society, 1954. Dr. Benjamin Clary Bates, Austin, Pres.; Dr. William McLean, 4618 Burnet Road, Austin, Secy.

Eighth District Society. Dr. Howard Z. Fretz, Wharton, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society, Brenham, March 25, 1954. Dr. George D. Bruce, Baytown, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society, Nacogdoches, April 17, 1954. Dr. Edmund D. Jones, Beaumont, Pres.; Dr. O. W. Harris, Jr., Liberty, Secy.

Eleventh District Society, Crockett, April 15, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society, Corsicana, July 13, 1954. Dr. Neil Buie, Marlin, Pres.; Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society, Fort Worth, March 24, 1954. Dr. William E. Crump, Wichita Falls, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society, Denton, 1954. Dr. J. W. Atchison, Gainesville, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Longview, April 20, 1954. Dr. Bain Leake, Gladewater, Pres.; Dr. George Tate, Longview, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 15-18, 1954. Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco, April 7, 1954. Dr. Walter B. King, 2320 Columbus Ave., Waco; Secy.

International Medical Assembly of Southwest Texas, San Antonio, Feb. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 8-11, 1954. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Sept. 22, 1954. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, July 19-21, 1954. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls, March 31, 1954. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences, Austin, April 23-24, 1954. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, June 21-23, 1954. Dr. M. H. Crabh, 1714 Medical Arts Bldg., Fort Worth, Secy.

Blasingame to Speak for AAPS

Nine speakers have been announced for the April 1-3 meeting of the Association of American Physicians and Surgeons to be held in Jackson, Miss. Dr. F. J. L. Blasingame, Wharton, President-Elect of the Texas Medical Association and Trustee of the American Medical Association, is among those named. Others include Dr. Lewis A. Aleson, Los Angeles, past president of the California Medical Association; George S. Benson, Searcy, Ark., president of Harding College; Mrs. Mary D. Cain, Summitt, Miss., editor and publisher; Dr. M. G. Ewing, Amory, Miss., president of the Mississippi State Medical Association; Dr. Thomas G. Goldsmith, Greenville, S. C., president of AAPS; J. Bracken Lee, Salt Lake City, governor of Utah; Dr. Stirling S. McNair, Jackson, Miss., president of the Central Medical Society of Mississippi; and Hugh White, Jackson, Miss., governor of Mississippi.

No registration fee will be charged members and guests, and ladies are invited to attend the programs of speeches, exhibits, and president's luncheon and annual banquet. Tickets for the latter events will be on sale. Requests for room reservations and for additional information should be addressed to the AAPS, 360 North Michigan Avenue, Chicago.

Some of San Antonio's many attractions are the Nix Professional Building *(upper left)* which includes a storage garage, offices, and a modern hospital; the new maternity wing of the Baptist Memorial Hospital *(upper right)*, a hospital which now includes the old Physicians and Surgeons and the Medical and Surgical Hospitals; La Villita, "the little town" *(center left)*, where entertainment for the Association's President will be held May 4; the famous Alamo *(center)*, the shrine of Texas liberty; San Jose Mission *(center right)*, built in 1720 and known as the "Queen of the Missions" for its architecture and sculpture; and the San Antonio River *(lower left)*, which winds 6 miles through the city, including part of the downtown business district. Pictured lower right is the San Antonio skyline.

Where Life Is Different

San Antonio, host city for the Texas Medical Association's 1954 annual session May 3 to 5, is known as the city "where life is different," a "city of contrasts." With its romantic past and colorful present, San Antonio combines the old world charm with the modern and arrives at a picturesque contrast.

The medical facilities in the city show evidence of the modern. During the past few years extensive modernization projects, including new buildings, additional facilities, and late model equipment, have been under way among the nineteen hospitals and clinics in San Antonio.

The Robert B. Green Memorial Hospital, one of the oldest community charity hospitals in Texas, is being enlarged to approximately 375 beds and completely modernized under a $3,000,000 improvement plan. The hospital will have a new five-story wing and other additions for surgery, emergency, clinical laboratory, x-ray, autopsy, main kitchen, and storeroom.

The Baptist Memorial Hospital several years ago opened a new obstetrics building, complete with new, modern equipment. The hospital also provided a new sprinkler system in the old building and is completing new parking space to accommodate an additional eighty automobiles.

A third remodeling project, the Santa Rosa Hospital, is nearing completion, with added facilities for a hundred beds and a new operating room which will represent an investment of almost $3,000,000.

A newly constructed 150-bed tuberculosis sanatorium located about 12 miles from the city is part of the county hospital system, and bids were to be received in March for a new 600-bed San Antonio State Tuberculosis Hospital to be built adjacent to the present tuberculosis hospital for mental patients, which is part of the San Antonio State Hospital.

In addition to the many hospitals and clinics in San Antonio, there are two large office buildings principally devoted to the medical profession. The Medical Arts Building, classed among the most beautiful architectural structures in the South, houses a modern hospital on the top floor of the ten-story building. The other office building chiefly used by physicians is the Nix Professional Building, which was built after national research to determine the type building which would be most suitable for medical offices and a hospital as well as other modern conveniences. The twenty-four-story building is composed of a storage garage for tenants and patients, offices for physicians and members of allied professions, and a modern hospital.

Military Center

San Antonio also is the site of the Air Force School of Aviation Medicine, with headquarters at Randolph Air Force Base, the "West Point of the Air." The school is the main laboratory for basic aeromedical research and provides a consultative service for the diagnosis and treatment of unusual medical conditions that are peculiar to fliers. At present, this school is the only institution that offers an integrated training program in the specialty with the cooperation of civilian medical schools and Air Force medical units.

The largest military medical installation in the nation, Brooke Army Medical Center, located at Fort Sam Houston, the largest Army post in the United States, includes Brooke Army Hospital, Medical Field Service School, Fourth Army Area Medical Laboratory, Central Dental Laboratory, Surgical Research Unit, and Hospital Management Research Unit. A seventh unit, the Medical Training Center, is to become a part of Brooke in March when training activities at the Medical Replacement Training Center at Camp Pickett, Va., are taken over by the new unit. Professional activities at Brooke occupy the main hospital building and three large annexes. Administrative and supporting services occupy an additional seventy adjacent, smaller buildings.

The largest capital investment in aviation in the world is located adjacent to San Antonio. In addition to Randolph Field, there are Alamo Field, Stinson Field, Brooks Field, San Antonio Personnel Distribution Center, Kelly Field, which is the nation's largest repair depot for airplanes maintained by the United States Air Force, and Lackland Air Base, the largest United States Air Force training base.

Fort Sam Houston, headquarters for the Fourth Army, and Camp Bullis, San Antonio Quartermaster Depot, and San Antonio Arsenal make San Antonio an army center as well as a military aviation center. For more than 200 years San Antonio has been a military stronghold of the western world. France, Spain, Mexico, the Confederate States of America, the Republic of Texas, and the United States of America have all fought to hold the city.

Historic San Antonio

The city has many attractions in addition to its medical and military establishments. Following the San Antonio River as it winds lazily through the city, one could count for a distance of 6 miles forty-two bridges crossing the river, which has a water level 20 feet below the surface of the streets. Convention guests may wish to tour the city by boat on this river, which flows through part of the downtown business district. The guide may relate the story of the naming of San Antonio, point out places of interest seen along the river bank, and mention other interesting historic sights in the city.

The guide could tell guests that San Antonio was named by the Franciscan Father Damian Massenet, who celebrated the first mass under the great cottonwood trees on the feast day of St. Anthony of Padua in 1691. During the same year that New Orleans was founded by France, 1718, Spain began a chain of missions and fortresses, and on May 1 established the mission-fort of San Antonio de Valero, the chapel of which later became the Alamo.

Located in the heart of downtown San Antonio, the Alamo is the shrine of Texas liberty, for it was there that Travis, Bowie, Crockett, and others courageously fought to the last man against overwhelming odds. But from their deaths came victory. Sparked by the cry, "Remember the Alamo," Texas rallied to win her independence in 1836. The Alamo, as well as the adjoining Alamo Museum and Alamo Library, is open to the public, as are most of the other structures of historic importance.

Within less than 8 miles of the downtown area are four more of these age-old missions, Concepcion, San Jose, Espada, and Capistrano. San Jose, known as the "Queen of the Missions" for its architecture and sculpture, was established in 1720; the other three were established in 1731.

In San Antonio also is found the Spanish Governors' Palace, which blends simple beauty with an air of gracious living in a courtly atmosphere. Carved in the keystone over the entrance is the Hapsburg coat of arms with the date 1749, but the actual date of construction is unknown. The building contains ten rooms furnished in a colonial manner and in the rear is a patio, about which there are many tales of buried treasures, and a picturesque wishing well.

Many of the Association's annual session activities will be held at the Plaza *(upper left)*, Gunter *(upper right)*, and Menger *(lower left)* Hotels. Scientific meetings of related organizations will be held in the Gunter and Plaza Hotels as well as in the Municipal Auditorium. The House of Delegates will convene at the Gunter Hotel. Activities of the Woman's Auxiliary will be held at the Menger Hotel.

In the courtyard of La Villita, "the little town," the Texas Medical Association will entertain for its President on May 4. La Villita was established as a home for soldiers and their families when the first mission was founded in San Antonio. The little stone and adobe buildings of La Villita, covering a full block, have witnessed the transformation of San Antonio from a wilderness outpost to a great, modern city.

Another of San Antonio's many attractions is the beautiful Brackenridge Park, containing one of the nation's largest and finest zoos. The park spreads over 320 acres within the city limits. The Texas Open Golf Tournament is held at the Brackenridge Park course, and the Richard Friedrich Aquarium at the park is one of two west of the Mississippi where rare fish from fresh, salt, and tropical waters are found. The beautiful Chinese Sunken Gardens and the Witte Museum are among the points of interest at the park.

At the direction of the King of Spain in 1730, when a settlement was laid out in what is now San Antonio, two plazas were provided for recreation, and as a result, San Antonio now has more than 2,000 acres of parks devoted to sports, relaxation, and entertainment.

And San Antonio is rich in cultural and light entertainment. The Sunken Garden Theater offers outdoor entertainment as does the unique Arneson River Theater where, against the permanent background of a mission-type building, actors play to spectators seated across the river. Other noted spots include the beautifully designed Municipal Auditorium, where symphonies, operas, and concerts by great artists are held and where most of the activities during the Texas Medical Association annual session will be held, and the new Coliseum, where great trade expositions, livestock shows, circuses, rodeos, and other events are held. The Coliseum is one of the four largest in the country. Top sporting events in the Southwest are held in San Antonio's Alamo Stadium with seating capacity of 23,000; the new Alamo Stadium Gymnasium, with seating capacity of 6,500, is used for exhibitions and shows in addition to athletic events.

Once the home of O. Henry, San Antonio has excellent educational facilities in 101 schools, two junior colleges, and four universities. Much stress is placed on vocational high school training as well as business and professional and art training. San Antonio was the home of many world-famous painters and sculptors and has a spacious Art Institute with beautiful landscaped grounds.

A city of everlasting sunshine, San Antonio is the center of the southwestern Texas livestock industry and has many types of agriculture. With an abundance of raw materials, labor, and markets, a move toward industrial development is the city's newest activity.

Considering the wealth of appeal of the convention city and the arrangements that have been made for this year's meeting of the Texas Medical Association and its Woman's Auxiliary, members will not want to miss this opportunity to visit America's fastest growing major city and to take part in the 1954 annual session.

PERSONALS

Dr. Clyde Elkins, Lubbock, will be a speaker at the annual meeting of the American College of Allergy in Miami Beach, Fla., April 5-10.

Dr. Felix L. Butte, Dallas, was appointed by the Board of Trustees of the American Medical Association to serve on a special committee to study "all aspects of the problems of public relations created by recent adverse publicity." Establishment of the committee was called for at the interim session of the AMA.

Dr. John E. Hill, Marshall, became chief surgeon of the Texas and Pacific Railway Company January 1 at which time *Dr. Carl McCurdy* retired from that position after forty-two years of medical service with the railroad.

Dr. Gordon Madding, San Angelo, has been elected to the Western Surgical Association, of which only four other Texans are members.

Dr. Hamilton Ford, Galveston; *Dr. John A. Wiggins,* Fort Worth; *Dr. Edgar S. Ezell,* Fort Worth; and *Dr. Henry R. Hoskins,* San Antonio, are members of an advisory committee of citizens interested in furthering the program administered by the Board for Texas State Hospitals and Special Schools.

Dr. J. M. Travis, Jacksonville, has been honored with a plaque in the entrance to the Jacksonville city hall commemorating his selection in 1952 as general practitioner of the year by the American Medical Association.

Dr. M. L. Gray, Jacksonville, was recognized for outstanding civic service for 1953 by the local Lions Club, which presented him with a bronze plaque for his work with a well-baby clinic.

Dr. G. V. Brindley, Jr., Temple, defeated his fellow townsman, *Dr. Raleigh White,* to become golf champion of the Southern Surgical Association. Dr. White was the defending champion when the tournament began at Hot Springs, Va.

Dr. J. W. Pittman, Belton physician for thirty-seven years, was honored on a recent birthday by the young adult Bible class of the Church of Christ, of which he is teacher.

Dr. J. C. Kern, Burnet, lost his father, Methodist Bishop Paul B. Kern, in Nashville, Tenn., in December. Bishop Kern had been on the faculty at Southern Methodist University and pastor of the Travis Park Methodist Church in San Antonio.

Mrs. Sarah Ann Guthrie, Floydada, widow of Dr. J. H. Guthrie and mother of *Dr. A. E. Guthrie,* Floydada, died December 17, 1953.

Dr. and Mrs. Herbert Beavers, Fort Worth, have announced the marriage of their daughter Betty to William James Bond on February 6.

Dr. Thomas J. Pennington and Miss Dorothy Nell Reese were married December 30 in Nacogdoches.

Recent births in Fort Worth have been announced as follows: *Dr. and Mrs. H. W. Thomas,* Cecilia Anne, December 22; *Dr. and Mrs. R. E. Snyder,* a boy, January 30; *Dr. and Mrs. T. J. Coleman,* Thomas Joseph, Jr., January 3; *Dr. and Mrs. Emory Davenport,* Karen Beth, December 10; and *Dr. and Mrs. Lawrence P. Kleuser,* Lawrence Joseph, January 21; and in Arlington, *Dr. and Mrs. Robert Brentlinger,* Gary Rae, in December.

Boys have been born recently to *Dr. and Mrs. A. P. Thaddeus,* Galveston; *Dr. and Mrs. G. H. Lang,* Midland; *H. E. and Dr. Grace K. Jameson,* Galveston; and *Dr. and Mrs. J. F. Cox, Jr.,* Houston.

Girls have been born to *Dr. and Mrs. J. E. Green, Jr.,* Ballinger, and *Dr. and Mrs. P. C. Higgs,* Harlingen.

HOLLE NAMED STATE HEALTH OFFICER

Dr. Henry A. Holle, recently regional medical director of regions 1 and 2 (ten states) of the United States Public Health Service with headquarters in New York, was to become state health officer for Texas as soon after March 1 as he could be replaced in his New York position. Announcement of the appointment of the 49 year old native Texan to succeed Dr. George W. Cox, who resigned effective March 1 after seventeen years as head of the Texas State Department of Health, was made in mid-February by Dr. J. B. Copeland, San Antonio, chairman of the State Board of Health.

Born near Brenham, Dr. Holle received his medical degree from the University of Texas School of Medicine in 1927. After an internship in Houston, he practiced in Brenham for six and one-half years before accepting a commission with the United States Public Health Service. Dr. Holle has served in numerous positions, including chief quarantine and immigration officer of the Panama Canal and chief medical officer of a special mission to Poland. Since 1948 he has been in New York, first as regional director for region 2 and recently for the combined regions 1 and 2. Dr. Holle is a diplomate of the American Board of Preventive Medicine and Public Health, a fellow of the American Medical Association and American Public Health Association, and a member of the New York Academy of Sciences.

Dr. Holle was among the "former Texans" who participated in the program of the 1953 annual session of the Texas Medical Association celebrating its centennial anniversary.

Ophthalmologists and Otolaryngologists Meet

The Texas Society of Ophthalmology and Otolaryngology held its twenty-eighth annual session December 4 and 5 in Fort Worth, with Dr. Dohrmann K. Pischel, San Francisco, and Dr. David DeWeese, Portland, Ore., as special guests.

Those on the scientific program in addition to the two guests were Dr. Everett L. Goar, Houston; Dr. Grady Reddick (by invitation), Dallas; Dr. Edwin G. Grafton, Jr., Dallas; Dr. F. H. Newton, Dallas; Dr. Frederick C. Rehfeldt (by invitation), Fort Worth; Dr. Herbert H. Harris, Houston; Dr. Fletcher Clark, Jr., San Antonio; Dr. King Gill, Corpus Christi; Dr. Frederick R. Guilford, Houston; Dr. Claude C. Cody, III, Houston; and Dr. Boen Swinny (by invitation), San Antonio.

Discussions were presented by Drs. Lester H. Quinn, Dallas; C. Keith Barnes, Fort Worth; Oscar Marchman, Jr., Dallas; Oliver Suehs, Austin; Haskell Hatfield, El Paso; Chase Thompson, San Angelo; Dr. Harris; Lyle M. Sellers, Dallas; William McKinney (by invitation), Fort Worth; William C. Grater (by invitation), Galveston; J. M. Robison, Houston. C. O. Haug, M. A., Houston, also took part in a discussion.

New officers were named as follows: Dr. John L. Matthews, San Antonio, president; Dr. A. E. Jackson, Fort Worth, president-elect; Dr. James T. Robison, Austin, vice-president; and Dr. Gatlin Mitchell, Fort Worth, secretary. Dr. J. D. Singleton, Dallas, again will serve as treasurer. Dr. E. D. Dumas, San Antonio, became chairman of the councilors.

Drs. Charles R. Lees, Fort Worth, and A. E. Jackson, Fort Worth, presided over the ophthalmology sessions, and Drs. William J. Snow, Houston, and John Barrett, Houston, presided over the otolaryngology sessions.

Luncheons, golf, cocktails, and a banquet-dance were included in the program.

Physical Therapy Meeting in San Antonio

The Texas Chapter of the American Physical Therapy Association will meet at the Plaza Hotel, San Antonio, May 1 and 2, immediately preceding the annual session of the Texas Medical Association.

Selected orthopedic subjects ranging from management of specific types of fractures to training and rehabilitation of amputees with various types of prostheses, ultrasonics with demonstration of the application of ultrasonic energy, and psychological management of patients with acute and chronic diseases and disabilities will be considered. Professional and commercial exhibits will be on display. Special entertainment at the Indian Village is scheduled for the evening of May 1.

Capt. Mary S. Lawrence, San Antonio, is convention chairman; Mrs. Marion N. Boyer, Dallas, is president.

CENTRAL TEXAS CLINIC IN APRIL

The Central Texas Journal Club has announced plans for its annual spring clinic to be held in Waco on April 7. Members of the Texas Medical Association and physicians on duty with federal agencies are invited to attend without payment of a registration fee.

Speakers at the one day meeting include Drs. Raymond Gregory, Department of Medicine, University of Texas Medical Branch, Galveston; Louis M. Hellman, Department of Obstetrics, Long Island College of Medicine, Brooklyn; Margaret Smith, Department of Microbiology, Tulane University of Louisiana School of Medicine, New Orleans; Robert S. Sparkmen, Department of Surgery, Southwestern Medical School of the University of Texas, Dallas; and Stewart Wolf, Department of Medicine, University of Oklahoma School of Medicine, Oklahoma City.

Further information may be obtained from the secretary, Dr. Walter B. King, Jr., 2320 Columbus Avenue, Waco.

UNIVERSITY OF TEXAS MEDICAL BRANCH

Dr. Charles T. Stone, professor of medicine at the University of Texas Medical Branch, Galveston, has been invited by the government of West Germany to visit German medical and hospital installations and centers. Dr. Stone was to leave early in February for a month's visit in Germany.

Dr. Douglas Guthrie, medical historian of the University of Edinburgh, and Paul Larson, Ph. D., professor of pharmacy at the Medical College of Virginia, Richmond, were recent visitors at the Medical Branch.

NEW AMERICAN ACADEMY OF PEDIATRICS MEMBERS

The following physicians of Texas recently have been elected to membership in the American Academy of Pediatrics: Drs. H. H. Bevil, Beaumont; Frank Cohen, Fort Worth; Albert L. Exline, Jr., Austin; Theodore C. Panos, Galveston; Catherine Juanita Elizabeth Roett, Houston; Gilbert C. Schreiner, Bryan Air Force Base; David I. Schrum, Houston; Virginia S. Stovall, San Antonio; Sam W. Wilborn, Austin; Lee Williamson, Abilene; and John Phillip Fairchild, Fort Sam Houston.

NEW OPHTHALMOLOGY DIPLOMATES

New Texas diplomates of the American Board of Ophthalmology are Dr. Robert E. Nystrom, Abilene; Dr. C. R. Little, Corpus Christi; Dr. Mary A. Lancaster, Dallas; Dr. Robert R. Kelley, El Paso, Dr. Richard E. Leigh, Jr., Houston; Dr. Willis T. Carson, Odessa; and Dr. John W. Linfesty, Sheppard Air Force Base.

Texas Radiological Society

One hundred forty-seven members and visitors attended the meeting of the Texas Radiological Society January 29 and 30 in Dallas. Dr. E. F. Lyon, Jr., San Antonio, became president. Newly elected officers are Drs. Martin Schneider, Galveston, president-elect; J. R. Riley, Corpus Christi, first vice-president; and T. G. Russell, Houston, second vice-president. Dr. R. P. O'Bannon, Fort Worth, remains secretary-treasurer and Dr. R. T. Wilson, Austin, historian.

The scientific program included talks by the following guest speakers: Dr. John Caffey, Columbia University, New York; Dr. Manuel Garcia, Tulane University, New Orleans; Dr. Harold O. Peterson, University of Minnesota, St. Paul; Dr. A. Justin Williams, University of California, San Francisco; and Kenneth E. Corrigan, Ph. D., Wayne University, Detroit.

Other participants in the program were Dr. Milton V. Davis, Dallas; Dr. Alvin Thaggard, San Antonio; Dr. A. K. Doss, Fort Worth; Dr. Palmer Wigby, Houston; and Dr. J. E. Miller, Dallas.

Presiding over various sessions were Dr. B. K. Lovell, McKinney; Dr. Delphin Von Briesen, El Paso; Dr. John J. Sazama, Jr., Dallas; and Dr. Otto H. Grunow, Fort Worth.

A tea and luncheon were provided for the ladies. Luncheons and a cocktail party and banquet also were held.

BASIC SURGERY TO BE REVIEWED

A postgraduate course in basic principles of surgery will be offered by the Southwestern Medical School of the University of Texas in Dallas, April 22, 23, and 24. Originally announced for April 19-21, the course will be given at Scottish Rite Hospital. Tuition and registration fee will be $25. A detailed program may be obtained from Dr. John S. Chapman, assistant dean for graduate and postgraduate education at the medical school, 2211 Oak Lawn Avenue, Dallas 19.

Medical Technologists to Meet

The annual meeting of the Texas Society of Medical Technologists will be held April 23 and 24 in El Paso, Miss Wanda Moskalski, El Paso, publicity chairman, announces.

The American Society of Medical Technologists will meet June 13-17 in Miami Beach, Fla., with headquarters at the Delano and DiLido Hotels, Mesdames Maxine T. Ace and Anna L. Rundell, Miami, co-chairmen of the publicity committee, report.

Television's March of Medicine Resumes

Three spring programs in the "March of Medicine" series televised over the National Broadcasting Company's network have been announced for March 11, April 29, and June 24. Sponsored by Smith, Kline and French Laboratories in cooperation with the American Medical Association, the new series will touch on overweight and arthritis in the first two programs; the third will originate from the AMA's annual session in San Francisco, the subject to be announced.

American Goiter Association to Meet

The American Goiter Association will meet in Boston, April 29-May 1 for a program of papers and discussions on the physiology and diseases of the thyroid gland. Further information may be obtained from Dr. John C. McClintock, corresponding and recording secretary of the association, 149½ Washington Avenue, Albany, N. Y.

LIBRARY SECTION

SUMMARY OF SERVICE, 1953

The staff of the Memorial Library of the Texas Medical Association takes pleasure in presenting a summary of the use of the Library for 1953. It is hoped the Library facilities will be used by even more members in 1954.

Material is mailed prepaid to members; it is no longer necessary to refund this postage. The only expense is the cost of return postage.

In each issue of the JOURNAL have been acknowledgments of gifts received from members and friends of the Association, but the many libraries which have aided in completing the journal and index files have not been listed heretofore. To the Library of the Medical and Chirurgical Faculty of the State of Maryland, Tulane University School of Medicine Library, Southwestern Medical School Library, and the Mayo Clinic Library special gratitude is due. They have done their best to answer a constant cry for back issues.

The Film Library has improved its service, and it is hoped that with the purchase of more new films all requests can be supplied. Changes in the postal regulations made it possible to take advantage of a lower shipping rate, so that films are now being sent to members prepaid. Thus the only expense to borrowers is the return shipping cost.

The Library staff will endeavor to supply every request to the best of its ability and resources. This Library belongs to members of the Texas Medical Association, and it is being built around their needs. If any member has not used the Library and is in need of material on any medical subject, he is urged to try his own Memorial Library.

GIFTS IN 1953

Unbound journals	8,432
Bound journals	493
Books	362
Other publications	392
Total	9,679

LIBRARY CIRCULATION

	1952	1953
Books	188	661
Journals	1,842	4,097
Reprints	3,322	7,579
Movies	787	776
Packages	935	1,584
Bibliographies and other requests		80

BOOKS RECEIVED IN FEBRUARY

Addis, Thomas: *Glomerular Nephritis, Diagnosis and Treatment,* New York, Macmillan, 1950.

Advances in Pediatrics, vol 5, Chicago, Year Book Publishers, 1953.

American Psychiatric Association: *The Psychiatrist, His Training and Development,* Washington, American Psychiatric Association, 1953.

Armed Forces Medical Library Catalog, Washington, Library of Congress, 1953.

Bodian, Martin: *Fibrocystic Diseases of the Pancreas,* New York, Grune and Stratton, 1953.

Ciba Foundation Colloquia on Endocrinology: vol. 5, *Bioassay of Anterior Pituitary and Adrenocortical Hormones;* vol. 6, *Hormonal Factors in Carbohydrate Metabolism;* vol. 7, *Synthesis and Metabolism of Adrenocortical Steroids,* Boston, Little, Brown and Company, 1953.

Combes, Frank C.: *Coal Tar and Cutaneous Carcinogenesis in Industry,* Springfield, Ill., Charles C Thomas, 1954.

Doherty, Beka: *Cancer,* New York, Random House, 1949.

Garcia-Vicente, S.: *Aportacion de la escuela espanola a la tecnica endobronquial,* Madrid, 1953.

Gordon, Edgar S.: *A Symposium on Steroid Hormones,* Madison, University of Wisconsin Press, 1950.

Gordon, Richard: *Doctors at Sea,* New York, Harcourt Brace and Co., 1954.

Grollman, Arthur: *Pharmacology and Therapeutics,* ed 2, Philadelphia, Lea and Febiger, 1954.

Katz, Louis N.: *Electrocardiography,* ed. 2., Philadelphia, Lea and Febiger, 1946.

Katz, Louis N.: *Exercises in Electrocardiography Interpretations,* ed. 2, Philadelphia, Lea and Febiger, 1946.

Lerner, Marguerite Rush, and Lerner, Aaron Bunsen: *Dermatologic Medications,* Chicago, Year Book Publishers, 1954.

Michaelson, I. C.: *Retinal Circulation in Man and Animals,* Springfield, Ill., Charles C Thomas, 1954.

Patten, Bradley: *Human Embryology,* ed. 2, New York, Blakiston, 1953.

Podolsky, Edward, ed.: *Music Therapy,* New York, Philosophical Library, 1954.

The University of Texas, M. D. Anderson Hospital and Tumor Institute, *Annual Report, 1952-1953.*

Wilson, James M.: *Pelvic Relaxations and Herniations,* Springfield, Ill., Charles C Thomas, 1954.

Yorke, Edward T.: *Salt and the Heart,* Linden, N. J., Drapkin, 1953.

CONTRIBUTIONS TO LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library for the following recent gifts:

Ciba Pharmaceutical Products, Inc.: Three books from the series "Colloquia on Endocrinology"—vol. 5, Bioassay of Anterior Pituitary and Adrenocortical Hormones; vol. 6, Hormonal Factors in Carbohydrate Metabolism; and vol 7, Synthesis and Metabolism of Adrenocortical Steroids.

Dr. Wylie F. Creel, Austin: 175 journals.

Dr. Walter D. Roberts, Austin, 15 journals.

Mr. L. C. Scheh, Seguin, 2 journals.

Dr. N. L. Schiller, Austin, 13 journals.

Dr. Earl L. Yeakel, Austin, 26 journals.

MOTION PICTURES AVAILABLE FOR LOAN

Once Upon a Time

16 mm., sound, color, 10 minutes.

This amusing, animated cartoon was designed especially for children, although it is entertaining to all ages. The film was designed to teach traffic safety to children utilizing various Mother Goose characters to prove its point. This film is excellent for children's groups, but is also useful for adults.

A Stitch in Time

16 mm., sound, 25 minutes.

Designed to make the American farm a safer place at which to work and live, this film brings out vividly the peacefulness and beauty of the countryside, and then awakens one to the many hazards that are lurking unseen in

all this serenity. The picture stresses the importance of self-protection through education and preventive methods. Farmers are not more careless than other people, but from pioneer days they learned to be fearless and courageous, and perhaps take more chances that easily could be avoided.

This film is highly recommended for all rural groups. Physicians practicing in rural areas will find it helpful in presenting programs to lay groups.

Vitamin A in Human Nutrition

16 mm., sound, 34 minutes. (Courtesy of Mead Johnson and Company, Evansville, Ind.)

This film presents the history of the discovery of vitamin A, and includes the techniques for detection of the vitamin A status within the body. The film also presents the part played by this vitamin in the life and well-being of infants and children. This motion picture should be of interest to general practitioners and pediatricians.

Proof of the Pudding

16 mm., sound, color, 10 minutes. (Courtesy of Metropolitan Life Insurance Company, New York.)

The essentials of good nutrition and its relation to health are presented. Excellent animated scenes are interspersed to amplify the explanation.

This film is excellent for all lay groups, from elementary school age to adult. It is frequently used in nursing schools.

Appraisal of the Newborn

16 mm., sound. 20 minutes. (Courtesy of Mead Johnson and Company, Evansville, Ind.)

This picture shows the importance of family history, prenatal history, natal history, and postnatal history as valuable preventive measures and to supply information for future reference in helping make the day old infant into a normal and healthy person. This is an excellent film for all medical groups.

BOOK NOTICES

[1]Surgical Pathology

LAUREN V. ACKERMAN, M. D., *Professor of Surgical Pathology and Pathology, Washington University School of Medicine; Surgical Pathologist, Barnes Affiliated Hospitals, St. Louis; Consultant to Armed Forces Institute of Pathology. 836 pages. $14.50. St. Louis, C. V. Mosby, 1953.*

This is a beautifully illustrated treatise covering the broad field of surgical pathology. Particular emphasis is placed on the gross appearance of various lesions, and an attempt is made to correlate the pathologic findings with the clinical observations.

The book obviously represents compilation of a tremendous amount of material by a capable man of wide and varied experience and will be a valuable addition to the library not only of the surgeon and pathologist but also of the general practitioner and medical student. It is felt, however, that the book probably will be of more value to the surgeon and general practitioner than to the pathologist as more emphasis is placed on the gross identification of lesions than on the fine points of histologic interpretation. Although the material is ably and thoroughly presented from both the clinical and pathologic standpoints, the style of presentation is perhaps somewhat less lucid than one would expect. It is particularly stimulating, however, to note that this book apparently represents a meticulous compilation of the author's own experience in surgical pathology rather than a review of old and time-honored concepts of the many lesions encountered in the fields of pathology and surgery.

[1]*C. D. Fitzwilliams, M. D., Fort Worth.*

[2]Practical X-Ray Treatment

ARTHUR W. ERSKINE, M. D., *Fourth edition, 195 pages. $5. Saint Paul, Minn., Bruce Publishing Company, 1953.*

This 195 page book is the fourth edition under this title. The first edition was published in 1931. The author planned to report briefly, simply, and clearly what he did in the practice of radiology. He recognized the perplexing, changing, and unsolved problems of x-ray therapy. His plan was attained.

Illustrations and tables are freely interspersed throughout the book, a format which aids appreciably in the brevity of the book. There is a generous bibliography.

About half of the book is devoted to the history of x-ray, apparatus, protection, measuring instruments, factors affecting skin and depth dose, filters and other physical factors, and effects of x-rays on tissues.

The chapter devoted to treatment of skin diseases calls attention to the fact that some eighty different diseases of the skin benefit from x-ray therapy but only a small group is briefly and separately discussed. One recognized the author's practical viewpoint that radiologists must exercise some knowledge of general medicine to be the best consultants. The group of diseases considered in this section is most prevalent in the practice of radiology not limited to hospital work.

Two brief chapters are devoted to treatment of infections, inflammations, and nonmalignant conditions. These consist of frank expressions concerning the desirability and limitations of and technique for treating these conditions.

There is a brief discussion of "the cancer problem and the radiologist," showing the importance of that specialist in the prevention, educational program, and treatment of malignancies.

The section devoted to treatment of malignancies is limited to this important problem, but the author gives his frank opinions gathered from many years of experience. He recognizes variations in techniques and possible approach. One can only appreciate his attitude since his wide experience shows the progress made toward success in this difficult problem.

This book was not compiled for the "expert therapist," but it is valuable to any young physician and will serve as a review for any roentgenologist in practical x-ray treatment.

[2]*A. G. Barsh, M. D., Lubbock.*

[3]An Atlas of Surgical Exposures of the Extremities

SAM W. BANKS, M. D., *Associate Professor of Orthopaedic Surgery, Northwestern University Medical School; Attending Orthopaedic Surgeon, Chicago Memorial Hospital and Woodlawn Hospital; and* HAROLD LAUFMAN, M. D., Ph. D., *Associate Professor of Surgery and Director of Experimental Surgery, Northwestern University Medical School; Associate Attending Surgeon, Michael Reese Hospital. 391 pages. $15. Philadelphia, W. B. Saunders, 1953.*

All too frequently in medical literature an operative procedure is described without adequate consideration being given to the surgical approach. In many instances the exposure is the most difficult part of the operation and, unless carried out properly, may result in prolonged operating time and unnecessary trauma.

This book presents the technique of surgical exposures of bones, joints, and nerves of the extremities. Often several approaches to the same area are described. Each procedure is

[3]*F. C. Lowry, M. D., Austin.*

outlined step by step, both by written text and by drawings. Indications for each exposure are given, as well as special notes regarding the avoidance of damage to nearby nerves and vessels. The descriptions are clear and concise. The drawings are excellent; 552 illustrations are used to portray 143 exposures.

This atlas will be a valuable addition to the library of every surgeon who operates on the extremities. It will be useful to the student, the intern, and the resident in general surgery or orthopedic surgery.

May's Manual of the Diseases of the Eye

Edited by CHARLES A. PERERA, M. D., *Associate Clinical Professor, College of Physicians and Surgeons, Columbia University, New York; Attending Ophthalmologist, Presbyterian Hospital, New York. Twenty-first edition, 512 pages, $6. Baltimore, Williams and Wilkins, 1953.*

Written primarily for medical students and general practitioners, this text first appeared in print in 1900. Dr. Perera has skillfully brought this twenty-first edition up to date without increasing its size.

[4]Injuries of the Spinal Cord

Edited by GEORGE C. PRATHER, M. D., F.A.C.S. *and* FRANK H. MAYFIELD, M. D., F.A.C.S., *396 pages, $8.75. Springfield, Ill., Charles C Thomas, 1953.*

One cannot escape the conclusion that "Injuries of the Spinal Cord" is a reissue of George C. Prather's monograph published in 1949 by the same publisher. Actually, another title might have been "The Urological Aspects of Spinal Cord Injuries, With Some Timely Remarks on the Neurosurgical, Nutritional, and Rehabilitation Aspects." Such a title, however, might be misleading, though essentially accurate. Frank Mayfield has written a dandy synopsis, which is concise and practical. The same may be said of the chapters on nutrition, rehabilitation, treatment of decubitus ulcers, orthopedic problems, psychologic considerations, and associated injuries.

One would be trite to say the authors are familiar with the subject. Actually, they are intimate with it. This intimacy makes for the marshalling of pertinent facts in a small volume.

Hospital libraries everywhere should own this small volume. Injuries of the spinal cord demand immediate attention. A surgeon remote from a neurosurgeon could obtain a good working notion of the immediate care of his patient from this volume. In fact, he might be able to read it through while waiting for a consultant to finish his golf game.

The page size is 9 by 6 inches. The 125 illustrations are well chosen and well reproduced.

[5]Atlas of Medical Mycology

EMMA SADLER MOSS, M. D., *Director, Department of Pathology, Charity Hospital of Louisiana at New Orleans; Clinical Professor of Pathology, Louisiana State University School of Medicine; and* ALBERT LOUIS MCQUOWN, M. D., *Pathologist, Our Lady of the Lake Sanitarium, Baton Rouge; Clinical Assistant Professor of Pathology, Louisiana State University School of Medicine. 245 pages, $8. Baltimore, Williams and Wilkins, 1953.*

The field of medical mycology is much in need of an adequate atlas for reference and teaching. This book answers this need only in part. There is a good quantity of illustrations, and the quality of most is good-to-excellent; however, there are some that are not satisfactorily clear.

The arrangement of the illustrations is fairly consistent and orderly for the most part. This statement is not true, however, for the dermatomycoses; here the illustrations are not at all orderly so that one may skip about over many pages to run down the description of a given organism.

Editing of the book has left considerable to be desired. "Intercalary" and "racquet" (mycelium) are regularly misspelled "intercallary" and "raquet." Species names derived from proper nouns are capitalized, which is not usual custom, and the index is not adequate. For example T. metagrophytes is indexed as appearing on two pages; this reviewer found illustrations and references to this organism on nine different pages.

The text is brief and appears to be a summary of what is found in standard textbooks; obviously it is intended only for orientation and not for clinical guidance, as is customary in atlases. The bibliography is extremely short, and there are no cross referrals between it and the material in the book itself.

On the whole, this appears to be a book of limited usefulness, with many interesting illustrations, some of them of outstanding quality. The book, however, does not bear out the implied suggestion in its preface that it could be used as a manual of determinative mycology.

Textbook of Public Health (Formerly Hope and Stallybrass)

W. M. FRAZER, O.B.E., N. D., Ch. B., M. Sc., D.P.H., *Barrister-at-Law, Gray's Inn; Medical Officer of Health, City and Port of Liverpool, and Medical Officer to the Liverpool Education Committee; Professor of Public Health, University of Liverpool. Thirteenth edition. 663 pages. $8.50. E. & S. Livingstone, Edinburgh and London, 1953. Distributed by Williams and Wilkins, Baltimore.*

The thirteenth edition of the standard British textbook on public health has been thoroughly revised and the many changes in the public health laws have been included. The chapter on public health administration gives a breakdown on the functions of each department and a brief history of each. Chapter 24, "The Social Services," a brief history leading up to the National Assistance Act of 1948, is followed by the act and explanations of the duties of the local authorities under the law.

Many leading authorities in the field of public health have cooperated to make this publication outstanding in its field. It is well written and should be used by public health officers regardless of their location. The illustrations, floor plans for clinics, maps, and charts are worthy of mention. There is an extensive index.

From the Workshop of Discoveries

OTTO LOEWI, *Research Professor of Pharmacology, New York University College of Medicine. Porter Lectures, Series 19. 62 pages. $2. Lawrence, University of Kansas Press, 1953.*

There are three lectures in this series: "Reflections in the Study of Medicine," "From the Workshop of Discoveries," and "Problems in the Field of Adrenal Function."

The study and practice of medicine are discussed from a broad point of view. To study and to hold fast to all that is good and to reach beyond your grasp are just two of the many philosophical ideas that are presented.

Three categories of discoveries are discussed—discoveries made by chance, those made by intention, and those made by intuition. Each method is discussed and examples are given.

The last lecture is the presentation of recent studies on adrenal function.

[4]*F. C. Rehfeldt, M. D., Fort Worth.*
[5]*Morris Polsky, M. D., Austin.*

ORGANIZATION SECTION

Announcements and Program of the EIGHTY-SEVENTH ANNUAL SESSION of the TEXAS MEDICAL ASSOCIATION

San Antonio, Texas

ANNOUNCEMENTS

Scientific activities of the Texas Medical Association will be housed in the Municipal Auditorium. Scientific meetings of related organizations will be held in the Municipal Auditorium, Gunter Hotel, and Plaza Hotel. Specific locations will be found under announcements of specific activities.

Registration, Information, and Messages

On Sunday, May 2, the Registration Desk will be located on the east mezzanine floor of the Gunter Hotel. Monday through Wednesday, May 3-5, registration will be in the foyer of the Municipal Auditorium. Members, medical visitors, and guests should register immediately upon arriving in the city and obtain badges and programs.

Badges will be required for attendance at any meeting or for admission to the exhibit area.

Information may be obtained from the ticket seller near the Registration Desk or from one of the Message Centers, at which messages for physicians will be accepted and telephones will be maintained for use by physicians. The Message Centers will be as follows:

Gunter Message Center (May 1-5), Blue Bonnet Room, third floor, telephone Fannin 3111.

Auditorium Message Center (May 3-5), west end of lower level, telephone Fannin 7396.

Plaza Message Center (May 2-3), lobby, telephone Garfield 2134.

All mail and telegrams should be addressed in care of the Texas Medical Association, Gunter Hotel, during the period of the annual session.

Woman's Auxiliary

The Woman's Auxiliary will have its headquarters at the Menger Hotel, where courtesy and information committees from the Woman's Auxiliary to the Bexar County Medical Society will be on duty. All women in attendance at the annual session should register at the Auxiliary Registration Bureau in the Gay Nineties Lounge immediately upon arriving in the city.

Hotel Information

Those who attend the annual session should obtain room reservations from the hotel of their choice. Additional hotel information may be secured from Dr. John M. Smith, Jr., chairman of the Hotels Committee, who may be reached through the San Antonio Medical Exchange, Garfield 6331.

A list of hotels and motels, their addresses, total rooms, and minimum charges follows:

HOTELS

Bluebonnet, 426 N. St. Mary's, 250 rooms, $3.
Crockett, 301 E. Crockett, 150 rooms, $3.
Gunter, 205 E. Houston, 550 rooms, $5 (Association officials).
Menger, 204 Alamo Plaza, 130 rooms, $5.50 (Auxiliary officials).
Plaza, 309 S. St. Mary's, 500 rooms, $5 (technical exhibitors).
Robert E. Lee, 311 W. Travis, 250 rooms, $3.50.
St. Anthony, 300 E. Travis, 250 rooms, $5.
White Plaza, 203 E. Travis, 204 rooms, $3.25 (Association officials).

MOTELS

Aero Motel, 3535 Broadway, 24 units, $5.
Casa Linda Motel, 3215 Broadway, 36 units, $6.
El Montan Motor Courts, 6806 San Pedro, 23 units, $6.
Park Mo-Tel, Inc., 3617 Broadway, 52 units, $4.
Ranch Motel, 3101 Broadway, 27 units, $5.
Rio Lado Drive In Hotel, 1100 N. St. Mary's, 30 rooms, $6.
Siesta Motor Courts, 4341 Fredericksburg Road, 36 units, $4.50.
The Westerner, 1116 Austin Highway, 85 rooms, $5.

Press Room

A Press Room will be maintained in Room 450 of the Gunter Hotel throughout the annual session. The telephone number will be Garfield 1663.

Stenographers

A Stenographers Room will be set up in the Alamo Room, third floor of the Gunter Hotel. Stenographers will be furnished upon request at the Gunter Message Center in the Blue Bonnet Room.

House of Delegates

The House of Delegates will meet in the North Terrace,

DAILY SCHEDULE

SUNDAY, MAY 2	MONDAY, MAY 3	TUESDAY, MAY 4	WEDNESDAY, MAY 5
8 A.M.—5 P.M. REGISTRATION	8 A.M.—6 P.M. REGISTRATION	8 A.M.—6 P.M. REGISTRATION	8 A.M.—12 NOON REGISTRATION
9 A.M.; 8 P.M. HOUSE OF DELEGATES	8:45 A.M.—9:40 A.M. OPENING EXERCISES, MEMORIAL SERVICES, AND GENERAL MEETING	8 A.M.—12 NOON 2 P.M.—5:30 P.M. SECTION A (MEDICAL) GENERAL PRACTICE INTERNAL MEDICINE PUBLIC HEALTH CLINICAL PATHOLOGY PEDIATRICS SECTION B (SURGICAL) GENERAL PRACTICE SURGERY OBSTETRICS AND GYNECOLOGY EYE, EAR, NOSE, AND THROAT RADIOLOGY	8 A.M.—12 NOON SECTION A (MEDICAL) SECTION B (SURGICAL)
RELATED ORGANIZATIONS TEXAS AIR-MEDICS ASSOCIATION TEXAS CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS TEXAS DIABETES ASSOCIATION TEXAS NEUROPSYCHIATRIC ASSOCIATION TEXAS SOCIETY OF ANESTHESIOLOGISTS	RELATED ORGANIZATIONS TEXAS AIR-MEDICS ASSOCIATION TEXAS DERMATOLOGICAL SOCIETY TEXAS HEART ASSOCIATION TEXAS ORTHOPEDIC ASSOCIATION TEXAS RAILWAY AND TRAUMATIC SURGICAL ASSOCIATION TEXAS SOCIETY OF GASTROENTEROLOGISTS AND PROCTOLOGISTS TEXAS SOCIETY OF PATHOLOGISTS CONFERENCE OF CITY AND COUNTY HEALTH OFFICERS		12:30 P.M.—2:40 P.M. GENERAL MEETING LUNCHEON
2 P.M. REFERENCE COMMITTEES			Recesses to Visit Exhibits Tuesday: 10-10:30 a.m., 3:30-4 p.m. Wednesday: 10-10:30 a.m.
Register and Obtain Party and Luncheon Tickets Early	6 P.M.—8 P.M. ALUMNI BANQUETS	6:30 P.M.—8 P.M. FRATERNITY PARTIES	
	8:30 P.M. HOUSE OF DELEGATES	7:30 P.M.—11:30 P.M. PRESIDENT'S PARTY	
Visit Technical and Scientific Exhibits, Monday, Tuesday and Wednesday			

mezzanine floor, Gunter Hotel. The first session will be held Sunday, May 2, at 9:00 a. m. (p. 187).

Reference Committees

Reference committees will hold their first meetings at 2:00 p. m., Sunday, May 2, at the locations specified below. Additional meetings will be at such other times as the chairmen of the committees may find necessary. All meeting places other than for Sunday afternoon will be assigned at the Gunter Message Center in the Blue Bonnet Room, and the assignments will be posted there. Committee chairmen are urged to inform the Message Center staff when they have called meetings so that inquirers can be directed properly.

Stenographers will be furnished upon request at the Gunter Message Center.

Any member of the Association may arrange with a reference committee for appearance in opposition to or defense of reports submitted to the House of Delegates.

Meetings of reference committees Sunday afternoon will be held in the Gunter Hotel as follows:

Reports of Officers and Committees—Room 461.

Resolutions and Memorials—North Terrace, mezzanine floor.

Finance—Room 463.

Amendments to Constitution and By-Laws—Texas Room, third floor.

Scientific Work—Cactus Room, third floor.

Medical Service and Public Relations—Mezzanine C.

Board of Councilors—Room 462.

Board of Trustees—Room 1026.

Opening Exercises

The Opening Exercises will be held in Room A, Municipal Auditorium, at 8:45 a. m., Monday, May 3 (p. 175).

Memorial Services

The Memorial Services will be held in conjunction with the Opening Exercises in Room A, Municipal Auditorium, at 8:45 a. m., Monday, May 3 (p. 175).

President's Party with Buffet

The party honoring the President will be a buffet supper followed by entertainment with a Spanish flavor—all with the charm and atmosphere of "A Night in Old San Antonio." This gay evening will take place Tuesday, May 4, at La Villita, corner of South Presa and Villita Streets. The buffet will be served from 7:30 to 9:30 p. m., and the entertainment will be given thereafter. Eddie Martinez and his company of 18 performers will appear in twelve different numbers, with Rosita, San Antonio's well-known Spanish TV songstress, as one of the featured players. From 10:30 p. m. until 12:00 midnight the orchestra will play for dancing.

All members of the Association, Woman's Auxiliary, guests, and visitors are invited. Tickets at $6 each will be on sale near the Registration Desk until 2:00 p. m. the afternoon of the party. No refunds will be made after 12:00 noon. Tickets will be required for supper, but those who come at 9:30 p. m. for the entertainment only will not need tickets. Dress will be informal or cocktail.

In case of rain the party will be held in the Ballroom of the Plaza Hotel.

General Meeting Luncheon

The General Meeting Luncheon will be held Wednesday, May 5, at 12:30 p. m. in the Grand Ballroom, mezzanine floor, Gunter Hotel. Members of the Association and Woman's Auxiliary, guests, and visitors are invited. Tickets at $2 each will be on sale near the Registration Desk until 10:00 a. m. of the day of the luncheon. No refunds will be made after 9:00 a. m. that morning. Tickets will be required for admittance to the luncheon.

Alumni Banquets

Alumni banquets will be held beginning at 6:00 p. m., Monday, May 3. Tickets will be on sale Sunday, May 2, on the east mezzanine floor of the Gunter Hotel and Monday, May 3, in the foyer of the Municipal Auditorium. Dr. William D. Montgomery is general chairman.

The following banquets have been arranged:

The University of Texas Medical Branch, Colonial Room, Menger Hotel. Cocktails at 6:30 p. m. will precede a 7:30 p. m. dinner. Separate tickets for cocktails and the dinner will be on sale. Reservations can be made ahead of time by writing to the Alumni Association, Galveston. Dr. G. G. Passmore, chairman.

Baylor University College of Medicine, North Terrace, Gunter Hotel, Dr. C. C. Shotts, chairman.

Southwestern Medical School, Grand Ballroom Foyer, Gunter Hotel, Dr. J. Walter Park, III, chairman.

Tulane University, Cos House, 503 Villita Street, Dr. James E. Pridgen, chairman.

University of Arkansas, Cactus Room, Gunter Hotel, Dr. William M. Center, chairman.

Louisiana State University, Texas Room, Gunter Hotel, Dr. Mildred E. Ward, chairman.

University of Tennessee and Vanderbilt University, South Terrace, Gunter Hotel, Dr. Thomas H. Diseker, chairman.

Fraternity Parties

Fraternity parties will be held from 6:30 to 8:00 p. m., Tuesday, May 4. Tickets will be on sale Sunday, May 2, on the east mezzanine floor of the Gunter Hotel and Monday, May 3, in the foyer of the Municipal Auditorium. Dr. William J. Johnson, Jr., is general chairman.

The following parties have been arranged:

Alpha Kappa Kappa, Parlor A, Plaza Hotel, Dr. Edwin M. Sykes, Jr., chairman.

Nu Sigma Nu, Walnut Room, Plaza Hotel, Dr. Hugh P. Reveley, chairman.

Phi Beta Pi, Roof Garden, Plaza Hotel, Dr. S. Perry Post, Jr., chairman.

Phi Chi, Fiesta House, La Villita, Dr. James L. Mims, Jr., chairman.

Phi Delta Epsilon, Parlor B, Plaza Hotel, Dr. R. Bernard Pomerantz, chairman.

Phi Rho Sigma, Cos House, La Villita, Dr. John L. Matthews, chairman.

Theta Kappa Psi, Florian House, La Villita, Dr. William J. Fetzer, chairman.

Council on Scientific Work

A Council on Scientific Work breakfast for members of the council and section officers for the 1954 and 1955 annual sessions will be held in the Texas Room, Gunter Hotel, at 7:00 a. m. Tuesday, May 4, with the Texas Medical Association as host. A breakfast for the council and section secretaries for the 1954 and 1955 sessions will be held Wednesday, May 5, at the same hour and place.

Delegates to American Medical Association

A breakfast for delegates and alternate delegates to the American Medical Association will be held at 7:30 a. m., Sunday, May 2, in the Texas Room of the Gunter Hotel.

Past Presidents' Association

The annual Past Presidents' Association luncheon will be held in Mezzanine C, Gunter Hotel, at 12:00 noon, Monday, May 3. Dr. L. H. Reeves, Fort Worth, secretary of the association, is in charge of arrangements.

Fifty Year Club

The Fifty Year Club for physicians who have been in medical practice at least fifty years will meet for breakfast at 7:30 a. m., Tuesday, May 4, in Mezzanine B, Gunter Hotel. Dr. L. H. Reeves, Fort Worth, is in charge of arrangements.

Society of Life Insurance Medical Directors

The Society of Life Insurance Medical Directors of Texas will have a luncheon Tuesday, May 4, at 12:00 noon in the Texas Room of the Gunter Hotel. Dr. C. Frank Brown, Dallas, secretary, is making the arrangements.

Texas Geriatrics Society

A meeting to organize a Texas Geriatrics Society will be held at 8:00 p. m., Monday, May 3, in the Oriental Room of the Gunter Hotel. Interested members of the Texas Medical Association are invited. Arrangements are in charge of Dr. Henry H. Niehuss, Longview.

History of Texas Medical Association

"A History of the Texas Medical Association, 1853-1953" by Dr. P. I. Nixon, published by the University of Texas Press in cooperation with the Association in celebration of the centennial of the Association, will be on display and for sale on the east mezzanine floor of the Gunter Hotel, Sunday, May 2, and in the lower level of the Municipal Auditorium Monday through Wednesday, May 3-5.

Golf

The Texas Medical Association Golf Tournament will be held Monday, May 3, at 1:00 p. m. at the San Antonio Country Club. Further information may be obtained from the chairman of the Golf Committee, Dr. John B. Case, 625 Medical Arts Building. Prizes will be awarded.

GEORGE TURNER, M. D., El Paso.
Eighty-Eighth President, Texas Medical Association.

MRS. EDWARD W. COYLE, San Antonio.
President, Woman's Auxiliary to the Texas Medical Association.

F. J. L. BLASINGAME, M. D., Wharton.
President-Elect, Texas Medical Association.

MRS. MARK H. LATIMER, Houston.
President-Elect, Woman's Auxiliary to the Texas Medical Association.

GUEST SPEAKERS

SIMEON T. CANTRIL, M. D., F.A.C.R., Seattle, Wash.
Director, Tumor Institute of the Swedish Hospital; Associate Professor of Radiology, University of Washington School of Medicine; Consultant in Radiation Therapy, Veterans Administration and United States Public Health Service Hospitals; Regional Consultant, Atomic Energy Commission.

GEORGE T. HARRELL, JR., M. D., F.A.C.P., Gainesville, Fla.
Professor of Medicine and Dean, University of Florida College of Medicine.

HAROLD D. PALMER, M. D., F.A.C.P., F.C.A.P., Denver, Colo.
Pathologist and Medical Director, Children's Hospital of Denver; Associate Professor of Pathology, University of Colorado School of Medicine and Graduate College.

WILLIAM ALAN RICHARDSON, Rutherford, N. J.
Editor, *Medical Economics.*

ROBERT L. SANDERS, M. D., LL.D., F.A.C.S., Memphis, Tenn.
Senior Surgeon, Baptist Memorial Hospital; Professor of Surgery (inactive), University of Tennessee College of Medicine.

E. STEWART TAYLOR, M. D.,
Denver, Colo.
Professor and Head of Department of Obstetrics, University of Colorado School of Medicine.

OPENING EXERCISES, MEMORIAL SERVICES, AND GENERAL MEETING

Monday, May 3

8:45 a. m. to 9:40 a. m.

Room A, Municipal Auditorium

GEORGE TURNER, El Paso, President, Presiding

1. (8:45) *Prayer.*
THE REV. GEORGE MAUZE, D.D., Pastor, First Presbyterian Church, San Antonio.
2. (8:50) *"Twenty-Third Psalm" (Malotte).*
MR. MORRIS WHITEHEAD, San Antonio.
3. (8:55) *Memorial Address for Deceased Members of Woman's Auxiliary.*
MRS. G. V. BRINDLEY, Temple.
4. (9:00) *Memorial Address for Deceased Physicians: In Memoriam.*
THE REV. E. J. GREGORY, Superintendent, Mexican Baptist Orphans Home of Texas, San Antonio.
5. (9:05) *Introductions.*
F. J. L. Blasingame, Wharton, President-Elect, Texas Medical Association.
Mrs. Mark H. Latimer, Houston, President-Elect, Woman's Auxiliary to the Texas Medical Association.
Merton M. Minter, San Antonio, President, Bexar County Medical Society.
Mrs. John C. Parsons, San Antonio, President, Woman's Auxiliary to Bexar County Medical Society.
Mrs. Leo J. Schaefer, Salina, Kan., President, Woman's Auxiliary to American Medical Association.
Mrs. George D. Feldner, New Orleans, La., President, Woman's Auxiliary to Southern Medical Association.
L. Bonham Jones, San Antonio, Chairman, Committee on General Arrangements for Annual Session.
B. F. Stout, San Antonio, Chairman, Committee on Memorial Services.
6. (9:10) *Address of Auxiliary President.*
MRS. EDWARD W. COYLE, San Antonio.
7. (9:20) *Address of President.* GEORGE TURNER, El Paso.

EXPECTING A GOOD TIME?

Make Hotel Reservations Now,

Then Buy Tickets for Social Functions Immediately upon Arrival in San Antonio

Plan to Stay for the Full Session

SECTION A (MEDICAL)

General Practice, Internal Medicine, Public Health, Clinical Pathology, Pediatrics

Chairman—John R. Winston, Temple.

Co-Chairman—Richard E. Nitschke, San Antonio.

Secretary—Robert A. Gardner, Houston.

TUESDAY, MAY 4

Room A, Municipal Auditorium

8:00 a. m. to 8:30 a. m.

1. *Motion Picture: Congenital Malformations of the Heart; Cyanotic Congenital Heart Disease* (University of Washington, Seattle).

8:30 a. m. to 10:00 a. m.

John R. Winston, Temple, Presiding

2. (8:30) *Clinical Evaluation and Management of Liver Diseases.* RICHARD D. HAINES and J. A. COLEMAN, JR., Temple.

This is a review of the pertinent disturbed mechanisms in hepatic insufficiency, including carbohydrate, protein, and vitamin metabolism; altered hormonal balance; and salt and water derangements. Current concepts of treatment relative to these disturbed functions are stressed including value of diet (salt restricted), lipotropic substances, hormones, liver extract, diuretics, and resins.

3. (8:50) *Clinical Evaluation and Management of the Painful Joint.* HOWARD COGGESHALL, Dallas.

The following topics are discussed: (1) Diagnostic consideration of joint pain. (2) Monarticular pain caused by traumatic lesions, neoplastic disease, degenerative joint disease, septic joint disease, neuropathic joint disease, and rheumatoid arthritis. Then comes a consideration of the most common joint involvement and recent developments in therapy such as injections of hydrocortisone into joints and Benamid or Butazolidine for gout.

4. (9:10) *Clinical Evaluation and Management of Metabolic Bone Diseases.*
MAVIS P. KELSEY, Houston.

Rare metabolic bone diseases are mentioned mainly for diagnostic exclusion while the everyday problems of bone disease are emphasized. Osteoporosis is extremely common postmenopause and during senility and shows therapeutic response to estrogens and androgens. Parathyroid adenoma should be excluded in every case of renal stones and should be diagnosed long before serious renal or bone damage occurs. Diagnostic features of Paget's disease, fibrous dysplasia, myeloma, and widespread malignancy are discussed.

5. (9:30) *Clinical Evaluation of I^{131} as a Diagnostic and Therapeutic Agent.* RALPH CLAYTON, Dallas.

The properties of radioactive iodine (I^{131}) which make it valuable in clinical medicine are reviewed briefly. Because its greatest use is in the diagnosis and treatment of thyroid diseases, the major portion of the discussion concerns its current value in this field. Other practical uses of I^{131} in everyday practice are mentioned in broad principle. Detailed theory is omitted.

6. (9:50) *Questions and Answers.*

10:00 a. m. to 10:30 a. m.

7. *Recess to Visit Exhibits.*

10:30 a. m. to 12:00 noon

A. J. Gill, Dallas, Presiding

8. *Announcement of Scientific Exhibit Awards.*

9. (10:30) *Symposium: Problems in Blood Transfusion.*
a. (10:30) *Relationship of the Physician to the Problems of Blood Banking.*
JARRETT E. WILLIAMS, Abilene.

As blood transfusion therapy became safer and more popular, the physician began to relinquish the technical aspects to medical technologists or special physicians. With the advent of blood banks the physician began to order blood without acquainting the patient with the necessity of replacing the blood. The loss of the physician-patient relationship in blood procurement and transfusion may take blood banking entirely away from the medical profession with which it appears properly to belong. This is an appeal to maintain this relationship that patients and public may be better protected.

b. (10:50) *Modern Techniques in Crossmatching.*
O. J. WOLLENMAN, JR., Fort Worth.

Included is discussion of the accepted methods of crossmatching, possible errors in procedures, and interpretation of results. Special emphasis is placed on accurate identification of recipient, ideal technical methods of crossmatching, other factors producing agglutination, and the keeping of adequate records.

c. (11:10) *Minor Incompatibilities of Blood Transfusions.*
E. E. MUIRHEAD, Dallas.

Incompatible blood transfusions result from an increased rate of destruction of red blood cells due to the action of antibodies. This report enlarges on the various aspects of incompatible transfusions with emphasis on identification and differential diagnosis of minor incompatible blood transfusions.

10. (11:30) *What Makes the Doctor-Patient Relationship Tick.* WILLIAM ALAN RICHARDSON, Rutherford, N. J.

12:00 noon to 1:30 p. m.

11. *Recess for Luncheon.*

1:30 p. m. to 2:00 p. m.

12. *Motion Picture: Steps of Age* (International Film Bureau, Chicago).

The problems of old age from a social, economic, and psychologic standpoint are considered.

2:00 p. m. to 3:30 p. m.

Maurice A. Roe, Dallas, and Austin E. Hill, Houston, Presiding

13. (2:00) *Symposium: Geriatrics.*
a. (2:00) *Medical Care and Social and Economic Problems of the Aged.*
O. M. PHILLIPS, Fort Worth.

The life span has been increased, and the percentage of older people is growing. Because of this, we are faced with many problems. Facilities for proper care of the aged are inadequate, from both a social and an economic standpoint. Many states, communities, and private enterprise are becoming more aware of the situation. One particular project for the aged is discussed.

b. (2:20) *Public Health Aspects of the Aging Population.*
MAURICE A. ROE, Dallas.

Important public health problems affecting the aged are discussed with special reference to abnormal conditions or diseases considered preventable or controllable, particularly through programs of public agencies. Special emphasis is given on home accidents, diabetes, tuberculosis, venereal disease, cancer, obesity, nutritional disorders, anemias, and cardiovascular conditions to stress the importance of their recognition as well as prevention.

c. (2:40) *Modern Concepts of Physiologic Changes with Old Age.*
ROBERT A. HETTIG, Houston.

d. (3:00) *Psychiatric Aspects in Care of the Aged.*
MELBOURNE J. COOPER, San Antonio.

Care of the aged in the home requires careful attention to psychiatric needs. In addition to physical necessities, such as good diet, hygiene, and rest, the person's health and happiness demand emotional satisfactions. Such emotional necessities include a stabilized home environment; identification with both a home and a social group; an attitude of affection, respect, and tolerance on the part of others; and a planned program of work and recreation suitable to the person's capacities.

14. (3:20) *Questions and Answers.*

3:30 p. m. to 4:00 p. m.

15. *Recess to Visit Exhibits.*

4:00 p. m. to 5:30 p. m.

John A. Welty, Harlingen, Presiding

16. (4:00) *Changing Concepts in the Purpuric Syndrome.*
HAROLD D. PALMER, Denver, Colo.

With the development of the concept of immunohemolytic disease as applied in the various syndromes of acquired hemolytic anemia have come various laboratory methods of study which permit one to establish the presence of antibodies. These methods have been applied to purpuric diseases. This paper develops the information which leads to the conclusion that idiopathic thrombocytopenic purpura is also a manifestation of autoimmunization.

17. (4:30) *Myxedema* (motion picture).
GEORGE T. HARRELL, Gainesville, Fla.

Myxedema is a condition which is easily diagnosed clinically from the symptoms and signs. It is unfortunate that it is so frequently overlooked until irreversible damage has been done by the development of arteriosclerosis. Oral thyroid replacement therapy is easily controlled and is effective in restoring the patient to a happy and useful life. If the disease is recognized early and treatment is carefully carried out, patients with myxedema are among the most satisfying that a physician can have.

18. (5:00) *Effect of Potassium Depletion in Essential Hypertension.* ARTHUR RUSKIN, Galveston.

Potassium depletion was accomplished in 22 cases of uncomplicated essential hypertension by (1) low potassium diet, (2) oral administration of a potassium-free cation exchange resin, and (3) rare injections of mercaptomerin. The arterial pressures fell 30 mm. systolic and 20 mm. diastolic in the majority of cases, parallel to the developing hypopotassemia.

19. (5:20) *Questions and Answers.*

WEDNESDAY, MAY 5

Room A, Municipal Auditorium

8:00 a. m. to 8:30 a. m.

20. *Motion Picture: Tuberculosis of the Larynx, Tracheobronchial Tree, and Esophagus* (Holinger Memorial Fund, Chicago).

This film consists of endoscopic photographs of laryngeal, bronchial, and esophageal tuberculosis.

8:30 a. m. to 10:00 a. m.

Sheldon M. Tucker, Houston, Presiding

21. (8:30) *Symposium: Current Trends of Therapeutics.*
a. (8:30) *Bacterial Filtrates in the Treatment of Allergic Diseases.*
JACK M. ROSE, Houston.

A series of 35 patients were treated with bacterial filtrates. In all, the infectious component was of primary importance in producing manifestation of either asthma or allergic rhinitis. All had been previously treated unsuccessfully with other forms of therapy including vaccines and hyposensitization. The rationale of therapy, skin testing in bacterial hypersensitivity, and the results of treatment are discussed.

b. (8:45) *Recent Additions to the Therapy of Neurologic Conditions.*
F. KEITH BRADFORD, Houston.

Progress in the antibiotic field has continued to aid in combating infections of the central nervous system. Further experience with

older antibiotics, in many instances, has been as important as the development of new ones. Cortisone and ACTH appear promising in the treatment of polyneuritis of the Guillain-Barré type and in the treatment of early Bell's palsy, although they have failed to alter the course of multiple sclerosis and other more prevalent neurologic illnesses.

c. (9:00) *Some Complications of Antimicrobial Therapy.*
JESSE W. HOFER, Houston.

The widespread use of antimicrobial agents may have resolved many perplexing problems of infectious diseases. Yet new and more perplexing problems have been created. Among these are the untoward effects which have been increasing progressively. Some of these are directly toxic, some allergic, and some related to the biologic activities of the specific antibiotics. This discussion attempts to classify the complications of antimicrobial agents according to different organ systems.

d. (9:15) *Need for Therapeutic Skepticism.*
WILLIAM H. GORDON, Lubbock.

Osler was known as a therapeutic nihilist, yet he considered himself a therapeutic skeptic. Although many present day drugs and biologicals are marvelously effective when used properly, the practice is to treat first and diagnose later, if at all. Many of the better drugs are being prostituted to the detriment of the patient occasionally, and to the medical profession often. The author's views regarding the need for some of Osler's healthy therapeutic skepticism are presented.

22. (9:30) *Role of Radiation Therapy in the Treatment of Lymphomas.*
SIMEON T. CANTRIL, Seattle, Wash.

Radiation therapy, primarily roentgen therapy, has long been the chief agent in the treatment of lymphomas (Hodgkin's disease, lymphosarcoma, giant follicle lymphoma, and reticulum cell sarcoma). Decisions for irradiation and its course are influenced by the type of lymphoma, the presenting clinical state, and the anticipated natural course of the disease. The place of chemotherapy and radioisotopes as adjuncts to x-ray therapy is discussed. Case presentations illustrate the management of the more common clinical states.

23. *Questions and Answers.*

10:00 a. m. to 10:30 a. m.

24. *Recess to Visit Exhibits.*

10:30 a. m. to 12:00 noon

Richard E. Nitschke, San Antonio, Presiding

25. (10:30) *Panel Discussion: Cortisone, Hydrocortisone, and ACTH.*

a. (10:30) *Their Nature.*
CHARLES I. SPURR, Houston.

b. (10:42) *Uses in Rheumatoid Arthritis and Rheumatic Fever.*
W. W. BONDURANT, JR., San Antonio.

c. (10:54) *Uses in Allergic Conditions.*
WILLIAM C. GRATER, Dallas.

d. (11:06) *Uses in Hematologic and Neoplastic Diseases.*
HAROLD D. PALMER, Denver, Colo.

e. (11:18) *Complications and Contraindications.*
GEORGE T. HARRELL, Gainesville, Fla.

26. (11:30) *Questions and Answers.*

A HISTORY OF
THE TEXAS MEDICAL ASSOCIATION
1853-1953
by PAT I. NIXON, M. D., San Antonio
will be on display and for sale
Gunter Hotel, May 2—Municipal Auditorium, May 3-5

SECTION B (SURGICAL)

General Practice; Surgery; Obstetrics and Gynecology; Eye, Ear, Nose, and Throat; Radiology

Chairman—O. W. English, Lubbock.
Secretary—Robert F. Short, Jr., Dallas.

TUESDAY, MAY 4

Room B, Municipal Auditorium

8:00 a. m. to 8:30 a. m.

1. *Motion Picture: Fractures of the Humerus* (Veterans Administration).

8:30 a. m. to 10:00 a. m.

Van D. Goodall, Clifton, Presiding

2. (8:30) *Midforceps Operations.*
E. STEWART TAYLOR, Denver, Colo.

Advances in obstetrics have brought a gradual decrease in use of the midforceps operation. It has long been recognized that forceps operations done when the vertex is at the level of the midpelvis carry a high fetal and maternal risk. Until recently cesarean section after several hours of labor was extremely dangerous, and midforceps delivery, internal version, and craniotomy were the only procedures available for delivery when spontaneous descent of the vertex to below the ischial spines failed to occur. It is the purpose of this paper to show how infrequently midforceps operations need be elected in modern obstetric practice.

3. (9:00) *The Bone Graft in Reconstructive Surgery.*
T. WILEY HODGES, Dallas.

This paper discusses the types of bone grafts employed in reparative surgery for injuries, deformities and defects; indications and contraindications for each type; and the histologic and physiologic behavior of grafts formed of cortical and of cancellous bone. Healing time to be anticipated for each major type of graft is given. Proper preparation of the graft bed is emphasized. The causes of nonunion of fractures with appropriate treatments are discussed, with remarks on proper postoperative care and protection of the grafted bone.

4. (9:20) *Better PR—The Detour Around Socialized Medicine.* WILLIAM ALAN RICHARDSON, Rutherford, N. J.

5. (9:50) *Questions and Answers.*

10:00 a. m. to 10:30 a. m.

6. *Recess to Visit Exhibits.*

10:30 a. m. to 12:00 noon

Ernest E. Anthony, Fort Worth, Presiding

7. *Announcement of Scientific Exhibit Awards.*

8. (10:30) *Panel Discussion: Acute Infections Complicating Pregnancy.*
Moderator: S. FOSTER MOORE, JR., San Antonio.
Panel: H. FRANK CONNALLY, JR., Waco; A. LOUIS DIPPEL, Houston; ROBERT P. MCDONALD, Fort Worth; WILLIAM F. MENGERT, Dallas.

9. (11:30) *Endocrine Treatment of Gynecologic Problems.*
E. STEWART TAYLOR, Denver, Colo.

10. *Questions and Answers.*

12:00 noon to 1:30 p. m.

11. *Recess for Luncheon.*

1:30 p. m. to 2:00 p. m.

12. *Motion Picture: A Bronchoscopic Clinic* (Holinger Memorial Fund, Chicago).

The case histories, roentgenograms, bronchoscopic findings, and histology of 10 patients with bronchopulmonary disease are presented.

2:00 p. m. to 3:30 p. m.

Oliver W. Suehs, Austin, Presiding

13. (2:00) *Treatment of Acute Ophthalmic Injuries.* HAL W. MAXWELL, Dallas.

Abrasions and eyes irritated by extraocular foreign bodies, after removal of the foreign matter, should have antibiotics and patching. Contusions are best treated by splinting the eye with cycloplegics. Lacerations of the lid and globe require plastic repair by an ophthalmic surgeon during the first forty-eight hours. Mild thermal burns heal quickly with patching; severe ones may require skin and conjunctival grafts. Chemical burns should be copiously lavaged with watery solution, removing foreign substances. With any eye injury, antitetanus booster injections, cycloplegics, antibiotics, cortisone, patching, and surgery should be considered.

(2:20) Discussion—
JAMES P. ADERHOLD, San Antonio.

Hal W. Maxwell, Dallas, Presiding

14. (2:30) *Management of Recent Nasal Fractures.* WILLIAM K. WRIGHT and FREDERICK R. GUILFORD, Houston.

Nasal fractures are frequently mishandled because they are overlooked or not reduced at the proper time. Proper technique in reduction and adequate care of associated injuries are important. A logical method of handling these cases and a reduction technique based on a simple classification of fractures are presented.

(2:50) Discussion—
CHARLES ENGELKING, San Angelo.

15. (3:00) *Diagnosis and Treatment of Inhalant Allergy.* DOR W. BROWN, Fredericksburg.

Slides giving a brief review of the techniques used in the diagnosis and treatment of inhalant allergy are presented. Skin titration is then explained in detail for seasonal and perennial allergens. Kodachrome slides of the physical facilities for testing and treatment and slides of the etiology of inhalant allergens including dusts, molds, and plants are shown.

16. (3:20) *Questions and Answers.*

3:30 p. m. to 4:00 p. m.

17. *Recess to Visit Exhibits.*

4:00 p. m. to 5:30 p. m.

Royal Wertz, Amarillo, Presiding

18. (4:00) *Radiation Therapy in Management of Cutaneous Hemangiomas.* SIMEON T. CANTRIL, Seattle, Wash.

Radiation is one of several methods for treatment of hemangiomas. The method should be selected for the individual case and particularly with a view to whether any treatment other than the natural tendency to spontaneous regression will be required. The discussion outlines the common forms of hemangiomas seen in more than 500 cases referred for radiation therapy. A considerable proportion received no therapy or were treated by means other than irradiation. Cases demonstrate the more common varieties requiring therapy and the varied techniques of irradiation utilized. The presentation also emphasizes the importance of extended time in taking advantage of the natural tendency to thrombosis and regression which, however, may require the stimulus of irradiation for its initiation. Indications for surgical management of hemangiomas also are discussed, and specific illustrative cases are included.

19. (4:20) *Study of the Gallbladder and the Common Duct by Oral Dye.* HERMAN C. SEHESTED, Fort Worth.

Increased density of the shadows with the newer dyes and correct stimulation of motility and timing of films allows visualization of the gallbladder and cystic and common ducts in a higb percentage of cases. The significance of the findings in organic and functional disturbances of the extrahepatic biliary system is discussed. The danger of basing a diagnosis on negative findings is pointed out. Technical procedures for increasing the positive findings are methods to increase the density of the dye in the gallbladder, variations in positioning, spot filming, and laminography.

(4:35) Discussion—
EVERETT E. SEEDORF, Temple.

20. (4:40) *Duodenal Ulceration in Children.* LESLIE L. LEMAK, JOHN E. MARTIN, and PALMER E. WIGBY, Houston.

Two cases of duodenal ulceration in 10 year old girls are presented, showing roentgen evidence of the disease. Problems of diagnosis from a roentgen standpoint are discussed briefly. A short review of the literature concerning etiology of the disease is given.

(5:00) Discussion—
ALBERT G. BARSH, Lubbock.

21. (5:05) *Appraisal of McWhirter Technique in Breast Surgery.* VINCENT P. COLLINS, Houston.

The role of radiotherapy in treatment of breast cancer bas been warmly debated. Taylor has denied its value in preventing recurrences or in prolonging survival when used in conjunction with radical mastectomy. McWhirter has questioned the usefulness of radical mastectomy and, relying on simple mastectomy and radiotherapy, has produced ten year results which appear to equal those of conventional surgery. An attempt is made to reconcile these opposing views.

(5:25) Discussion.

WEDNESDAY, MAY 5

Room B, Municipal Auditorium

8:00 a. m. to 8:30 a. m.

22. *Motion Picture: Surgical Approaches to the Sternoclavicular and Acromioclavicular Joints* (Churchill-Wexler Films, Los Angeles).

8:30 a. m. to 10:00 a. m.

O. W. English, Lubbock, Presiding

23. (8:30) *Surgery on the Aged.* JOHN V. GOODE, Dallas.

This paper discusses the physiologic changes that take place with advancing age and factors influencing a decision to operate in (1) diseases immediately dangerous to life, (2) those dangerous but not immediately so, and (3) those not dangerous but uncomfortable. Emphasis is on preoperative, operative, and postoperative treatment, with establishment of a diagnosis, general points about the operation itself, and the psychiatric side of postoperative care receiving special attention.

24. (8:50) *Benign Tumors of the Breast.* FRANK SELECMAN, Dallas.

A simple classification of benign breast tumors is presented. Etiologic factors such as bormones, nervous influences, and beredity are discussed with review of experimental and clinical studies. Age incidence, diagnosis, pathology, and treatment of the various forms of mammary dysplasia are discussed. Statistics on the relation of benign tumors to carcinoma are presented. Simple mastectomy is shown to be seldom indicated. Practical points in handling patients are presented.

25. (9:10) *Cholecystic Disease and Its Complications.* ROBERT L. SANDERS, Memphis, Tenn.

This paper deals with (1) tbe distinction between noncalculous and calculous cholecystitis and the indications for operation in eacb type; (2) the mechanism and diagnosis of acute cbolecystitis and the question of immediate or delayed operation; (3) the deleterious effects of prolonged obstruction of the ducts on the liver, pancreas, and ducts; (4) considerations involved in the choice of the operation upon the gallbladder and in the technical performance; (5) the criteria for choledochostomy; and (6) the principles and cbief points in the technique of choledochoduodenostomy.

26. (9:40) *Questions and Answers.*

10:00 a. m. to 10:30 a. m.

27. *Recess to Visit Exhibits.*

10:30 a. m. to 12:00 noon

Robert F. Short, Jr., Dallas, Presiding

28. (10:30) *Symposium: Lesions of the Upper Gastrointestinal Tract.*

a. (10:30) *Roentgen Examination of the Upper Gastrointestinal Tract.* J. E. MILLER, Dallas.

Conventional fluoroscopic and radiographic examination of the upper gastrointestinal tract is the safest and most informative study

of this system. This discussion concerns technical factors necessary to produce an adequate roentgen examination of the upper gastrointestinal tract. An attempt also is made to define the limitations of the roentgen examination of the gastrointestinal tract.

b. (10:50) *Lesions of the Esophagus.*
MILTON V. DAVIS, Dallas.

Congenital lesions including atresia of the esophagus with and without tracheoesophageal fistula, congenital strictures of the esophagus, congenitally short esophagus, and vascular ring anomalies constricting the esophagus; non-neoplastic acquired lesions, including diverticulum of the hypopharynx, foreign bodies, caustic burns, and strictures, achalasia of the esophagus, and esophagitis; and neoplastic acquired lesions including benign and malignant tumors are discussed.

c. (11:10) *Discussion of Lesions of the Upper Gastrointestinal Tract.*
ROBERT L. SANDERS, Memphis, Tenn.

29. (11:40) *Questions and Answers.*

GENERAL MEETING LUNCHEON

Wednesday, May 5

12:30 p. m. to 2:40 p. m.

Grand Ballroom, Gunter Hotel

GEORGE TURNER, El Paso, President, Presiding

1. (12:30) *Luncheon.*
2. (1:30) *Introductions.*
President-Elect, Texas Medical Association.
President-Elect, Woman's Auxiliary to Texas Medical Association.
General Practitioner of the Year.
3. (1:35) *Report of Activities of House of Delegates.*
H. O. DEATON, Fort Worth, Speaker.
4. (1:45) *Address of Incoming President: Medical Leadership.* F. J. L. BLASINGAME, Wharton.
5. (2:05) *Address.*
GUEST SPEAKER.
6. (2:35) *Presentation of Gavel and of Past Presidents' Medallion.*

EXHIBITS

SCIENTIFIC EXHIBITS

The scientific exhibits will be displayed in the lower level of the Municipal Auditorium. Awards of merit will be given for the best scientific exhibits by an individual and by an institution.

A list of exhibits follows:

BRONCHOGENIC CARCINOMA SIMULATING BENIGN PULMONARY DISEASE (Dr. G. V. Brindley, Jr., Scott and White Clinic, Temple). This exhibit contains photographs of roentgenograms and pathologic moulages.

NEW TREATMENT FOR VAGINAL AND CERVICAL LEUKORRHEA (Dr. Karl John Karnaky, Houston). Drawings of interest to physicians doing gynecology are presented.

THE IMPORTANCE OF BLOOD IN THE URINE (Dr. Michael K. O'Heeron, Dr. James R. Fish, Dr. Richard Harrison, and Dr. James Boren, Houston). Mounted pictures, charts, printed material, and photographs describe the importance of hematuria.

TUMORS OF INFANTS AND CHILDREN (Dr. Luke W. Able, Houston). This is a display of photographs of various tumors, both in situ and excised, preoperative and postoperative, and diagnostic aids and treatment.

DIAGNOSIS AND TREATMENT OF LEPROSY (United States Public Health Service Hospital, Carville, La.; Texas State Department of Health; Dr. Fred C. Kluth, Corpus Christi). This exhibit gives diagnostic points, procedures, and clinical and statistical observation on various types of treatment.

VALUE OF SCALENE NODE BIOPSY (Dr. Lawrence M. Shefts, San Antonio). This display shows a number of roentgenograms, drawings, and statistical tables demonstrating the value of scalene node biopsy.

MUSCLE TRANSPOSITION IN POST-POLIOMYELITIC FOOT (Dr. Richard DeYoung, Houston). Photographs deal with indications, procedures, and results of muscle transposition.

SURGICAL CORRECTION OF CONGENITAL ANOMALIES (Dr. T. G. Blocker, Jr., Dr. Stephen R. Lewis, and Dr. C. C. Snyder, Galveston). This display depicts preoperative and postoperative congenital anomalies such as absence of the vagina, loss of anal sphincter, cysts, sinuses, hemangiomas, and defects of face and scalp, and the results of surgical correction.

BODY SECTION RADIOGRAPHY (Dr. Francis E. O'Neill, Dr. Alvin Thaggard, Jr., and Dr. Jerome J. Wiesner, San Antonio). This is a visual demonstration of roentgenograms and descriptive placards of body section radiography of the lungs, skull, bones, and urinary tract.

ACTIVE IMMUNIZATION IN POLIOMYELITIS (Dr. Hart E. Van Riper, National Foundation for Infantile Paralysis, New York). The exhibit presents material on research leading to the development of a vaccine, minimal standards for production of a vaccine, and how the results of the vaccine trials will be evaluated.

KISSING BUG BITE, ITS RELATIONSHIP TO CHAGAS' DISEASE (Dr. E. N. Walsh and Dr. T. L. Shields, Fort Worth). This display is made up of placards and Kodachrome pictures which explain the relationship of the kissing bug and Chagas' disease.

TECHNIQUE OF PHYSICAL EXERCISE IN THE TREATMENT OF BRONCHIAL ASTHMA (Dr. Bernard T. Fein and Miss Eugenia P. Cox, San Antonio). The exhibit presents a technique of respiratory and physical exercise employed as a supplementary measure in the treatment of bronchial asthma.

COULD YOU USE PHYSICAL THERAPY? (Texas Chapter, American Physical Therapy Association, Miss Laura K. Smith, Houston). The exhibit shows how physical therapy is useful in orthopedics, neurology, pediatrics, internal medicine, and dermatology.

FREEDOM EXHIBIT (Association of American Physicians and Surgeons, Dr. Ernest E. Anthony, Fort Worth). This exhibit consists of placards on socialism, AAPS essay contest material, information for interns and residents, and bulletins and freedom literature.

ASSISTIVE DEVICES IN REHABILITATION OF UPPER EXTREMITY DISABILITIES (Dr. Odon F. Von Werssowetz, Miss Betty Schlosser, and Miss Rose Elliott, Gonzales Warm Springs Foundation, Gonzales). This is an exhibit and demonstration of devices used in the treatment of injury or disabilities resulting from disease and accidents such as hemiplegia, poliomyelitis, and multiple sclerosis.

AMERICAN ASSOCIATION OF BLOOD BANKS (Miss Marjorie Saunders, Dallas). The exhibit is designed to show the doctor, technologist, nurse, and researcher as well as administrative personnel of hospitals and blood banks how a good blood bank can be set up, what it can accomplish, and how the association can be of assistance in the setting up and improvement of the blood bank activities. An outline of a national blood bank clearinghouse also will be displayed.

LUNG CANCER (American Cancer Society, Texas Division, J. Louis Neff, Executive Director, Austin).

CORNEAL TRANSPLANTATION (Dr. Louis Daily, Jr., and Dr. Ray K. Daily, Houston).

OPERATIVE AND POSTOPERATIVE CHOLANGIOGRAPHY (Dr. R. P. O'Bannon and Dr. Otto H. Grunow, Fort Worth and Arlington). The exhibit contains radiographs, photographs, and legends detailing the method of examination and the merits and demerits of the two types of examinations.

Motion Pictures

Instead of continuous showing of motion pictures in a separate theater, as has been customary in previous years, selected films are included as a part of the scientific programs of Section A (Medical) and Section B (Surgical). Reference to these section programs will indicate the titles and hours of presentation of films (pp. 175 and 177).

TECHNICAL EXHIBITS

The technical exhibits will be displayed in the lower level of the Municipal Auditorium. These exhibits provide much of educational value for the physician. Without the armamentarium furnished by the concerns which exhibit at annual sessions, doctors would be seriously handicapped in the practice of scientific medicine. These exhibits are worth all the time and attention registrants at the sessions can give them. They should be visited without fail sometime between Monday morning, May 3, and Wednesday noon, May 5. Recesses in the program have been provided Tuesday and Wednesday from 10:00 to 10:30 a. m. and Tuesday from 3:30 to 4:00 p. m. to assure opportunity for everyone to view the exhibits.

An alphabetical list of exhibitors follows:

Abbott Laboratories, North Chicago, Booth 64

Erythrocin (Erythromycin, Abbott) will be displayed by Abbott Laboratories. Erythrocin, a new wide range antibiotic effective against a variety of organisms, especially against gram-positive ones, is indicated for treatment of infections such as pharyngitis, tonsillitis, scarlet fever, erysipelas, and pneumococcic pneumonia. The Abbott product is a small tablet specially coated to mask the bitter taste of the drug and effect higher blood concentrations. Erythrocin is effective against some strains of pathogenic organisms not responsive to penicillin or to other antibiotics.

Alcon Laboratories, Inc., Fort Worth, Booth 13

Alcon-efrin, Alcon's nonstinging and nonirritating nasal decongestant, supplied in three strengths, will be exhibited at booth 13 along with sterile ophthalmic solutions. In addition to Zincfrin, Op-thal-zin, Isopto Cetamide, and Isopto Alkaline—three new specialties for the treatment and control of glaucoma, namely, Isopto Carpine 1 per cent, Isopto Carpine 2 per cent, and Isopto Eserine .5 per cent, supplied in Drop-tainer (Alcon's new ophthalmic dropper container), will be displayed.

A. S. Aloe Company, St. Louis, Booth 74

Physicians are invited to visit booth 74, where the Aloe representative will show a cross section of the complete line of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline—tomorrow's treatment room furniture today—featuring the body contour table top, magnetic door catches, and advanced design, all in new decorators' colors.

American Medical Education Foundation, Chicago, Booth 56

Mr. Hiram Jones, executive secretary of the American Medical Education Foundation, will be at booth 56 to discuss the foundation with members and guests of the Texas Medical Association. Because of a growing disproportion between the rising costs associated with inflation and the decrease in income from endowments and fewer large benefactions contributed for basic educational needs, the foundation was organized in 1950 as an instrument through which contributions could be made in support of medical education. The state chairman is Dr. S. W. Thorn, Houston.

Audio-Digest Foundation, Glendale, Calif., Booth 57

The Audio-Digest Foundation, a nonprofit subsidiary of the California Medical Association, was established recently to further postgraduate medical education by means of tape recorded abstracts from current scientific literature and tape recorded lectures and panel discussions by medical and surgical authorities. The foundation will present an exhibit at booth 57.

Baby Development Clinic, Chicago, Booth 67

A maternity counseling service, offering demonstration material to aid in teaching expectant mothers care and support of the breast, support of abdomen and relief of back strain, and personal cleanliness, will be presented by the Baby Development Clinic. Preparation for infant and child care and aids on bathing, feeding, and toileting, as well as care of feet, also will be demonstrated. Material will be available for well baby conferences.

The Baker Laboratories, Inc., Cleveland, Booth 68

Physicians are invited to visit the Baker booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, will be on display. Baker representatives will be glad to discuss the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins, and other important factors which help to eliminate many problems in modern infant feeding.

Ballard Surgical Supply Company, San Antonio, Booth 33

Ballard Surgical Supply Company will exhibit its products in booth 33.

The Borden Company, New York, Booth 22

Physicians are invited to talk over the latest information on infant feeding at the Borden prescription products booth. On display will be the complete line of Borden's infant formula products for every feeding purpose or preference. Almost any baby can be fed Bremil, Mullsoy, Dryco, or Biolac.

George A. Breon and Company, New York, Booth 30

George A. Breon and Company, distributors of Lanteen products, invites convention members to its exhibit of reproductions of well-known paintings by famous European artists at booth 30. Lithographic prints of these beautiful paintings will be available on request. Representatives also will be happy to discuss Lanteen products with physicians.

Brown Schools for Exceptional Children, Austin and San Marcos, Booth 58

Brown Schools for Exceptional Children, of Austin and San Marcos, Texas, private schools for children with educational and emotional difficulties, will exhibit scale models of their six residential units along with materials describing their facilities and services. Representatives of the schools will be available for consultation, and materials will be distributed.

Carnation Company, Los Angeles, Booth 69

At booth 69 physicians may see an attractive display on Carnation Evaporated Milk—"the milk every doctor knows." Some valuable information on the use of this milk for in-

fant feeding, child feeding, and general diet will be explained as well as the reasons why Carnation Milk deserves consideration as the first choice for infant formulas. Interesting and valuable literature also will be available.

Charles Pharmacy, San Antonio, Booth 28

The exhibit in booth 28 will be presented by Charles Pharmacy of San Antonio.

Ciba Pharmaceutical Products, Inc., Summit, N. J., Booth 38

The Ciba exhibit will feature Apresoline, a phthalazine derivative which is an orally effective and relatively safe therapy in hypertension of diverse etiology. Representatives in attendance will be glad to discuss and to provide literature on this and other Ciba products.

Coca-Cola Bottling Company, Booth 12

The Coca-Cola Bottling Company will occupy booth 12 at the annual session in San Antonio.

Curtis Surgical Supply Company, Waco, Booth 20

The Curtis Surgical Supply Company will have on display some of the latest diagnostic equipment and surgical instruments of interest to the medical profession.

Cutter Laboratories, Berkeley, Calif., Booth 55

Cutter Laboratories, booth 55, will display Alhydrox adsorbed toxoids and combined vaccines as well as the exclusive human blood fractions—Albumin, Hypertussis, and the new human fibrinogen, Parenogen. Also on exhibit will be the complete Cutter Saftiflask Solutions line, featuring the Saftitab Stopper—safer because it is solid, yet with open stopper convenience. The new built-in Bend-the-Blue Safticlamp on intravenous and blood and plasma infusion equipment will be demonstrated.

Eaton Laboratories, Inc., Norwich, N. Y., Booth 62

Furadantin®(N.N.R.), the new chemotherapeutic nitrofuran for treatment of urinary tract infections, will be emphasized. The latest clinical reports prove its rapid effectiveness against the majority of bacteria without serious side effects. Various dosage forms of Furacin will be displayed, including Furacin Ophthalmic Liquid and Ointment. When pregnancy is contraindicated, Lorophyn Suppositories offer a simple technique of proven effectiveness.

First Texas Chemical Manufacturing Company, Dallas, Booth 19

The First Texas Chemical Manufacturing Company will exhibit its products at booth 19.

C. B. Fleet Company, Inc., Lynchburg, Va., Booth 35

C. B. Fleet Company, Inc., cordially invites physicians of Texas to stop at booth 35 to see the exhibit of Phospho-Soda (Fleet). Phospho-Soda (Fleet) is a solution containing in each 100 cc., sodium biphosphate 48 Gm. and sodium phosphate 18 Gm. Over the years Phospho-Soda (Fleet) has won discriminating preference by thousands of physicians because of its controlled action, its freedom from undesirable side effects, and its ease of administration. There is only *one* Phospho-Soda (Fleet).

General Electric Company, X-Ray Department, Dallas, Booth 73

The General Electric Company X-Ray Department representatives will be happy to visit with the company's many customer-friends. On display and available for demonstration will be the new DWB Cardioscribe.

The Gilbert X-Ray Company of Texas, Dallas, Booth 41

In booth 41, representatives of the Gilbert X-Ray Company of Texas will be on hand to greet their many friends attending this excellent medical meeting.

Graham Laboratories, Dallas, Booth 34

Graham Laboratories will feature allergenic extracts and plant oleoresins for the diagnosis and treatment of various allergic diseases. On display will be custom made Plexiglas Vial Trays and various type of serum vials and stoppers. Physicians are invited to visit the exhibit. Miss Paula Whitten will be in charge.

Group Hospital Service, Inc., Group Medical and Surgical Service, Dallas, Booth 39

Blue Cross and Blue Shield of Texas will exhibit items of interest to the doctors of Texas, relative to the experience of the plan over the past few years.

The Harrower Laboratory, Inc., Jersey City, Booth 10

Mucotin, which is the featured product at the exhibit of the Harrower Laboratory, Inc., is indicated in peptic ulcer and gastric hyperacidity. The product combines two antacids, magnesium trisilicate and aluminum hydroxide gel, with gastric mucin. A recent development in the processing of Mucotin tablets now has provided a tablet which disintegrates so rapidly that chewing is not required. Physicians have found that patients welcome this added convenience.

Hedgecock Artificial Limb Company, Dallas, Booth 11

Featured in the Hedgecock exhibit at booth 11 will be APRL Hook and Hand with the plastic arms developed and perfected by the University of New York and the University of California in cooperation with the Veterans Administration Research Program. The items are made, fitted, and completed in the Dallas factory. The newest type of socket for wearers of suction socket artificial legs also will be presented.

H. J. Heinz Company, Pittsburgh, Booth 44

Physicians are invited to visit the Heinz booth to receive the latest information about the Heinz baby food line. Literature will be available for office use concerning nutritional data and Heinz baby foods. For use by the patients there will be available booklets on "Your Baby's Diet," "Junior Foods for Older Babies," "Recipe Magic Using Heinz Strained and Junior Foods," and "Facts About Foods." Spill-proof tumblers will be a premium offer.

The Karmac Company, Dallas, Booth 32

On exhibit at booth 32 will be Plaster of Paris Bandages and Splints, manufactured by Karmac and made entirely by hand according to rigid specifications. Uniform in quality and performance, Karmac Bandages soak quickly and make a strong, light-weight cast. Available in both fast-setting and slow-setting types, the bandages are "Made in Texas by Texans for Texas Surgeons."

R. P. Kincheloe Company, Dallas, Booth 40

The R. P. Kincheloe Company will display Keleket x-ray apparatus, Cambridge direct writer electrocardiograph, and Liebel-Flarsheim short wave diathermy unit.

Eli Lilly and Company, Indianapolis, Booth 42

Physicians are invited to visit the Lilly exhibit in booth 42. The display will contain information on recent therapeutic developments and will feature the story of the Lilly junior taste panel. Lilly sales personnel will welcome questions about Ilotycin (Erythromycin, Lilly) and other Lilly products.

J. B. Lippincott Company, Philadelphia, Booth 63

J. B. Lippincott Company will present for physicians' approval a display of professional books and journals geared

to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

P. Lorillard Company, New York, Booth 24

P. Lorillard Company, manufacturers of Old Gold and Embassy Cigarettes as well as Briggs Pipe Mixture and other famous tobacco products, will exhibit and demonstrate its new Kent Cigarettes with the exclusive Micronite Filter, which takes out up to seven times more nicotine and tars than other filter cigarettes.

J. A. Majors Company, Dallas, Booth 31

The latest editions on medicine and surgery published by W. B. Saunders Company will be available for examination: "1954 Current Therapy"; Child, "Hepatic Circulation and Portal Hypertension"; Conant, "Clinical Mycology"; Mackie, "Manual of Tropical Medicine"; Sweet, "Thoracic Surgery"; "Mayo Clinic Diet Manual"; and Shackelford, "Surgery of Alimentary Tract" (two-volume set). Mr. L. B. Shaver will be in charge of the exhibit.

Mead Johnson and Company, Evansville, Ind., Booth 23

Mead Johnson and Company, booth 23, will show the recent change of formulation and other improvements in Dextri-Maltose. Lactum and Olac, Mead's two convenient, modified milk formulas for routine infant feeding, also will be featured, as well as the four Pablum Cereals.

Medcalf and Thomas, Fort Worth, Booth 70

In booth 70 representatives of the Surgical Department of Medcalf and Thomas will display surgical instruments, equipment, and supplies.

The Medical Protective Company, Fort Wayne, Ind., Booth 17

Exclusive application to the field of professional liability insurance endows The Medical Protective Company with a "know-how" in defense unlimited that distinguishes it from all others. It produces an enviable record in which policyholders suffer no involuntary loss from their own pockets in malpractice suits. Thereby, defense, rather than coverage limits, continues to prove the most effective protective factor.

Miles Reproducer Company, Inc., New York, Booth 8

Case histories, lectures, and dictation may now be recorded at a 60-foot radius with Walkie-Recordall, an 8-pound, self-powered battery recorder-transcriber. The voice-activated "self-start-stop" feature automatically starts and stops the recording from microphone or telephone, thus eliminating supervision and the recording of silent periods. Up to eight hours of permanent recordings may be accumulated at intervals on an endless belt costing 25 cents.

Mission Pharmacal Company, San Antonio, Booth 18

Featured by the Mission Pharmacal Company will be Isoval, the safe daytime nonbarbiturate sedative, together with Homapin, an effective antispasmodic. Messrs. H. N. Walsdorf, T. Y. Chapin, and O. B. Adams, Jr., will be in attendance.

Murray Agency, Corpus Christi, Booth 43

A physician will be paid $8,800 a year when he is unable to work at his profession as the result of sickness or accident. On exhibit at booth 43 will be the new improved combined coverage contract written by the Metropolitan Casualty Insurance Company of New York and the Washington National Insurance Company of Chicago. Physicians are invited to meet "Sid Murray Pays in a Hurry," general agent.

Pendleton and Arto, Inc., Houston, Booth 61

Pendleton and Arto invites its many friends to visit booth 61, where the new Raytheon Microtherm and a complete line of instruments will be on display. The company's representative, Mr. M. Pat Daley, will be on hand to welcome visitors.

Pfizer Laboratories, Brooklyn, Booth 72

Physicians are invited to visit the Pfizer booth where well-informed representatives will be happy to supply information and answer any questions relative to Pfizer products. Terramycin dosage forms and Bonamine will be the feature attractions of the Pfizer exhibit.

Physicians and Surgeons Supply Company, San Antonio, Booth 46

The Physicians and Surgeons Supply Company of San Antonio will present an exhibit of its surgical products at booth 46.

R. J. Reynolds Tobacco Company, Winston-Salem, N. C., Booth 26

Welcome will be extended to physicians at the Camel-Cavalier exhibit, and cigarette cases (monogrammed with initials) containing Camels, America's most popular cigarette, or Cavaliers, the king size cigarette of extra mildness and distinctive flavor, will be given to guests.

Richards Manufacturing Company, Memphis, Booth 65

One of the most complete lines of fracture equipment and orthopedic instruments in the country will be shown by Richards. There will be a full line of splints for simple fractures as well as instruments for all types of orthopedic surgery and neurosurgery. Intramedullary nails, both cloverleaf and diamond, will be displayed, as well as Jewett (one piece forged) trochanteric nails, pneumatic tourniquets, and all sundry items. Mr. Johnson will be glad to see all his friends at booth 65.

A. H. Robins Company, Inc., Richmond, Va., Booth 21

The A. H. Robins Company exhibit will feature Robalate, N.N.R. antacid-demulcent indicated in peptic ulcer therapy and hyperacidity. The pharmaceutically elegant tablets, each containing 0.5 Gm. dihydroxy aluminum aminoacetate, are notable for exceptional palatability.

Schering Corporation, Bloomfield, N. J., Booth 16

Members of the Texas Medical Association and their guests are cordially invited to visit the Schering exhibit, where new therapeutic developments will be featured. Schering representatives will be present to welcome physicians and to discuss the company's products.

G. D. Searle and Company, Chicago, Booth 71

Physicians are invited to visit the Searle booth, where members of the medical and medical service departments will be happy to answer questions regarding Searle Products of Research, such as new approved uses for Dramamine and Banthine as well as such items as Searle Aminophyllin, Alidase, Metamucil, and Diodoquin.

The Sommers Drug Stores Company, San Antonio, Booth 59

The Sommers Drug Stores Company, San Antonio, will occupy booth 59.

SoundScriber of San Antonio, Inc., San Antonio, Booth 29

The SoundScriber exhibit in booth 29 will display the complete line of SoundScriber electronic disk dictation equipment. This will include the new and unique "Tycoon" individual and combination units, pace-setter in modern dictation. Interview and telephone recording accessories also

will be featured. Physicians are invited to see SoundScriber, world's most versatile dictation system.

Southern Medical Association, Booth 36

Southern Medical Association will display at booth 36 booklets of information about the organization and copies of the *Southern Medical Journal*. The group's president-elect, Dr. Robert L. Sanders, Memphis, who will preside over the 1955 meeting in Houston, is to be one of the guests of the Texas Medical Association at this annual session.

Noa Spears Company, San Antonio, Booths 53 and 54

Noa Spears Company will exhibit its line of surgical instruments at booths 53 and 54.

Taylor Laboratories, Inc., Houston, Booth 47

Taylor Laboratories will be pleased to call to the attention of Texas physicians the following products: Aminophylline Tablets and Aminophylline in combination with Phenobarbital. Also, the franchise held by the Taylor Laboratories of the Wilson Laboratories in Chicago will enable Taylor representatives to present Corticotropin, Gel and Solution, in the most acceptable potencies.

Terrell Supply Company, Fort Worth, Booth 15

The Terrell Supply Company will exhibit its products at booth 15.

Texas Medical Association Memorial Library, Austin, Booth 27

The Memorial Library of the Texas Medical Association will feature in its exhibit at booth 27 "A History of the Texas Medical Association, 1853-1953" by Dr. Pat I. Nixon, San Antonio. Copies of the book will be available for sale, and Dr. Nixon will be on hand to autograph them. Material explaining the services of the Memorial Library also will be on display.

Texas Pharmacal Company, San Antonio, Booth 49

On exhibit at booth 49 will be products of the Texas Pharmacal Company.

United Medical Equipment Company, Kansas City, Booth 9

The new Profexray 300 milliampere, 100 kilovolt motor driven tilt table with the completely automatic control will be exhibited. Also on display will be the all new PC-3 Cardiotron, the direct-writing electrocardiographic machine; the Raytheon Microwave Diathermy; plus the new E. P. L. Portable Meta-Basal.

U. S. Vitamin Corporation, New York, Booth 45

Physicians are invited to visit booth 45 to see the "oil-in-water" demonstration of natural vitamin A oil in water solution—a vitamin technical achievement pioneered by the U. S. Vitamin Corporation Research Laboratories—with further clinical proof of superior absorption and utilization of aqueous vitamin A. Also, physicians may wish to see and taste the new and different sodium-free salt substitute, Co-Salt, which actually tastes like salt, looks like salt, and sprinkles like salt—a great boon to patients on restricted sodium intake.

VanPelt and Brown, Richmond, Va., Booth 14

VanPelt and Brown extends a cordial invitation to visit the exhibit in booth 14, where representatives will be happy to answer questions and supply clinical samples of their products.

Varick Pharmacal Company, Inc., New York, Booth 37

E. Fougera and Company, Inc., and its division, Varick Pharmacal Company, cordially invite physicians to discuss with professional service representatives new preparations of importance to their everyday practice. Descriptive literature and samples of all products will be available.

Walden Industries, Inc., New York, Booth 7

Simple, automatic, and economical equipment for clinical close-up photography will be shown. Quick-Clix Projection Bulb and Strobe Outfits feature fully automatic aperture and shutter control mechanisms for finest color or black and white pictures. The low-priced Walco Lighting Unit utilizes fixed focus applicators to make photography extremely easy for busy practitioners.

William A. Webster Company, Memphis, Tenn., Booth 48

The Webster Company plans to exhibit its complete line of suppositories, trade named Supprettes, and five drugs using the exclusive, newly developed water-soluble suppository base, Neocera, which blends high and low molecular weight waxes for controlled break-down and complete, uniform absorption and requires no refrigeration. The products using this unique base for the administration of medicine rectally are Aquachloral (chloral hydrate), Pentobarbital Sodium, Gentian Violet, Theophylline, and Theophylline-Pentobarbital.

Westinghouse Electric Corporation, Baltimore, Booths 50 and 51

Representatives of Westinghouse will be pleased to meet and discuss with Texas physicians future or present requirements, from the details in the darkroom to the style and type of equipment for any specialty. Representatives are well prepared to custom-plan x-ray facilities. Westinghouse appreciates this opportunity to present its x-ray products to Texas physicians at this meeting.

Westwood Pharmaceuticals, Buffalo, N. Y., Booth 25

Gentia-Jel, the specific gentian violet therapy in vaginal moniliasis of pregnancy, in the new, single-dose disposable applicator, will be on exhibit at booth 25, as well as Lowila Cake, the only lathering soapless skin cleanser for patients sensitive to soap, and Pro-Derna, a silicone skin protective cream, the first really effective skin protective to prevent contact dermatitis.

Wilson X-Ray and Surgical Company, Austin, Booth 60

The formal opening of the complete laboratory department of Wilson X-Ray and Surgical Company has been announced. This includes all laboratory equipment as well as supplies and incorporates the merchandise of Clay-Adams, Glasco, American Optical Company (Spencer Division), E. Leitz, Inc., Difco, Anderson Laboratories, and others. This department is now headed by a registered laboratory technician who is in a position to help physicians with their problems and will be happy to furnish information as to types of equipment and supplies needed to do specific tests. An invitation is extended to physicians to visit booth 60.

Winthrop-Stearns Inc., New York, Booth 66

Winthrop-Stearns, Inc., invites physicians to visit booth 66, where Levophed and Telepaque will be featured. Levophed bitartrate is a powerful pressor antidote for shock due to myocardial infarction, surgical and nonsurgical trauma, hemorrhage, and other causes. Levophed is noted for its prompt, predictable, reliable, and easily controlled action and is administered diluted in 5 per cent dextrose or dextrose in saline infusion. Telepaque, a highly effective and well tolerated oral cholecystopaque medium, gives denser, clear cut pictures of the gallbladder and, in a substantial number of cases, also permits visualization of the biliary ducts.

OFFICERS, COUNCILS, AND COMMITTEES

Following are the officers, councils, and committees of the Texas Medical Association for the year 1953-1954 with the year in which their terms of office expire indicated in parentheses:

Officers

George Turner, El Paso, President.
F. J. L. Blasingame, Wharton, President-Elect.
Andrew S. Tomb, Victoria, Vice-President.
J. M. Travis, Jacksonville, Secretary (1956).
N. C. Forrester, Austin, Executive Secretary.
T. H. Thomason, Fort Worth, Treasurer (1956).
Hobart O. Deaton, Fort Worth, Speaker of the House of Delegates.
Charles P. Hardwicke, Austin, Vice-Speaker of the House of Delegates.

Board of Trustees

Robert W. Kimbro, Cleburne, Chairman (1957).
G. V. Brindley, Temple, Vice-Chairman (1955).
Denton Kerr, Houston, Secretary (1958).
Sam N. Key, Austin (1956).
E. A. Rowley, Amarillo (1954).

Board of Councilors

First District, J. Leighton Green, El Paso (1955); C. E. Oswalt, Jr., Fort Stockton, Vice-Councilor.
Second District, R. B. G. Cowper, Big Spring (1954); Chester U. Callan, Rotan, Vice-Councilor.
Third District, Frank B. Malone, Lubbock (1956); H. H. Latson, Amarillo, Vice-Councilor.
Fourth District, H. L. Locker, Brownwood (1955); O. H. Chandler, Ballinger, Vice-Councilor.
Fifth District, J. L. Cochran, San Antonio (1956); J. J. Hinchey, San Antonio, Vice-Councilor.
Sixth District, Franklin W. Yeager, Corpus Christi (1956); Stanley W. Bohmfalk, Weslaco, Vice-Councilor.
Seventh District, J. M. Coleman, Austin, Vice-Chairman (1954); W. B. Hahn, Austin, Vice-Councilor.
Eighth District, James H. Wooten, Jr., Columbus (1954); John L. Otto, Galveston, Vice-Councilor.
Ninth District, J. T. Billups, Houston, Secretary (1954); A. M. Dashiell, Houston, Vice-Councilor.
Tenth District, L. C. Heare, Port Arthur (1954); Stephen B. Tucker, Nacogdoches, Vice-Councilor.
Eleventh District, C. E. Willingham, Tyler (1955); Lynn Hilbun, Henderson, Vice-Councilor.
Twelfth District, J. Wilson David, Corsicana (1956); Howard O. Smith, Marlin, Vice-Councilor.[1]
Thirteenth District, R. G. Baker, Fort Worth, Chairman (1955); L. J. Webster, Abilene, Vice-Councilor.[2]
Fourteenth District, Mayo Tenery, Waxahachie (1955); L. W. Johnston, Terrell, Vice-Councilor.
Fifteenth District, H. O. Padgett, Marshall (1956); Hugh M. Ragland, Gilmer, Vice-Councilor.

Delegates to American Medical Association

T. C. Terrell, Fort Worth (1955).
M. O. Rouse, Dallas (1955).
J. B. Copeland, San Antonio (1955).
A. C. Scott, Jr., Temple (1954).
John K. Glen, Houston (1954).
Robert B. Homan, Jr., El Paso (1954).
Delegate Designate, James H. Wooten, Jr., Columbus (1954).

Alternate Delegates to American Medical Association

J. C. Terrell, Stephenville (1955).
Troy Shafer, Harlingen (1955).
George Turner, El Paso (1955).
John L. Otto, Galveston (1954).
Robert W. Kimbro, Cleburne (1954).
L. C. Heare, Port Arthur (1954).

Executive Council

Ex-officio, President (Chairman), President-Elect, Vice-President, Secretary, Executive Secretary, Treasurer, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, Board of Trustees, Board of Councilors, Texas Delegates to the American Medical Association, Chairmen of All Councils, Members of the Council on Medical Jurisprudence, and Chairman of the Committee on Public Relations.

Council on Medical Defense

Charles L. McGehee, San Antonio, Chairman (1955).
Joe Nichols, Atlanta (1958).
P. M. Kuykendall, Ranger (1957).
Harold M. Williams, Austin (1956).
John H. Wootters, Houston (1954).
George Turner, El Paso (ex-officio).
N. C. Forrester, Austin (ex-officio).

Council on Medical Jurisprudence

J. B. Copeland, San Antonio, Chairman (1957).
J. W. Rainer, Odessa (1958).
Robert D. Moreton, Fort Worth (1956).
John K. Glen, Houston (1955).
G. W. Cleveland, Austin (1954).
George Turner, El Paso (ex-officio).
N. C. Forrester, Austin (ex-officio).

Council on Scientific Work

May Owen, Fort Worth, Chairman (1957).
Clyde A. Stevenson, Temple (1958).
L. Bonham Jones, San Antonio (1956).
Kleberg Eckhardt, Corpus Christi (1955).
George W. Waldron, Houston (1954).
George Turner, El Paso (ex-officio).
N. C. Forrester, Austin (ex-officio).

Council on Medical Economics

Harvey Renger, Hallettsville, Chairman (1957).
E. W. Jones, Wellington (1958).
A. G. Barsh, Lubbock (1956).
Raleigh R. Ross, Austin (1955).
H. H. Cartwright, Breckenridge (1954).
George Turner, El Paso (ex-officio).
N. C. Forrester, Austin (ex-officio).

Council on Medical Education and Hospitals

M. O. Rouse, Dallas, Chairman (1958).
John L. Matthews, San Antonio (1957).
Truman G. Blocker, Jr., Galveston (1956).
W. S. Barcus, Fort Worth (1955).
R. Lee Clark, Jr., Houston (1954).
George Turner, El Paso (ex-officio).
N. C. Forrester, Austin (ex-officio).

War Council

Ex-officio, President (Chairman), President-Elect, Vice-President, Secretary, Executive Secretary, Treasurer, Speaker of the House of Delegates, Board of Trustees, Board of

[1] *Appointed September 16, 1953, to fill the vacancy created by the resignation of Dr. Clifford G. Swift, Cameron.*
[2] *Appointed September 16, 1953, to fill the vacancy created by the resignation of Dr. H. H. Cartwright, Breckenridge.*

Councilors, Chairmen of All Councils, and Chairman of the Committee on Public Relations.

Committee on Cancer

Porter Brown, Fort Worth, Chairman (1958).
C. T. Ashworth, Fort Worth (1957).
R. E. Windham, San Angelo (1956).
John H. Wootters, Houston (1955).
Charles Phillips, Temple (1954).

Committee on Medical History

Vacancy, Chairman (1954).[3]
Tate Miller, Dallas (1958).
W. E. Whigham, McAllen (1957).
L. H. Reeves, Fort Worth (1956).
A. A. Ross, Sr., Lockhart (1955).

Committee on Public Relations

Troy Shafer, Harlingen, Chairman (1957).
Van D. Goodall, Clifton (1957).
Sam Barnes, Trinity (1957).
Hugh Savage, Fort Worth (1957).
H. M. Anderson, San Angelo (1956).
M. C. Overton, Jr., Pampa (1956).
W. D. Blassingame, Denison (1956).
Councilors (advisory members).

Two advisory members from each Councilor District:

First District, Delphin Von Briesen, El Paso; F. M. Applegate, Monahans.

Second District, David L. Greenlees, Odessa; George E. Peacock, Big Spring.

Third District, George V. Edgar, Levelland; James A. Odom, Memphis.

Fourth District, Richard C. Felts, San Saba; Floyd T. McIntire, San Angelo.

Fifth District, Louis M. Cartall, Jr., Del Rio; J. K. Schaefer, New Braunfels.

Sixth District, M. C. Kendrick, Corpus Christi; vacancy.[4]

Seventh District, Winston M. Brook, Lampasas; Robert W. Loveless, Bastrop.

Eighth District, John L. Otto, Galveston; Andrew S. Tomb, Victoria.

Ninth District, George D. Bruce, Baytown; George V. Pazdral, Somerville.

Tenth District, H. Grady Bevil, Beaumont; L. H. Denman, Lufkin.

Eleventh District, J. E. Ross, Henderson; L. L. Travis, Jacksonville.

Twelfth District, Stanley Cox, Groesbeck; Charles A. Garrett, Hillsboro.

Thirteenth District, C. E. Adams, Abilene; Bailey R. Collins, Wichita Falls.

Fourteenth District, N. L. Barker, Paris; Herbert Donnell, Waxahachie.

Fifteenth District, James H. Harris, Marshall; V. R. Hurst, Longview.

Committee on Tuberculosis

W. D. Anderson, San Angelo, Chairman (1956).
Orville E. Egbert, El Paso (1958).
John A. Wiggins, Fort Worth (1957).
Ralph E. Gray, Lake Jackson (1955).
Ernest E. Holt, College Station (1954).

Committee on Library Endowment

J. M. Travis, Jacksonville, Chairman (1957).
Joe T. Gilbert, Austin (1958).
V. R. Hurst, Longview (1956).
R. D. Little, Wharton (1955).
August J. Streit, Amarillo (1954).

Committee on Mental Health

Hamilton Ford, Galveston, Chairman (1958).
David Wade, Austin (1957).
A. B. Cooper, El Paso (1956).[5]
Abe Hauser, Houston (1955).
E. S. Ezell, Fort Worth (1954).

Committee on Public Health

Hugh Welsh, Houston, Chairman (1956).[6]
T. A. Fears, Beaumont (1958).
William E. Lockhart, Jr., Alpine (1958).
John F. Pilcher, Corpus Christi (1957).
Arthur G. Schoch, Dallas (1957).
H. D. Gilliam, McAllen (1956).
Thomas H. Diseker, San Antonio (1955).
H. K. Brask, San Angelo (1955).
Guy A. Tittle, Dallas (1954).
H. H. Latson, Amarillo (1954).

Committee on General Arrangements for the 1954 Annual Session (all of San Antonio).—L. Bonham Jones, Chairman; Robert R. Nixon; Charles L. McGehee; Edward D. Dumas; John M. Smith, Jr.

Committee on Memorial Services.—B. F. Stout, San Antonio, Chairman; Emmett V. Headlee, Odessa; Jay J. Johns, Taylor; Minnie L. Maffett, Dallas; Carroll F. Crain, Corpus Christi.

Committee on Scientific Exhibits.—James D. Murphy, Fort Worth, Chairman; Dean B. Jones, San Antonio; J. E. Miller, Dallas; H. F. Connally, Jr., Waco; Edward T. Smith, Houston.

Advisory Board to Texas Society of Medical Technologists.—S. W. Bohls, Austin, Chairman (1954); William O. Russell, Houston (1955); M. S. Hart, El Paso (1956).

Committee on Rural Health.—Chester U. Callan, Rotan, Chairman; R. D. Holt, Jr., Meridian; Harold Lindley, Pecos; Stephen B. Tucker, Nacogdoches; James H. Harris, Marshall; George D. Bruce, Baytown.[7]

Committee on Revision of the Constitution and By-Laws.—Charles P. Hardwicke, Austin, Chairman; Robert B. Homan, Jr., El Paso; G. V. Edgar, Levelland; Harvey Renger, Hallettsville; D. Scott Hammond, Paris; Hobart O. Deaton, Fort Worth; Jack G. Kerr, Dallas; J. J. Hinchey, San Antonio.

Committee on Nursing Care.—A. C. Scott, Jr., Temple, Chairman; C. Forrest Jorns, Houston; R. H. Bell, Palestine; Neil Buie, Jr., Marlin; R. D. Holt, Meridian; G. E. Brereton, Dallas; Joseph F. McVeigh, Fort Worth; Truman G. Blocker, Jr., Galveston; Jesson L. Stowe, El Paso.

Committee on Negro Medical Facilities.—Tate Miller, Dallas, Chairman; L. C. Powell, Beaumont; Michael E. DeBakey, Houston; William L. Marr, Galveston; G. V. Pazdral, Somerville; Paul B. Stokes, Crockett; L. L. D. Tuttle, Houston; J. Weldon Birdwell, Tyler.

Committee on Study of Alcoholism.—Andrew S. Tomb, Victoria, Chairman; P. C. Talkington, Dallas; W. W. Bondurant, Jr., San Antonio; M. D. Levy, Houston; Walter C.

[3] *Vacancy created by the death on July 31, 1953, of Dr. H. R. Dudgeon, Sr., Waco.*

[4] *Vacancy created by removal of Dr. H. L. Warres, Laredo, from the state.*

[5] *Appointed August 29, 1953, to fill the vacancy created by the resignation of Dr. Don P. Morris, Dallas, on August 13, 1953.*

[6] *Appointed chairman October 20, 1953, to fill the vacancy created by the resignation as chairman of Dr. John F. Pilcher, Corpus Christi, on October 15, 1953.*

[7] *Appointed July 27, 1953.*

Goddard, Austin; Raymond Gregory, Galveston; George A. Constant, Victoria.

State Council on National Emergency Medical Service.—Ozro T. Woods, Dallas, Chairman; W. J. Graber, Beaumont; Glenn D. Carlson, Dallas; Hamilton Ford, Galveston; W. H. Hamrick, Houston; H. H. Cartwright, Breckenridge; Everett C. Fox, Dallas; Raleigh R. Ross, Austin; R. B. G. Cowper, Big Spring; A. G. Barsh, Lubbock; E. W. Jones, Wellington; John L. Goforth, Dallas; J. L. Cochran, San Antonio; C. M. Phillips, Levelland; Troy A. Shafer, Harlingen.

Committee on Blood Banks.—E. E. Muirhead, Dallas, Chairman; T. P. Churchill, Amarillo; T. M. Oliver, Waco; C. B. Sanders, Houston; O. J. Wollenman, Jr., Fort Worth.

Advisers to Texas Chapters of the Student American Medical Association.—E. Sinks McLarty, Galveston; Jack G. Brannon, Houston; J. Glenn Terry, Dallas.

Committee on Liaison with State Bar of Texas.—John E. Skogland, Houston, Chairman; Earl Gaston, Kingsville, Vice-Chairman; James W. Rainer, Odessa; J. B. Copeland, San Antonio; R. W. Kimbro, Cleburne; R. G. Carpenter, Dallas; David M. Cameron, El Paso.

Committee on Doctor Distribution.—Chester U. Callan, Rotan, Chairman; Harvey Renger, Hallettsville; Troy Shafer, Harlingen; Allen T. Stewart, Lubbock; J. C. Terrell, Stephenville.

State Chairman of American Medical Education Foundation.—S. W. Thorn, Houston.

Telephone Postgraduate Broadcast Committee (Special Committee of Council on Medical Education and Hospitals).—Joe Kopecky, San Antonio, Chairman; C. T. Stone, Galveston; Henry M. Winans, Dallas; Mavis P. Kelsey, Houston; James D. Murphy, Fort Worth; Raleigh R. Ross, Austin; Asher R. McComb, San Antonio.

Committee for Coordination of Insurance Claims.—M. C. Overton, Jr., Pampa, Chairman; Tom B. Bond, Fort Worth; John H. Wootters, Houston; James W. Rainer, Odessa; J. B. Copeland, San Antonio.

Committee for Liaison with Workmen's Compensation Insurance Companies.—Sam N. Key, Jr., Austin, Chairman; Frederick C. Rehfeldt, Fort Worth; R. G. Carpenter, Dallas; M. H. Morris, San Antonio; Wendell H. Hamrick, Houston.

Appointees to Cooperate with the Board of Nurse Examiners.—A. C. Scott, Jr., Temple; C. Forrest Jorns, Houston.

Committee on Infringements on Private Practice.—T. C. Terrell, Fort Worth, Chairman; Laried S. Oates, Center; C. F. Crain, Corpus Christi; Neil D. Buie, Marlin; Robert A. Johnston, Houston; Joe Nichols, Atlanta.

Special Delegates

Texas Hospital Association.—T. C. Terrell, Fort Worth.

Texas State Nutrition Council.—Joe Nichols, Atlanta.

State Rural Health Council.—Chester U. Callan, Rotan.

Lone Star State Medical Association.—L. L. D. Tuttle, Houston.

Louisiana State Medical Association.—L. C. Heare, Port Arthur.

Arkansas Medical Society.—J. M. Travis, Jacksonville.

Texas State Dental Society.—Elliott Mendenhall, Dallas.

New Mexico Medical Society.—Leigh Wilcox, El Paso.

Texas Polio Planning Committee.—J. Edward Johnson, Austin.

Officers of Scientific Sections

Section A (Medical)

John R. Winston, Temple, Co-Chairman.
Richard E. Nitschke, San Antonio, Co-Chairman.
Robert A. Gardner, Houston, Secretary.

Section B (Surgical)

O. W. English, Lubbock, Chairman.
Robert F. Short, Jr., Dallas, Secretary.

Section on General Practice

Sheldon M. Tucker, Houston, Chairman.
Van D. Goodall, Clifton, Secretary.

Section on Internal Medicine

Richard E. Nitschke, San Antonio, Chairman.
John R. Winston, Temple, Secretary.

Section on Surgery

O. W. English, Lubbock, Chairman.
Robert F. Short, Jr., Dallas, Secretary.

Section on Obstetrics and Gynecology

E. E. Anthony, Fort Worth, Chairman.
S. Foster Moore, Jr., San Antonio, Secretary.

Section on Eye, Ear, Nose, and Throat

Hal W. Maxwell, Dallas, Chairman.
Oliver W. Suehs, Austin, Secretary.

Section on Radiology

Royal Wertz, Amarillo, Chairman.
Delphin Von Briesen, El Paso, Secretary.

Section on Public Health

Maurice A. Roe, Dallas, Chairman.
Austin E. Hill, Houston, Secretary.

Section on Clinical Pathology

A. J. Gill, Dallas, Chairman.
J. L. Goforth, Dallas, Secretary.

Section on Pediatrics

John A. Welty, Harlingen, Chairman.
Robert A. Gardner, Houston, Secretary.

Local Committees

Alumni.—William D. Montgomery, Chairman; G. G. Passmore, University of Texas School of Medicine; C. C. Shotts, Baylor University College of Medicine; J. Walter Park, III, Southwestern Medical School of the University of Texas; James E. Pridgen, Tulane University of Louisiana School of Medicine; William M. Center, University of Arkansas School of Medicine; Mildred E. Ward, Louisiana State University School of Medicine; Thomas H. Diseker, University of Tennessee College of Medicine and Vanderbilt University School of Medicine.

Fraternity.—William J. Johnson, Jr., Chairman; Edwin M. Sykes, Jr., Alpha Kappa Kappa; Hugh P. Reveley, Nu Sigma Nu; S. Perry Post, Phi Beta Pi; James L. Mims, Jr., Phi Chi; R. Bernard Pomerantz, Phi Delta Epsilon; John L. Matthews, Phi Rho Sigma; William J. Fetzer, Theta Kappa Psi.

Halls and Lanterns.—Robert R. Nixon, Chairman; John P. Heaney, Vernon S. Wier.

Hotels.—John M. Smith, Jr., Chairman; Jack B. Lee, Ralph A. Munslow.

Information.—S. Perry Post, Chairman; Benjamin B. Shaver, Pat I. Nixon, Jr.

Memorial Services.—B. F. Stout, Chairman; J. L. Cochran, P. I. Nixon.

Publicity.—A. F. Clark, Jr., Chairman; O. Roger Hollan, Jack M. Partain.

Scientific Exhibits.—Arthur C. Ressmann, Chairman; Lawrence M. Shefts, Frank M. Posey, Jr.

Social.—Joseph W. Palmer, Chairman; John C. Parsons, John J. DeLeon, William W. Sawtelle, Robert H. Vadheim, William J. Block, Jr.

Sports (Golf).—John B. Case, Chairman; John C. Parsons, Arthur B. Pyterek.

Technical Exhibits.—Carl E. Bosshardt, Chairman; Robert F. Gossett, Daniel D. Altgelt.

Transportation.—Adolfo Urrutia, Chairman; Walter Walthall, Phillip L. Day.

GUEST SPONSORS

For Dr. Simeon T. Cantril.—Francis E. O'Neill, San Antonio.

For Dr. George T. Harrell.—C. Ralph Letteer, San Antonio.

For Dr. Harold D. Palmer.—Benjamin B. Shaver, San Antonio.

For Mr. William Alan Richardson.—Jack M. Partain, San Antonio.

For Dr. Robert L. Sanders.—Robert F. Gossett, San Antonio.

For Dr. E. Stewart Taylor.—E. T. Coates, San Antonio.

HOUSE OF DELEGATES

First Meeting, Sunday, May 2, 9:00 a. m.

North Terrace, Gunter Hotel

1. Call to Order.
2. Preliminary Report of Reference Committee on Credentials.
3. Reading of Minutes of Previous Meeting.
4. Announcements of Reference Committees.
5. Address of President.
6. Election of General Practitioner of the Year.
7. Report of Executive Secretary.
8. Report of Treasurer.
9. Report of Board of Trustees.
10. Report of Board of Councilors.
11. Report of Delegates to American Medical Association.
12. Report of Councils:
    - Executive Council.
    - Council on Medical Defense.
    - Council on Medical Jurisprudence.
    - Council on Scientific Work
    - Council on Medical Economics.
    - Council on Medical Education and Hospitals.
13. Report of Standing Committees:
    - Committee on Cancer.
    - Committee on Medical History.
    - Committee on Public Relations.
    - Committee on Tuberculosis.
    - Committee on Library Endowment.
    - Committee on Mental Health.
    - Committee on Public Health
14. Report of Special Committees:
    - Committee on General Arrangements for the Annual Session.
    - Committee on Memorial Services.
    - Committee on Scientific Exhibits.
    - Advisory Board to Texas Society of Medical Technologists.
    - Committee on Rural Health.
    - Committee on Revision of the Constitution and By-Laws.
    - Committee on Nursing Care.
    - Committee on Negro Medical Facilities.
    - Committee on Study of Alcoholism.
    - State Council on National Emergency Medical Service.
    - Committee on Blood Banks.
    - Advisers to Texas Chapters of the Student American Medical Association.
    - Committee on Liaison with State Bar of Texas.
    - Committee on Doctor Distribution.
    - State Chairman of American Medical Education Foundation.
    - Committee for Coordination of Insurance Claims.
    - Committee for Liaison with Workmen's Compensation Insurance Companies.
    - Appointees to Cooperate with the Board of Nurse Examiners.
    - Committee on Infringement on Private Practice.
15. Report of Special Delegates:
    - Texas Hospital Association.
    - Texas State Nutrition Council.
    - State Rural Health Council.
    - Lone Star State Medical Association.
    - Louisiana State Medical Association.
    - Arkansas Medical Society.
    - Texas State Dental Society.
    - New Mexico Medical Society.
    - Texas Polio Planning Committee.
16. Presentation of Fraternal Delegates.
17. Reading of Communications.
18. Reading of Memorials and Resolutions.
19. Unfinished Business.
20. New Business.
21. Report of Reference Committees:
    - (1) Reference Committee on Reports of Officers and Committees.
    - (2) Reference Committee on Resolutions and Memorials.
    - (3) Reference Committee on Finance.
    - (4) Reference Committee on Amendments to Constitution and By-Laws.
    - (5) Reference Committee on Scientific Work.
    - (6) Reference Committee on Medical Service and Public Relations.
    - (7) Board of Councilors.
    - (8) Board of Trustees.
22. Presentation of General Practitioner of the Year.
23. Election of Officers and Council Members (morning of last day):
    - President-Elect.
    - Vice-President.
    - Speaker of the House of Delegates.
    - Vice-Speaker of the House of Delegates.
    - One Trustee (Term expires: E. A. Rowley, Amarillo, appointed to unexpired term, August, 1946; elected to full term, May, 1949).
    - Five Councilors (Term expires: R. B. G. Cowper, 2nd Dist., elected to full term April, 1948; elected to full term, May, 1951. J. M. Coleman, 7th Dist., elected to full term, May, 1951. James H. Wooten, Jr., 8th Dist., elected to full term, April, 1948; elected to full term May, 1951. J. T. Billups, 9th Dist., appointed to unexpired term, December, 1949; elected to full term, May, 1951. L. C. Heare, 10th Dist., elected to full term, May, 1951 —Nominations by district societies, at their regular meetings, or in the instance no such society exists or is in a position so to nominate, by a majority vote of the elected delegates of county societies from the district concerned).
    - Three Delegates to A.M.A. (Term expires: A. C. Scott, Jr., John K. Glen, Robert B. Homan, Jr.).

Delegate Designate to A.M.A. (Term expires: James H. Wooten, Jr.).
Three Alternate Delegates to A.M.A. (Term expires: John L. Otto, Robert W. Kimbro, L. C. Heare).
Member, Council on Medical Defense (Term expires: John H. Wootters, elected to full term, May, 1949—Nomination by President-Elect).
Member, Council on Medical Jurisprudence (Term expires: G. W. Cleveland, appointed to unexpired term, September, 1947; elected to full term, April, 1949—Nomination by President-Elect).
Member, Council on Scientific Work (Term expires: George W. Waldron, appointed to unexpired term, April, 1947; elected to full term, May, 1949—Nomination by President-Elect).
Member, Council on Medical Economics (Term expires: H. H. Cartwright, elected to full term, May, 1949—Nomination by President-Elect).
Member, Council on Medical Education and Hospitals (Term expires: R. Lee Clark, Jr., elected to full term, May, 1949—Nomination by President-Elect).

24. Announcement of Standing Committee Members.
25. Selection of Time and Place of 1956 Annual Session.

RELATED ORGANIZATIONS

The scientific programs of the specialty societies outlined hereafter are open to any member of the Texas Medical Association.

TEXAS AIR-MEDICS ASSOCIATION

Sunday, May 2, 2:00 p. m.

Mezzanine B, Gunter Hotel

President—George L. Gallaher, Harlingen.
President-Elect—John S. Minnett, Dallas.
Secretary-Treasurer—John S. Minnett, Dallas.

1. (2:00) *Round-Table Discussion: C. A. A. Problems.* W. R. STOVALL, Washington, D. C., and W. A. OSTENDORF, Fort Worth.

Monday, May 3, 10:00 a. m.

Mezzanine B, Gunter Hotel

2. (10:00) *Business Meeting—Election of Officers.*

11:00 a. m.

Texas Room, Gunter Hotel

3. (11:00) *Lunch.*

1:30 p. m.

Randolph Field

4. (1:30) *Visual Problems of Supersonic Speeds.* JOHN E. GREENWELL, JR., Lt. Col. (MC) USAF, Randolph Field.
5. (3:00) *Tour of Research Laboratories, School of Aviation Medicine.*

TEXAS CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Sunday, May 2, 9:00 a. m.

Oriental Room, Gunter Hotel

President—Henry R. Hoskins, San Antonio.
First Vice-President—Howard E. Smith, Austin.
Second Vice-President—Samuel Topperman, Tyler.
Secretary-Treasurer—Walter C. Brown, Corpus Christi.

1. (9:00-9:30) *Registration.*
2. (9:30-10:15) *Benign Lesions of the Esophagus.* CECIL O. PATTERSON, Dallas.
3. (10:15-11:00) *A Study of Pneumonias in Older Males in Relation to Carcinoma.* D. O. SHIELDS and others, McKinney.
4. (11:00-12:00) *Hendricks Memorial Address.* WILLIAM A. HUDSON, Detroit, Mich.

12:00 noon

South Terrace, Gunter Hotel

5. (12:00-2:00) *Luncheon and Business Meeting.*

2:00 p. m.

Oriental Room, Gunter Hotel

6. (2:00-2:45) *Vitamin B_{12} in the Treatment of Peripheral Neuritis Associated with Isoniazid Therapy.* A. N. LONGFIELD, Galveston.
7. (3:00-3:45) *A Study of Adjustment to Prolonged Hospitalization for Tuberculosis: I. Prediction of Criteria Groups.* L. J. MORAN, Houston.
8. (4:00-5:00) *X-Ray Conference.* E. F. LYON, JR., San Antonio.

TEXAS DERMATOLOGICAL SOCIETY

Monday, May 3, 10:00 a. m.

West Wing, Municipal Auditorium

President—Maurice C. Barnes, Waco.
Vice-President—Duncan Stewart, Corpus Christi.
Secretary—Thomas L. Shields, Fort Worth.

1. (10:00) *Penicillin Reactions.* JAMES H. STRAUCH, San Antonio.
   (10:15) Discussion—MYLES P. MOURSUND, San Antonio.
2. (10:25) *Diagnostic and Treatment Errors of Certain Vulvar Dermatoses.* C. H. MCCUISTION and EUGENE P. SCHOCH, JR., Austin.
   (10:40) Discussion—EVERETT C. FOX, Dallas.
3. (10:50) *Hydrocortisone Ointment in the Treatment of Various Dermatoses.* J. FRED MULLINS, Galveston.
   (11:05) Discussion—C. F. LEHMANN, San Antonio.
4. (11:15) *Recess.*
5. (11:30) *Kissing Bug Bites: Their Relationship to Chagas' Disease.* THOMAS L. SHIELDS and E. N. WALSH, Fort Worth.
   (11:45) Discussion—H. D. GARRETT, El Paso.
6. (11:55) *Swimming Pool Granuloma: Report of a Case.* J. B. RICHARDSON and EVERETT R. SEALE, Houston.
   (12:10) Discussion—MALCOLM HARRISON, Houston.
7. (12:20) *Letterer-Siwe Disease: Report of a Case.* J. MURRAY RIDDELL, JR., Fort Worth.
   (12:35) Discussion—EUGENE P. SCHOCH, JR., Austin.

TEXAS DIABETES ASSOCIATION

Sunday, May 2, 9:30 a. m.

Grand Ballroom Foyer, Gunter Hotel

President—Raymond L. Gregory, Galveston.
First Vice-President—George M. Jones, Dallas.
Second Vice-President—Lawrence B. Reppert, San Antonio.
Secretary-Treasurer—Edmond K. Doak, Houston.

1. (9:30) *Registration.*

2. (10:00) *The Role of Fructose in Carbohydrate Metabolism.* MORTON MASON, PH.D., Dallas.
3. (10:30) *The Insurability of Diabetics.* R. L. DROSS, Houston.
4. (11:00) *The Management of Diabetic Coma.* HERBERT POLLACK, New York, N. Y.
5. (11:30) *Bedside Acetone Blood Levels: Demonstration.* ROBERT E. BLOUNT, Col. (MC) AUS, Brooke Army Hospital.
6. (12:15) *Luncheon.*
7. (1:00) *Panel Discussion: The Newly Discovered Diabetic.* MERTON M. MINTER, San Antonio, Moderator.
   Diagnosis—HUGO ENGELHARDT, Houston.
   Diet—EDWIN L. RIPPY, Dallas.
   Insulin—RAYMOND L. GREGORY, Galveston.
   Infections—HERBERT POLLACK, New York, N. Y.
   Surgery—ALBERT W. HARTMAN, San Antonio.
8. (2:30) *The Relationship of Diabetes to Heart Disease.* JAMES SKELTON, Houston.
9. (3:00) *Dietary Requirements for the Diabetic Patient.* HERBERT POLLACK, New York, N. Y.
10. (3:30) *Posthypoglycemic Encephalopathy.* GEORGE M. JONES, Dallas.
11. (4:00) *Orthopedic Problems in Diabetes Mellitus.* R. A. MURRAY, Temple.
12. (4:30) *Business Meeting.*

TEXAS HEART ASSOCIATION

Monday, May 3, 10:00 a. m.

Ballroom, Plaza Hotel

President—Joseph F. McVeigh, Fort Worth.
President-Elect—George R. Herrmann, Galveston.
Vice-President—D. D. Warren, Waco.
Secretary-Treasurer—Mr. R. L. Thomas, Dallas.
Executive Director—Mr. Edgar M. Brown, Dallas.
Executive Secretary—Miss Roberta Miller, Dallas.

(Meetings of the Executive Committee at 10:00 a. m. and of the Board of Directors at 2:00 p. m. will be held Sunday, May 2, in Parlor B, Plaza Hotel.)

1. (10:00) *Registration and purchase of tickets for luncheon.*
2. (10:30) *Further Studies in Vector Cardiography.* M. R. HEJTMANCIK and H. M. PALEY, Galveston.
3. (10:50) *Studies on the Action of Mercurial Diuretics.* DONALD W. SELDIN and LEONARD L. MADISON, Dallas.
4. (11:10) *The Renal Hemodynamic Response to Acute Alterations of Blood Pressure with Hypotensive and Vasopressor Agents.* R. G. MCCONN, W. M. HUGHES, H. L. BEAZLEY, and JOHN H. MOYER, Houston.
5. (11:35) *The Treatment of Subacute Bacterial Endocarditis with Streptomycin and Erythromycin.* ELLARD M. YOW, L. C. JONES, and R. FLAKE, Houston.
6. (12:00) *Blood Volume Studies in Congestive Heart Failure by the Use of Isotopes.* GEORGE R. HERRMANN, M. RUTH BAXTER, and TED REUSS, Galveston.
7. (12:15) *Luncheon.*
   Treatment of Cardiac Arrhythmias. MYRON PRINZMETAL, Los Angeles, Calif.
8. (1:45) *Business Meeting.*
9. (2:10) *Relation of Obesity to Serum Cholesterol and Lipoprotein Levels and Their Modification by Dietary Means.* WELDON J. WALKER, Lt. Col. (MC) AUS, Brooke General Hospital.
10. (2:35) *Operation for Coronary Artery Disease.* JOHN J. KRALIK, 1st Lt. (MC) AUS, Brooke General Hospital.
11. (3:00) *Recess.*
12. (3:15) *Mechanisms of Diamox Diuresis.* ARTHUR RUSKIN, Galveston.
13. (3:40) *Uses and Limitations of the Electrocardiogram in the Diagnosis of Coronary Artery Disease.* MYRON PRINZMETAL, Los Angeles, Calif.
14. (4:20) *Questions and Answers.*

TEXAS NEUROPSYCHIATRIC ASSOCIATION

Sunday, May 2, 8:30 a. m.

Ballroom, Plaza Hotel

President—James R. Blair, Jr., San Antonio.
Vice-President—Stephen Weisz, Dallas.
Second Vice-President—Edgar S. Ezell, Fort Worth.
Secretary-Treasurer—John L. Otto, Galveston.

1. (8:30) *Registration.*
2. (9:00) *Business Session.*
3. (9:30) *A Case of Congenital Dyskeratosis and Response to Hypnotherapy.* NEVILLE MURRAY, Galveston.
   Discussion—FRED MULLINS, Galveston.
4. (10:00) *A Psychiatric Floor in a General Hospital; Report of First Year.* R. W. JOHNSON, Corpus Christi.
   Discussion—M. L. TOWLER, Galveston.
5. (10:30) *Organization of the Youth Development Council in Galveston County.* BROOKS MULLEN, Galveston.
   Discussion—
   EUGENE C. MCDONALD, JR., Galveston.
6. (11:00) *Advances in the Treatment of Epilepsy.* TRACY J. PUTNAM, Beverly Hills, Calif.
7. (12:30) *Luncheon* (Dutch Treat).
8. (2:00) *Gliomas of the Brain in Three Members of One Family.* RALPH A. MUNSLOW and ALFRED H. HILL, San Antonio.
   Discussion—ALFRED H. HILL, San Antonio.
9. (2:30) *Torular Meningitis Treated with Actidione.* ANN FARRELL and LEWIS M. HELFER, San Antonio.
   Discussion—ANN FARRELL, San Antonio.
10. (3:00) *A Rare Intracranial Lesion.* H. C. MITCHELL, Waco.
    Discussion—M. J. COOPER, San Antonio.
11. (3:30) *Frontothalamic Radiotomy with Radioactive Materials.* TRACY J. PUTNAM, Beverly Hills, Calif.
12. (4:30) *Business Session and Election of Officers.*

6:00 p. m.

Walnut Room, Plaza Hotel

13. (6:00) *Cocktail party sponsored by San Antonio membership.*

TEXAS ORTHOPEDIC ASSOCIATION

Monday, May 3, 10:00 a. m.

Grand Ballroom, Gunter Hotel

President—Edward T. Smith, Houston.
Vice-President—John J. Hinchey, San Antonio.
Secretary-Treasurer—Margaret Watkins, Dallas.

1. *Fractures of the Astragalus.*
PHILLIP L. DAY, San Antonio.
2. *Management of Soft Tissue Scars and Defects of the Anterior Leg.*
C. W. TENNISON and E. P. WALLER, San Antonio.
3. *A Fibular Graft to Replace the Upper End of the Humerus.* R. A. MURRAY, Temple.
4. *Discrepancy in Leg Length and Growth of the Extremity.*
WILLIAM T. GREEN, Boston, Mass.
5. *Sacrococcygeal Chordoma.*
DAVID R. OLIVER, San Antonio.

12:15 p. m.

Grand Ballroom Foyer, Gunter Hotel

6. *Lunch and Business Meeting.*

2:00 p. m.

Grand Ballroom, Gunter Hotel

7. *Mass Casualties.*
R. E. REINER, Col. (MC) AUS, Fort Sam Houston.
8. *Preliminary Report on Bone Conduction of Sound Waves.*
R. A. WARD, Capt. (MC) AUS, Fort Sam Houston.
9. *Echinococcus Disease of Bone: Report of a Case.*
D. C. KELLSEY, Maj. (MC) AUS, Fort Sam Houston.
10. *Gunshot Wounds of the Hip.*
G. E. OMER, JR., Capt. (MC) AUS, Fort Sam Houston.
11. *Fractures Due to Trip Flares and Land Mines.*
G. E. OMER, JR., Capt. (MC) AUS, Fort Sam Houston.
12. *Vitallium Elbow Prosthesis, Case Presentation.*
H. E. BLOCK, Col. (MC) USAF, Lackland Air Force Base.
13. *Utilization of Hydrocortone in Arthrotomy of the Knee.*
SI MOOREHEAD, Maj. (MC) USAF, Lackland Air Force Base.
14. *Review of Fractured Shaft of Tibia at Lackland Air Force Base.* R. H. EPPRIGHT, Lt. (MC) USAF, Lackland Air Force Base.

TEXAS RAILWAY AND TRAUMATIC SURGICAL ASSOCIATION

Monday, May 3, 2:00 p. m.

West Wing, Municipal Auditorium

President—William E. Crump, Wichita Falls.
Vice-President—Raleigh R. White, Temple.
Second Vice-President—Albert Singleton, Jr., Galveston.
Secretary-Treasurer—W. D. Marrs, Fort Worth.

1. *President's Remarks.*
WILLIAM E. CRUMP, Wichita Falls.
2. *The Objectives of Preplacement Roentgen Examination of the Low Back.* JOHN R. WINSTON, Temple.
3. *Radiographic Considerations of Preplacement Examination of the Spine with Primary Emphasis on Spondylolisthesis and Its Associated Defects.*
ROBERT D. MORETON, Fort Worth.
4. *Symposium: Management of Trauma Involving Disturbance of Cerebral and Cardiorespiratory Function.*
R. J. WHITE, Fort Worth, Moderator.
Panel: RALEIGH R. WHITE, Temple;
J. O. MCBRIDE, Fort Worth;
JAMES GREENWOOD, JR., Houston;
RICHARD D. PRICE, San Antonio;
WILLIAM D. SEYBOLD, Houston.
5. *Business Meeting—Election of Officers.*
6. *Remarks by the New President.*

5:30 p. m.

Renaissance Room, Menger Hotel

7. *Cocktails.* Members and their wives.

TEXAS SOCIETY OF ANESTHESIOLOGISTS

Sunday, May 2, 12:15 p. m.

Roof Garden, Plaza Hotel

President—James B. Robinett, Jr., Houston.
President-Elect—Frank O. Barrett, El Paso.
Vice-President—Joe B. Wood, Dallas.
Secretary-Treasurer—Charles R. Allen, Galveston.

1. (12:15) *Luncheon.* (Reservations should be made by noon April 30 with Dr. R. A. Miller, Nix Professional Building, San Antonio. Price $3.)

2:00 p. m.

2. *General Practice of Anesthesiology.*
DAVID O. JOHNSON, Austin.
3. *The Anectine Drip Technique.*
MARY L. SMITH, Houston.
4. *Cardiac Resuscitation.*
ROBERT PETERSON, San Antonio.
5. *Pediatric Anesthesia.*
DIGBY LEIGH, Vancouver, B. C., Canada.

4:00 p. m.

6. *Business Meeting.*

TEXAS SOCIETY OF GASTROENTEROLOGISTS AND PROCTOLOGISTS

Monday, May 3, 2:00 p. m.

Room A, Municipal Auditorium

President—Cecil O. Patterson, Dallas.
First Vice-President—J. Wade Harris, Houston.
Second Vice-President—Edward J. Lefeber, Galveston.
Secretary-Treasurer—William T. Arnold, Houston.

1. *Acute Diseases of the Liver.*
JOHN R. KELSEY, Houston.
2. *A Fourteen Year Survey of Over 1,000 Consecutive Gastroscopic Examinations.* EDWARD J. LEFEBER and JOHN C. MEADOWS, Galveston.
3. *Clinical Evaluation of Darstine.*
A. C. BRODERS, JR., Temple.
4. *Diagnosis and Treatment of Anorectal Complications of Oral Antibiotics.* JOHN MCGIVNEY, Galveston.
5. *Treatment of Common Rectal Disorders.*
HUGH C. WELSH, Houston.

6. *Surgical Correction of Rectal Prolapse.*
W. F. BOWER, Col. (MC) AUS, Fort Sam Houston (by invitation).
7. *Intestinal Motility* (motion picture). If time permits.
N. C. HIGHTOWER, Temple.

TEXAS SOCIETY OF PATHOLOGISTS

Monday, May 3, 1:30 p. m.

Mezzanine B, Gunter Hotel

President—John J. Andujar, Fort Worth.
President-Elect—Charles B. Sanders, Houston.
Vice-President—A. J. Gill, Dallas.
Secretary-Treasurer—Lloyd R. Hershberger, San Angelo.

1. (1:30) *Blood Oxygen Saturation Tests in Cardiac Catheterization.* F. C. COLEMAN and NORMAN JACOB, JR., San Antonio.
2. (2:00) *Presidential Address: Pathology's Mighty Mo.* JOHN J. ANDUJAR, Fort Worth.
3. (2:30) *Indications for Protein Fractionation; A Practical Laboratory Procedure.* MERVIN H. GROSSMAN, Dallas.
4. (3:00) *Comparative Study of Screening Methods in Hematology.* CHARLES T. ASHWORTH and C. D. FITZWILLIAM, Fort Worth.
5. (3:30) *Letterer—Siwe's Disease; Case Report with Analysis of Tissue Lipids.* JOHN H. CHILDERS, Galveston.
6. (4:00) *Lipoprotein in Traumatic Injuries.* LT. COL. LAWRENCE J. MILCH, USAF, San Antonio.
7. (4:30-5:30) *Semiannual Business Meeting.*

CONFERENCE OF CITY AND COUNTY HEALTH OFFICERS

Monday, May 3, 9:00 a. m.

East Wing, Municipal Auditorium

Chairman—George W. Cox, Austin.

1. *Air Pollution Problems in Harris County and the Action Being Taken to Correct This Condition.* L. D. FARRAGUT, Houston.
2. *Preparation for Community Disasters.* N. M. ATKINS, Waco.
3. *The Occurrence of Leprosy in Texas.* FRED C. KLUTH, Corpus Christi.
4. *Infectious Hepatitis.* GORDON W. GRACE, Los Angeles, Calif.
5. *Recent Advances in Poliomyelitis.* J. V. IRONS, Sc.D., Austin.

COUNTY SOCIETIES

Andrews-Ector-Midland Counties Society

Henrie Mast, Midland, is serving as president for 1954 of the Andrews-Ector-Midland Counties Medical Society; H. E. Hestand, Odessa, vice-president; Clarence Mast, Midland, secretary-treasurer; and Z. W. Hutcheson, Jr., Andrews, chairman of censors.

Armstrong-Donley-Childress-Collingsworth-Hall Counties Society

December 10, 1953

The Armstrong-Donley-Childress-Collingsworth-Hall Counties Medical Society and its woman's auxiliary held a Christmas party December 10 in Memphis. Memphis doctors and their wives were hosts for the turkey dinner. The party was in observance of Doctor's Day, and the physicians wore red carnations. Separate business meetings followed the party. Approximately thirty members and guests attended.

Bee-Live Oak-McMullen Counties Society

December 14, 1953

New officers were elected at the December 14 meeting of the Bee-Live Oak-McMullen Counties Medical Society in Beeville. They are L. W. Kirkland, Beeville, president; George W. Sansom, George West, vice-president; James L. Reagan, Beeville, secretary; and Ernest Miller, Beeville, public relations chairman.

Brazoria County Society

January 28, 1954

(Reported by Carlos E. Fuste, Jr., Secretary)

Placenta Previa—A. L. Dippel, Houston.

Members of Brazoria County Medical Society met January 28 at Freeport to hear Dr. Dippel present the above talk.

A. O. McCary, Freeport, announced that at a recent district meeting of the Texas Heart Association at Galveston, it was decided to establish a rehabilitation and reclassification clinic in connection with the Cardiac Clinic at John Sealy Hospital. M. Warren Hardwick, Angleton, is president of the Brazoria County Chapter of the Texas Heart Association.

Cameron-Willacy Counties Society

January 18, 1954

(Reported by Harry A. Miller, Executive Secretary)

Estate Tax Planning for Physicians—Mr. Herbert Croft, San Antonio.

The Cameron-Willacy Counties Medical Society met in Harlingen January 18, with approximately eighty-eight society and auxiliary members present for dinner.

Mr. Croft's talk on estate tax planning was followed by a brief question and answer period.

David Lancaster, Ned Chase, and Fred Duckworth were accepted as new members.

A finance report was given by David F. Nickell, Harlingen. Dr. Nickell proposed that a portion of the society's funds be used to purchase government bonds or some revenue bearing commodity.

Richard Bernard, Harlingen, in connection with the recent tuberculosis test survey held in the Harlingen vicinity, requested his colleagues to send in follow-up reports of the test cases as soon as possible so that they may be included in the report to the Texas Tuberculosis Association.

Dr. Bernard also called attention to the fact that Harlingen has not had a city health officer for over a year. A committee of Harlingen physicians, composed of Dr. Bernard, John Welty, and Howard Tewell, was appointed to confer with city commissioners in the hope of procuring a physician for the post of public health officer.

Comal County Society

December 8, 1953

LeRoy Schleicher was elected president of the Comal County Medical Society December 8 at the home of J. Frederick Casto, New Braunfels, outgoing president.

Other new officers are Jack Bergfeld, vice-president; Thomas H. Brandes, secretary-treasurer; W. W. Sullivan, delegate; Dr. Brandes, alternate; and John K. Schaefer, Dr. Schleicher, and Dr. Casto, censors. All officers are from New Braunfels.

Falls County Society

December 14, 1953

Officers for the coming year were elected at a December 14 dinner-meeting of the Falls County Medical Society in Marlin. J. S. Bussell became president; Walter Reese, vice-president; J. C. Hohf, secretary; E. P. Hutchings, censor; Neil Buie, delegate; and A. C. Bennett, alternate, all from Marlin.

A scientific paper was presented by M. A. Davison, Marlin, prior to the election. Following the business meeting, the group joined the woman's auxiliary for a Christmas party at the home of Thomas Glass.

Grayson County Society

December 15, 1953

New officers of the Grayson County Medical Society, elected December 15 in Denison, follow: Paul Pierce, Denison, president; John Hardy, Sherman, vice-president; Joseph Stout, Sherman, secretary; and E. L. Hailey, Denison, treasurer. Delegate and alternate are Robert Duncan, Denison, and D. C. Enloe, Sherman, respectively.

The election followed a dinner. Vernon L. Tuck, Sherman, presided.

Harris County Society

January 13, 1954

(Reported by Mrs. W. M. Palm, Public Relations Secretary)

Rh Factor and Its Significance—William R. Knight, Houston.

After hearing the above discussion by Dr. Knight, the Harris County Medical Society held a business meeting January 13 at the Medical Arts Building in Houston.

L. E. Williford, president-elect, discussed the Houston Academy of Medicine Library Building, which is under construction in the Texas Medical Center and is expected to be completed in late spring or early summer. The library will have 40,000 volumes and stack capacity for 150,000.

Denton Kerr explained the functions of the Manion Commission and stated that the society should cooperate in the work of this commission.

W. B. Thorning, chairman of the medical jurisprudence committee, reviewed pertinent legislation pending in the national Congress. Petitions were circulated supporting the Bricker Amendment and opposing the entrance of Red China into the United Nations.

Harrison County Society

December 11, 1953

Diagnosis and Treatment of Thyroid Diseases — C. F. Hamilton, Dallas.

Members and guests of the Harrison County Medical Society heard the above discussion December 11 in Marshall by Dr. Hamilton, who was the recipient of the Van Meter prize from the American Goiter Association for his work in radioactive iodine treatment of thyroid diseases.

The society's new officers include C. A. Wyatt, president; Roger Harmon, vice-president; N. F. Holcomb, secretary; R. G. Granbery, delegate; and J. H. Harris, alternate, all of Marshall.

Hays-Blanco Counties Society

December 15, 1953

J. R. deSteiguer, secretary of the Hays-Blanco Counties Medical Society for twenty years, at the group's meeting December 15 in San Marcos refused to accept nomination for the office again. Dr. deSteiguer, an honorary member of the Texas Medical Association and the only surviving charter member of the local society, is past 80 years old and has practiced medicine for sixty-three years.

The officers elected follow: Benge Elliott, San Marcos, president; M. C. Williams, San Marcos, vice-president; M. D. Heatly, San Marcos, secretary-treasurer; T. C. McCormick, Buda, delegate; and Dr. Heatly, alternate. Censors are W. L. Moore and C. W. Scheib of San Marcos and J. J. Flannery of Blanco.

Hidalgo-Starr Counties Society

December 8, 1953

New officers of the Hidalgo-Starr Counties Medical Society elected at the society's December 8 meeting in Pharr follow: Paul H. Frenzel, president; Berton F. Frink, vice-president; and Sheridan Evans, secretary-treasurer, all of McAllen.

The election was held after a dinner with the local woman's auxiliary.

Hunt-Rockwall-Rains Counties Society

December 8, 1953

John C. Vallancey was elected president of Hunt-Rockwall-Rains Counties Medical Society during a business session December 9 in the home of F. S. Carruthers, Greenville, preceding the annual dinner given by the local woman's auxiliary.

Other officers elected were Warren Hancock, vice-president; Ralph Jenks, secretary; S. D. Whitten, delegate; and C. B. Weis, alternate delegate. Joe Becton was named to the board of censors. All new officers are from Greenville.

Jasper-Newton Counties Society

December 17, 1953

J. W. McCall, Jasper, was elected president of the Jasper-Newton Counties Medical Society at its Christmas party with the woman's auxiliary December 18 in the home of W. F. McCreight, Kirbyville. Rider Stockdale, Jasper, is the new vice-president; Tom R. Jones, Pineland, secretary-treasurer; J. J. McGrath, Jasper, delegate; and John Moore, Kirbyville, alternate.

Jefferson County Society

January 1, 1954

Officers of Jefferson County Medical Society who assumed office on January 1 follow: Dan H. Byram, Port Arthur, president; W. Pierre Robert, Beaumont, president-elect; F. J. Beyt, Port Arthur, vice-president; and Irving M. Richman, Beaumont, secretary-treasurer.

Delegates to the Texas Medical Association are L. C. Carter, Port Arthur; J. C. Crager, Beaumont; and L. C. Powell, Beaumont. Alternate delegates include Paul R. Meyer, Port Arthur; Thomas B. Matlock, Port Arthur; and Dr. Robert Jefferson County board of censors consists of John M. White, Port Arthur, and C. H. Hendry and E. H. Lindsey, Beaumont. Dr. Hendry is chairman of the censors.

Kerr-Kendall-Gillespie-Bandera Counties Society

December, 1953

When the Kerr-Kendall-Gillespie-Bandera Counties Medical Society met in December, new officers were elected. They follow: H. C. Day, Boerne, president; Russell Guill, Kerrville, vice-president; Mathis Blackstock, Kerrville, secretary; George Meador, Bandera, treasurer; D. R. Knapp, Kerrville, delegate; Choice Matthews, Kerrville, alternate; William Earl Gregg, Kerrville, public relations chairman; and David McCullough, Kerrville, tuberculosis chairman.

Joshua Seidel, chief surgeon at the Veterans Administration Hospital in Kerrville, was elected to membership.

Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Society

December 11, 1953

Inoculation Program—John C. Spencer, Crystal City.
Fungus Diseases of Lungs—David McCullough, Kerrville.
Care and Correction of Congenital Intestinal Deformities—Robert Nixon, San Antonio.
Technique and Interpretation of Tests of Neurological Reflexes—Lewis Helfer, San Antonio.

At the meeting of Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Medical Society held at the Crystal City Country Club, December 11, the following physicians were elected as new officers: Frank H. Pratt, Rocksprings, president; B. O. Lewis, Eagle Pass, vice-president; Woods A. Howard, Uvalde, secretary-treasurer.

A resolution was adopted that persons handling food and drink should have a chest roentgenogram taken before being certified by any society members as being free from communicable disease.

After the above scientific program and a business meeting, a dinner was held with the local woman's auxiliary.

Navarro County Society

December 12, 1953

Newly elected officers of Navarro County Medical Society, who were chosen at its December meeting in Corsicana, are: W. W. Carter, president; Will Miller, vice-president; James Barnebee, secretary-treasurer; and William T. Shell, delegate, all of Corsicana.

Entertainers from Baylor University provided the program for the fifty-fourth annual banquet-meeting of the society.

Palo Pinto-Parker-Young-Jack-Archer Counties Society

December, 1953

Reminiscing—William M. Campbell, Weatherford.

Palo Pinto-Parker and Young-Jack-Archer Counties Medical Societies have joined to form one society. At the society's December meeting, held in Mineral Wells, John B. Merrick, Weatherford, was elected president. Other officers are William O'Quin, Mineral Wells, vice-president; Joe T. Nelson, Weatherford, secretary; E. F. Yeager, Mineral Wells, delegate; and B. B. Griffin, Graham, alternate delegate. R. C. Jordan, Mineral Wells, was named on the four-member censor committee.

It was decided that Mineral Wells will be the permanent meeting place.

Dr. Campbell, who has been in active practice for sixty-five years and who is 94 years of age, spoke on the above subject.

Potter County Society

January 11, 1954

(Reported by James L. Johnson, Secretary)

Surgical Treatment of Thrombotic Occlusion of Abdominal Aorta—Oscar Creech, Jr., Houston.
Discussion—Walter C. Watkins, Amarillo.

The Potter County Medical Society met January 11 in Amarillo to hear Dr. Creech, associate professor of surgery, Baylor University College of Medicine, speak on the above topic. His lecture was illustrated with color slides, and Dr. Watkins led a discussion on the subject.

At the business meeting the application for membership of S. Victor Yeakel was accepted, and Robert P. Gallagher was nominated to honorary membership.

Attention was called to the January 20 meeting in Amarillo of the Panhandle Area of the Academy of General Practice and to the Texas Medical Association county society presidents and secretaries meeting January 23 in Austin. It was voted that the society's president and secretary be sent at the society's expense to the Austin meeting.

Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Society

December 17, 1953

Fractures of Elbow in Children—Cecil Robinson, Kermit.

About forty doctors and their wives attended the Christmas party December 17 at Kermit of the Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Medical Society. Following the turkey dinner, separate meetings were held. The society heard the above scientific discussion and elected the follcwing new officers: B. A. Wight, Kermit, president; F. M. Applegate, Monahans, vice-president; and Harper Peddicord, Kermit, secretary-treasurer.

Tarrant County Society

January 19, 1954

(Reported by S. W. Wilson, Secretary)

Panel Discussion: Evaluation of Laboratory Procedures in the Study of the Patient—May Owen, Moderator; John J. Andujar; Charles T. Ashworth; C. D. Fitzwilliam; and O. J. Wollenman, Fort Worth.

Approximately seventy-five members of the Tarrant County Medical Society were present for its January 19 meeting in Fort Worth to hear the above scientific program.

C. M. Whorton was elected to membership. Tribute was paid C. C. Garrett, who died January 1.

A letter from the Texas Medical Association regarding telephone postgraduate broadcasts, scheduled for February 17 and March 9, was read by the secretary. The society decided to receive only the February broadcast.

A report of the legislative committee was given by Ernest E. Anthony, Jr., chairman. In connection with this report, a recording was heard of a portion of the address given at the Dallas County Medical Society inaugural banquet by Clarence Manion, J. D., former dean of Notre Dame Law School.

J. H. Steger announced that the Federal Narcotics Bureau plans to close the local office. It was decided that the society should write a letter of protest to the Commissioner of Narcotics.

War veteran physicians interested in forming a local chapter of medical veterans were invited by Ralph Clayton of Dallas to discuss plans for such a society with him.

Washington-Burleson Counties Society

December, 1953

Thomas Giddings was elected president of the Washington-Burleson Counties Medical Society at its December meeting in Brenham. Other new officers are Joe C. Smith, Caldwell, vice-president, and C. E. Southern, Brenham, secretary-treasurer. Dr. Giddings is from Brenham.

The group discussed plans for the Ninth District Medical Society meeting, for which it will be host on March 25.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

February 9, 1954

(Reported by S. E. Thompson, Secretary)

What State and County Medical Societies Mean to Medical Profession—Mr. N. C. Forrester, Austin.
Obstetric and Gynecologic Problems—Walter S. Morse and Hiram P. Arnold, Houston.

The scientific program outlined above was presented at the February 9 meeting of the Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society in Wharton. Mr. Forrester is executive secretary of the Texas Medical Association. Drs. Morse and Arnold led the panel discussion which consisted primarily of questions and answers of everyday obstetric and gynecologic problems arising in general practice.

Fifty-two members, auxiliary members, and guests were present.

Wichita County Society

December 8, 1954

Pelvic Pain—William F. Mengert, Dallas.

A meeting of the Wichita County Medical Society was held in Wichita Falls December 8. George Siebold, president, presided until James Lee, president-elect, was installed as new president.

A program committee was appointed by Dr. Lee with the following physicians as members: Julian Acker, Louis Theimer, and Kenneth Bebb. Members of the society voted to continue presentation of the fall clinical conference, and L. N. Simmons was named to direct next year's conference.

Named as delegate to the annual session was J. D. Hall. E. Aubrey Cox was elected as alternate delegate.

Bailey Collins urged attendance at cancer clinics and reminded members that the spring tumor clinic would be March 31.

Dr. Mengert, professor of obstetrics and gynecology at Southwestern Medical School of the University of Texas, talked on the above subject.

DISTRICT SOCIETIES

Seventh District Society

February 18, 1954

(Reported by William F. McLean, Secretary)

Dosimetric Determinations in Carcinoma of Cervix—John A. Wall, Houston.

Clinicopathologic Panel Discussion—Richard A. Lucas, Austin, Moderator; Roy H. Morris, Elgin; Henry Renfert, Austin; James F. Houghton, Taylor; Winston M. Brook, Lampasas; and C. F. Pelphrey, Austin.

The midwinter scientific session of the Seventh District Medical Society was held February 18 at the Texas Medical Association's headquarters building in Austin. The program was presented as outlined above. A movie was shown in connection with Dr. Wall's discussion. Sixty members attended. Clary Bates, Austin, district president, presided.

The society voted to nominate David Wade, Austin, as Councilor for District 7.

A buffet dinner was held and special entertainment provided by the Austin Civic Theater in the evening for 182 members and guests.

AUXILIARY SECTION

Announcements and Program

of the

THIRTY-SIXTH ANNUAL SESSION

of the

WOMAN'S AUXILIARY TO THE TEXAS MEDICAL ASSOCIATION

May 2, 3, 4, and 5, 1954

SAN ANTONIO, TEXAS

OFFICERS

Honorary Life Presidents.—Mrs. S. A. Collom, Texarkana; Mrs. Frank N. Haggard, San Antonio; Mrs. M. L. Graves, Houston.

Honorary Life Member.—Mrs. H. Leslie Moore, Dallas.

Past Presidents.—Mrs. E. H. Cary, Dallas; *Mrs. S. C. Red, Houston; Mrs. M. L. Graves, Houston; *Mrs. W. A. Wood, Waco; *Mrs. J. O. McReynolds, Dallas; Mrs. S. A. Collom, Texarkana; Mrs. E. V. DePew, San Antonio; Mrs. H. B. Trigg, Fort Worth; Mrs. Joe Gilbert, Austin; Mrs. H. C. Haden, Houston; Mrs. O. M. Marchman, Dallas; Mrs. H. R. Dudgeon, Waco; Mrs. G. V. Brindley, Temple; Mrs. Frank N. Haggard, San Antonio; *Mrs. Preston Hunt, Texarkana; *Mrs. S. D. Whitten, Greenville; *Mrs. John T. Moore, Houston; *Mrs. R. B. Homan, El Paso; Mrs. W. R. Thompson, Fort Worth; Mrs. F. F. Kirby, Waco; Mrs. S. H. Watson, Waxahachie; Mrs. Scott C. Applewhite, San Antonio; Mrs. William Hibbitts, Texarkana; Mrs. S. F. Harrington, Dallas; Mrs. P. R. Denman, Houston; Mrs. A. B. Pumphrey, Fort Worth; Mrs. Sam E. Thompson, Kerrville; *Mrs. Charles B. Alexander, San Antonio; Mrs. George Turner, El Paso; Mrs. Edward C. Ferguson, Beaumont; Mrs. Samuel M. Hill, Dallas; Mrs. Joseph B. Foster, Houston; Mrs. William M. Gambrell, Austin; Mrs. Oscar W. Robinson, Paris; Mrs. Robert Farris Thompson, El Paso.

President.—Mrs. E. W. Coyle, San Antonio.

President-Elect.—Mrs. Mark H. Latimer, Houston.

First Vice-President.—Mrs. John D. Gleckler, Denison.

Second Vice-President.—Mrs. Cecil O. Patterson, Dallas.

Third Vice-President.—Mrs. Ralph B. Payne, Amarillo.

Fourth Vice-President.—Mrs. Guy E. Knolle, Houston.

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Treasurer.—Mrs. O. M. Marchman, Jr., Dallas.

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Essay.—Mrs. A. O. Severance (Chairman), San Antonio; Mrs. Howard E. Puckett (Vice-Chairman), Amarillo; Mrs. C. L. Gary, Jr., Corsicana; Mrs. J. B. Robbins, El Paso; Mrs. William Rosenblatt, Wichita Falls; Mrs. J. E. Ross, Henderson; Mrs. Y. C. Smith, Corpus Christi; Mrs. Thomas Vanzant, Houston.

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Historical:

Archives.—Mrs. F. F. Kirby (Chairman), Waco; Mrs. George W. Tipton, Austin; Mrs. Henry O. Wyneken, San Antonio.

*Deceased.

History.—Mrs. Travis Smith (Chairman), Abilene; Mrs. John A. Crockett, Austin; Mrs. P. R. Denman, Houston; Mrs. Choice B. Matthews, Kerrville; Mrs. Walter G. Stuck, San Antonio.

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Memorial Service.—Mrs. G. V. Brindley (Chairman), Temple; Mrs. Max E. Johnson, San Antonio.

Mental Health.—Mrs. A. B. Pumphrey (Chairman), Fort Worth; Mrs. Clement C. Boehler, El Paso; Mrs. Joe Thorne Gilbert, Austin; Mrs. Ridings E. Lee, Dallas; Mrs. D. O. D. Ware, Fort Worth.

Nominating.—Mrs. Robert F. Thompson (Chairman), El Paso; Mrs. Ivan H. Readinger, Fort Worth; Mrs. R. C. Bellamy, Liberty; Mrs. Carlos R. Hamilton, Houston; Mrs. F. F. Kirby, Waco; Mrs. Troy Shafer, Harlingen; Mrs. Ridings E. Lee, Dallas.

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American Medical Education Foundation.—Mrs. J. L. Jinkins (Chairman), Galveston; Mrs. W. Frank Armstrong, Fort Worth; Mrs. Charles H. Cornwell, Marlin; Mrs. H. J. Ehlers, Houston; Mrs. John E. Hill, Marshall; Mrs. Allan Shields, Victoria; Mrs. Leone S. Thompson, Dallas.

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Publications:

Bulletin.—Mrs. E. H. Marek (Chairman), Yoakum; Mrs. Emmett Essin, Jr., Sherman; Mrs. Louis E. Gibson, Corsicana; Mrs. D. R. Reilly, San Angelo; Mrs. H. O. Smith, Marlin; Mrs. Allen T. Stewart, Lubbock.

News Letter.—Mrs. Haskell D. Hatfield (Editor), El Paso; Mrs. Jacob Rogde, El Paso; Mrs. George Turner, El Paso.

Public Relations.—Mrs. V. J. Simmon (Chairman), Temple; Mrs. A. A. Ross, Lockhart; Mrs. E. A. Rowley, Amarillo; Mrs. Truman C. Terrell, Fort Worth; Mrs. Andrew S. Tomb, Victoria; Mrs. L. L. D. Tuttle, Houston; Mrs. H. B. Williford, Beaumont.

Reference.—Mrs. Joseph B. Foster (Chairman), Houston; Mrs. William Hibbitts, Texarkana; Mrs. Max Woodward, Sherman.

Research.—Mrs. J. Peyton Barnes (Chairman), Houston; Mrs. Speight Jenkins, Dallas.

Resolutions.—Mrs. Joseph H. McCracken, Jr. (Chairman), Dallas; Mrs. Carlos R. Hamilton, Houston; Mrs. S. M. Hill, Dallas; Mrs. Newton F. Walker, El Paso.

Revisions.—Mrs. Edward C. Ferguson (Chairman), Beaumont; Mrs. T. H. Thomason, Fort Worth; Mrs. Scott C. Applewhite, San Antonio.

School of Instruction.—Mrs. Ramsay H. Moore (Chairman), Dallas.

Year Books.—Mrs. R. T. Travis (Chairman), Jacksonville; Mrs. Dudley Jackson, Jr., San Antonio.

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District 13.—Mrs. Jack A. Crow, Abilene.
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Hays-Blanco.—Mrs. C. W. Scheib, San Marcos.
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Wharton-Jackson-Matagorda-Fort Bend.—Mrs. Robert Leslie, El Campo.

District 9:
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Grimes.—Mrs. E. T. Ketchum, Navasota.
Harris.—Mrs. Jacob F. Schultz, Houston.
East Harris Chapter.—Mrs. H. O. Sappington, Baytown.
Montgomery.—Mrs. Henry D. Bell, Conroe.
Polk-San Jacinto.—Mrs. T. L. Gardner, Livingston.
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Washington-Burleson.—Mrs. G. V. Pazdral, Somerville.

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Jefferson.—Mrs. S. V. Granata, Beaumont.
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Nacogdoches.—Mrs. J. Frank Beall, Nacogdoches.
Orange.—Mrs. David Bennett, Orange.
Shelby-San Augustine-Sabine.—Mrs. Spencer Warren, Center.

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Freestone.—Mrs. Jack R. Cox, Teague.
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Falls.—Mrs. Clarence R. Miller, Marlin.
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Hill.—Mrs. James M. Buie, Whitney.
Johnson.—Mrs. Elmo L. Clark, Cleburne.
Limestone.—Mrs. O. T. Christoffer, Mexia.
McLennan.—Mrs. Eldon B. Fine, Waco.
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Baylor-Knox-Haskell.—Mrs. Edwin H. Balch, Seymour.
Clay-Montague-Wise.—Mrs. John W. Major, Nocona.
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Palo Pinto-Parker.—Mrs. William A. O'Quinn, Mineral Wells.
Tarrant.—Mrs. W. N. Jenkins, Fort Worth.
Taylor-Jones.—Mrs. Sol Estes, Abilene.
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Wilbarger.—Mrs. F. B. Steele, Vernon.
Young-Jack-Archer.—Mrs. Blaine Devine, Graham.

District 14:
Collin.—Mrs. Walter S. Wysong, II, McKinney.
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Dallas.—Mrs. Sidney S. Baird, Dallas.
Denton.—Mrs. Harry Farber, Denton.
Ellis.—Mrs. B. C. Wallace, Jr., Waxahachie.
Fannin.—Mrs. Lewie E. Morgan, Bonham.
Grayson.—Mrs. Stanley L. Clayton, Denison.
Hopkins-Franklin.—Mrs. Ray Hanna, Sulphur Springs.
Hunt-Rockwall-Rains.—Mrs. C. D. Savage, Greenville.
Kaufman.—Mrs. Louis W. Conradt, Terrell.
Lamar.—Mrs. George S. Woodfin, Paris.
Van Zandt.—Mrs. Horace A. Baker, Wills Point.

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Camp-Morris-Titus.—Mrs. Percy A. Reitz, Pittsburg.
Cass-Marion.—Mrs. O. R. Taylor, Linden.
Gregg.—Mrs. Ralph Crawford, Longview.
Harrison.—Mrs. Harold O. Padgett, Marshall.
Red River.—Mrs. James L. Wright, Clarksville.
Upshur.—Mrs. Joseph L. Fenlaw, Gilmer.

Local Convention Chairmen

Chairman.—Mrs. John C. Parsons, San Antonio.
Vice-Chairman.—Mrs. David A. Todd, San Antonio.
Courtesy.—Mrs. Frank N. Haggard, San Antonio.
Executive Board Luncheon.—Mrs. Scott C. Applewhite, San Antonio.
Favors.—Mrs. B. H. Passmore, San Antonio.
Finance.—Mrs. Dan A. Russell, San Antonio.
Hostess Rooms.—Mrs. W. H. Hargis, San Antonio.
Information.—Mrs. Frank Steed, San Antonio.
Luncheons.—Mrs. S. Foster Moore, Jr., San Antonio.
Past Presidents' Dinner.—Mrs. E. V. DePew, San Antonio.
Post Convention Executive Board Meeting.—Mrs. John L. Pridgen, San Antonio.
Publicity.—Mrs. James L. Mims, Jr., San Antonio.
Registration.—Mrs. Thomas H. Sharp, San Antonio.
Social.—Mrs. J. L. Pipkin, San Antonio.
Transportation.—Mrs. Jack Watts, San Antonio.

Tickets to all functions may be obtained upon registration.

Saturday, May 1

1:00 p. m.-4:00 p. m. Registration, Information, and Tickets, Gay Nineties Lounge, Menger Hotel. Mrs. Thomas H. Sharp, San Antonio, Chairman.

Sunday, May 2

8:30 a. m. Council Women's Breakfast, Cavalier Room, Menger Hotel, Mrs. John D. Gleckler, Denison, First Vice-President and Organization Chairman, Presiding.

10:00 a. m.-4:00 p. m. Registration, Information, and Tickets, Gay Nineties Lounge, Menger Hotel. Mrs. Thomas H. Sharp, San Antonio, Chairman.

10:00 a. m. Preconvention Meetings of State Committees.

1:00 p. m. State Executive Board Luncheon Meeting, Minuet Room, Menger Hotel. Mrs. E. W. Coyle, San Antonio, President, Presiding. Mrs. Scott C. Applewhite, San Antonio, Chairman.

Invocation.—Mrs. Robert F. Thompson, El Paso.

Address of Welcome.—Mrs. John C. Parsons, San Antonio, Chairman of Convention and President, Woman's Auxiliary to Bexar County Medical Society.

Response.—Mrs. O. N. Mayo, Brownwood, President, Woman's Auxiliary to Brown-Comanche-Mills-San Saba Counties Medical Society.

Presentation of Past Presidents.—Mrs. O. M. Marchman, Dallas.

Message from President-Elect.—Mrs. Mark H. Latimer, Houston.

Introduction of Guests.

Greetings from Woman's Auxiliary to the Southern Medical Association.—Mrs. George D. Feldner, New Orleans, La., President.

Recommendations from Officers and Chairmen of Committees.

7:00 p. m. Past Presidents' Dinner, Renaissance Room, Menger Hotel. Mrs. E. V. DePew, San Antonio, Chairman; Mrs. Frank N. Haggard and Mrs. Scott C. Applewhite, San Antonio, Co-Chairmen.

Monday, May 3

8:00 a. m.-4:00 p. m. Registration, Information, and Tickets, Gay Nineties Lounge, Menger Hotel. Mrs. Thomas H. Sharp, San Antonio, Chairman.

8:45 a. m.-9:40 a. m. Opening Exercises, Memorial Services, and General Meeting of the Texas Medical Association and Woman's Auxiliary, Room A, Municipal Auditorium. Dr. George Turner, El Paso, President, Presiding.

Prayer.—The Rev. George Mauze, D.D., Pastor, First Presbyterian Church, San Antonio.

"Twenty-Third Psalm" (Malotte).—Mr. Morris Whitehead, San Antonio.

Memorial Address for Deceased Members of Woman's Auxiliary.—Mrs. G. V. Brindley, Temple.

Memorial Address for Deceased Physicians: In Memoriam.—The Rev. E. J. Gregory, Superintendent, Mexican Baptist Orphans Home of Texas, San Antonio.

Introductions:

Dr. F. J. L. Blasingame, Wharton, President-Elect, Texas Medical Association.

Mrs. Mark H. Latimer, Houston, President-Elect, Woman's Auxiliary to Texas Medical Association.

Dr. Merton M. Minter, San Antonio, President, Bexar County Medical Society.

Mrs. John C. Parsons, San Antonio, President, Woman's Auxiliary to Bexar County Medical Society.

Mrs. Leo J. Schaefer, Salina, Kan., President, Woman's Auxiliary to American Medical Association.

Mrs. George D. Feldner, New Orleans, La., President, Woman's Auxiliary to Southern Medical Association.

Dr. L. Bonham Jones, San Antonio, Chairman, Committee on General Arrangements for Annual Session.

Dr. B. F. Stout, San Antonio, Chairman, Committee on Memorial Services.

Address of Auxiliary President.—Mrs. E. W. Coyle, San Antonio.

Address of President.—Dr. George Turner, El Paso.

10:00 a. m. First Business Session of Woman's Auxiliary to Texas Medical Association, Minuet Room, Menger Hotel. Mrs. E. W. Coyle, San Antonio, President, Presiding.

Invocation.—Dr. Hugh Robertson, San Antonio, Pastor, Alamo Heights Presbyterian Church.

Address of Welcome.—Mrs. John C. Parsons, San Antonio, Chairman of Convention and President, Woman's Auxiliary to Bexar County Medical Society.

Response.—Mrs. William Hibbitts, Texarkana.

Pledge and Credo Repeated in Unison.

Greetings.—Dr. George Turner, El Paso, President, Texas Medical Association.

Appointment of Special Committees.

Recommendations from the Executive Board.

Announcements.

Reports of County Presidents.

12:00 noon. Style Show Luncheon Honoring County Presidents, Colonial Room, Menger Hotel. Mrs. S. Foster Moore, San Antonio, Chairman.

Invocation.—Mrs. O. W. Robinson, Paris.

Presentation of the State Winner of the Association of American Physicians and Surgeons Essay Contest.—Mrs. A. O. Severance, San Antonio.

1:30 p. m.-4:00 p. m. Continuation of First Business Session, Minuet Room, Menger Hotel.

Reports of County Presidents Continued.

Tuesday, May 4

8:00 a. m.-4:00 p. m. Registration, Information, and Tickets, Gay Nineties Lounge, Menger Hotel. Mrs. Thomas H. Sharp, San Antonio, Chairman.

8:30 a. m. Second Business Session of Woman's Auxiliary to Texas Medical Association, Minuet Room, Menger Hotel. Mrs. E. W. Coyle, San Antonio, President, Presiding.

Invocation.—Mrs. W. R. Thompson, Fort Worth.

Greetings.—Dr. F. J. L. Blasingame, Wharton, President-Elect, Texas Medical Association.

Reports of Council Women, Committee Chairmen, and Officers.

12:00 noon. Luncheon Honoring Mrs. E. H. Cary, Dallas, First President of Woman's Auxiliary to Texas Medical Association, and Charter Members, Colonial Room, Menger Hotel.

Invocation.—Mrs. P. R. Denman, Houston.

Address.—Mrs. Leo J. Schaefer, Salina, Kan., President, Woman's Auxiliary to American Medical Association.

1:45 p. m.-3:45 p. m. Continuation of Second Business Session, Minuet Room, Menger Hotel.

Auxiliary Awards.—Mrs. Travis Smith, Abilene.

Resolutions.—Mrs. Joseph H. McCracken, Jr., Dallas.

Other Business.

Election of Officers.

Installation of Officers.—Mrs. George Turner, El Paso.

Presentation of Gavel and President's Pin.—Mrs. E. W. Coyle, San Antonio.

Acceptance of Gavel and President's Pin.—Mrs. Mark H. Latimer, Houston.

Presentation of Past President's Pin.—Mrs. Frank N. Haggard, San Antonio.

Acceptance of Past President's Pin.—Mrs. E. W. Coyle, San Antonio.

Adjournment of 1953-1954 Session.

3:45 p. m.-6:00 p. m. Tea and Tour of King William Street Homes. Honoring the State President, Mrs. E. W. Coyle, San Antonio, and President-Elect, Mrs. Mark H. Latimer, Houston; the National President, Mrs. Leo J. Schaefer, Salina, Kan., and President-Elect, Mrs. George Turner, El Paso. Other honored guests: Mrs. F. J. L. Blasingame, Wharton, wife of the President-Elect of the Texas Medical Association; Mrs. Merton M. Minter, San Antonio, wife of the President of the Bexar County Medical Society; Mrs. John C. Parsons, San Antonio, President of the Woman's Auxiliary to the Bexar County Medical Society. All members and visiting ladies are invited.

7:30 p. m.-12:00 midnight. President's Party and Buffet with Texas Medical Association, La Villita. Honoring Dr. George Turner, El Paso, President. (Buffet dinner will be served from 7:30 p. m. to 9:30 p. m. Entertainment will follow. From 10:30 p. m. until 12:00 midnight the orchestra will play for dancing. Dress, informal or cocktail. In case of rain the party will be in the Ballroom of the Plaza Hotel.)

Wednesday, May 5

8:30 a. m. Post Convention Executive Board Meeting and Breakfast, Pool Patio, Menger Hotel. Mrs. Mark H. Latimer, Houston, President, Presiding. Mrs. John L. Pridgen, San Antonio, Chairman.

Kick Off for 1954-1955. All past State Presidents, State Committee Members, Council Women, County Presidents, and Presidents-Elect are cordially invited and urged to attend. Officers and Committee Chairmen will present specific plans for the year's work accompanied by mimeographed outlines for all. Adjournment promptly at 11:00 a. m.

12:30 p. m.-2:40 p. m. General Meeting Luncheon with Texas Medical Association, Crystal Ballroom, Gunter Hotel. Dr. George Turner, El Paso, President, Presiding.

Introductions:

President-Elect, Texas Medical Association.

President-Elect, Woman's Auxiliary to Texas Medical Association.

General Practitioner of the Year.

Report of Activities of House of Delegates.—Dr. H. O. Deaton, Fort Worth, Speaker.

Address of Incoming President.—Dr. F. J. L. Blasingame, Wharton.

Address.—Guest Speaker.

Presentation of Gavel and of Past Presidents' Medallion.

COUNTY AUXILIARIES

Public relations is the project of the *Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Auxiliary* for the year, as its new officers assumed their duties March 12. The new officers, elected December 11 at Crystal City, are Mrs. L. M. Cartall, Del Rio, president; Mrs. B. O. Lewis, Eagle Pass, president-elect; Mrs. G. B. Cunningham, Uvalde, first vice-president; Mrs. Raul Montemayor, Eagle Pass, second vice-president; Mrs. Carey Poindexter, Crystal City, third vice-president; Mrs. John C. Spencer, Crystal City, parliamentarian; and Mrs. B. L. Burditt, Del Rio, secretary-treasurer.

Mrs. S. Byrd Longino discussed public relations at the January 6 meeting of the *Hopkins-Franklin Counties Auxiliary* in Sulphur Springs. She pointed out that state medical auxiliaries are discovering that in this eventful period public opinion is the mightiest force on earth.

Members of the dental auxiliary and wives of physicians at the Veterans Administration Hospital and the Amarillo Air Force Base Hospital were guests at a come-and-go Christmas tea given by the *Potter County Auxiliary* December 15 in the home of Mrs. A. J. Streit, Amarillo.

Mrs. A. L. Nelson was hostess for the Christmas party of the *Nacogdoches County Auxiliary* on December 9 at Nacogdoches. The auxiliary voted to contribute to the Jaycee Christmas cheer fund.

At its January 7 luncheon meeting in Longview, the *Gregg County Auxiliary* completed the shower of linens begun in December for the Cerebral Palsy Clinic in Kilgore. The shower is an annual project of the auxiliary. A Christmas theme was carried out at the group's December luncheon at the Gregg County Airport. It was decided to offer three cash prizes for the local essay contest sponsored nationally by the Association of American Physicians and Surgeons.

With a Valentine's Day theme, the *El Paso County Auxiliary* honored Mrs. Edward W. Coyle, San Antonio, State Auxiliary President, at a luncheon in El Paso on February 8. Sharing honors with her was Mrs. Harold Lindley, Pecos, council woman for District 1. Mrs. Coyle spoke of health education, public relations, and legislation.

Mrs. Coyle and Mrs. Mark H. Latimer, Houston, President-Elect of the State Auxiliary, were guests at a luncheon given by the *Jefferson County Auxiliary* January 12 in Beaumont. Presidents from District 10 auxiliaries were invited also.

The *Navarro County Auxiliary* voted to send a contribution to the American Medical Education Foundation and to the Student Loan Fund at its February 5 meeting at the home of Mrs. E. H. Newton, Corsicana. Plans also were completed for the heart fund drive which the auxiliary is sponsoring for the second year, and a film on the heart, "Be Your Age," was shown. On February 10 the group raised $200 for the heart fund from a benefit coffee at the home of Mrs. J. H. Barnebee. A pamphlet, "Fables and Facts About Heart Disease," was presented to each guest by Mrs. C. L. Gary, Jr.

A health education booth was sponsored by the *Bexar County Auxiliary* at the San Antonio Live Stock Exposition from February 12 to 21, with Mrs. John C. Parsons as chairman. Two exhibits were shown: "You and Your Body," with manikins showing the organs of the human body, and "Where Your Medical Dollar Goes." The auxiliary honored wives of doctors attending the International Medical Assembly with a luncheon and style show on January 28. A luncheon with a Valentine motif was held at the February meeting, at which new officers were elected, includ-

ing Mrs. J. Lewis Pipkin, president; Mrs. L. Bonham Jones, president-elect; Mrs. Ruskin Norman, first vice-president; Mrs. Thomas Diseker, second vice-president; Mrs. M. H. Morris, third vice-president; Mrs. James Blair, Jr., fourth vice-president; Mrs. E. A. Maxwell, recording secretary; Mrs. Louis Manhoff, corresponding secretary; Mrs. Graham Coffman, publicity secretary; Mrs. Martin Jensen, historian; Mrs. Jack Partain, treasurer; and Mrs. Fred Cooper, auditor.

Following the annual election on January 15, new officers were installed at the February meeting in Corpus Christi of the *Nueces County Auxiliary.* Mrs. E. Jackson Giles serves as president; Mrs. Paul Gray, president-elect; Mrs. Harold E. Griffin, first vice-president; Mrs. C. B. Slabaugh, second vice-president; Mrs. J. Gordon Bryson, third vice-president; Mrs. Hugh A. Kennedy, recording secretary; Mrs. C. R. Little, corresponding secretary; Mrs. Charles Clark, treasurer; Mrs. Maurice Nast, reporter; Mrs. G. S. Ahern, historian; and Mrs. Sam Powell, parliamentarian. Also at the February meeting a panel discussion was presented by members of various hospital auxiliaries.

AUXILIARY DEATHS

Mrs. Gayle Moore Joseph, wife of Dr. P. S. Joseph, Alice, died January 12, 1954. She was a member and past president of the Brooks-Duval-Jim Wells Counties Medical Auxiliary.

Mrs. Margaret Richardson, widow of the late Dr. Dalton Richardson, Austin, died February 18, 1954, in a local hospital. A member and past president of the Woman's Auxiliary to the Travis County Medical Society, Mrs. Richardson in 1949 served on the State Executive Board as chairman of the Committee on Resolutions.

DEATHS

J. F. PATTISON

Dr. John Frazer Pattison, Big Lake, Texas, died November 19, 1953, at a local hospital of acute myocardial failure due to bronchial asthma.

The son of Dr. Isreal and Alice (Coleman) Pattison, Dr. Pattison was born June 3, 1874, in Oelwein, Iowa, where his father was a physician and a state representative. Dr. Pattison joined the United States Navy when he was 14 years old and attended the naval school at Newport, R. I., and later made cruises to Europe and the Far East. He sailed for Japan and China in 1891 aboard the USS Lancaster, the Navy's last wooden vessel that was powered by both sail and steam. In 1895, after leaving the Navy, Dr. Pattison became a student at the College of Physicians and Surgeons, Kansas City, Kan., until the Spanish-American War broke out two years later. He reenlisted in the Navy as a gunner's mate and served aboard the USS New Orleans, then the fastest ship in the Navy, for a year, after which he returned to medical school and was graduated in 1900 from the College of Physicians and Surgeons. He did postgraduate work at Drake University College of Medicine, Des Moines; the University of Kansas School of Medicine, Lawrence-Kansas City; and Kentucky University Medical Department, Louisville.

Before moving to Texas, Dr. Pattison practiced at Oelwein, where he was assistant surgeon for Chicago-Great-Western Railway Company in the Dr. I. Pattison Emergency Hospital, and at Augusta, Kan., and served in France in the United States Army Medical Corps in World War I, reaching the rank of captain. He was physician and surgeon for the Texon Oil and Gas Company, Santa Rita, and surgeon for Humble Oil Company, Big Lake. Dr. Pattison was city health officer and Reagan County health officer for twenty-nine years, during which time he instituted free immmunization for all county school children.

An honorary member of the Texas Medical Association since 1949 and a member since 1930, Dr. Pattison also belonged to the American Medical Association and the Crane-Upton-Reagan Counties Medical Society, of which he was a charter member, the first president, and again president in 1939. He assisted in the organization of the American Legion at Big Lake and was the first commander, an honorary member, and holder of a silver lifetime membership card. Also at Big Lake he was first commander of the Veterans of Foreign Wars, a position he held until his death. Dr. Pattison had been a member of the Episcopal Church since 1901. He was a member of the Masonic Order for fifty-eight years.

Dr. Pattison married the former Miss Amy A. Beal on February 7, 1903, at Earlville, Iowa. She survives, as do a son, Donald I. Pattison, Barstow, Calif.; two sisters, Mrs. Alice Matthie, Los Angeles, and Mrs. Sara Phillips, Seattle; four grandchildren; and four great-grandchildren.

A. G. MARSHALL

Dr. Alex George Marshall, El Paso, Texas, died from injuries received in an automobile accident near Indio, Calif., December 25, 1953. Dr. Marshall and his wife, who also was killed in the accident, were en route to Los Angeles to visit their son, a student at the University of California.

Born in Chicago, September 29, 1904, Dr. Marshall was the son of Sam and Mollie Marshall. He attended public schools and Crane College in Chicago before being graduated in 1927 from the University of Illinois College of Medicine and serving an internship at Cook County Hospital, Chicago. He practiced in Chicago from 1928 until 1939, at which time he moved to El Paso as a specialist in internal medicine. There he was chief of medicine at Hotel Dieu, and on the staffs of Providence Memorial and Southwestern General Hospitals. While in Chicago, he was instructor in medicine at the University of Illinois and clinical assistant at Mt. Sinai Hospital dispensary.

A member of the Texas Medical Association through El Paso County Medical Society, Dr. Marshall was a member of the American Medical Association. He was a Mason, Shriner, and member of the board of directors of Congregation B'nai Zion.

Mrs. Marshall was the former Miss Augusta Rapoport. They married in Chicago in 1928.

Dr. Marshall is survived by two sons, Howard D. Marshall, Beverly Hills, Calif., and Edward Marshall, El Paso; and his mother, Mrs. Mollie Marshall, Chicago.

C. C. GARRETT

Dr. Clarence Coleman Garrett, Fort Worth, Texas, died suddenly January 1, 1954, of a heart attack in a local hospital where he was making rounds.

Born in Richmond, Texas, April 26, 1902, Dr. Garrett was the son of Clyde Barbee and Cora (Anders) Garrett. He attended high school in Crockett and Southern Methodist University in Dallas before receiving his medical

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1927. After interning at the Hospital of the University of Pennsylvania, Dr. Garrett moved to Fort Worth, where he was house physician at the Cook Memorial Hospital from 1929 to 1931 and then specialized in internal medicine.

Dr. Garrett belonged to the American Medical Association and the Texas Medical Association through the Tarrant County Medical Society, for which he had been editor of the *Bulletin* since 1947. He also belonged to the Thirteenth District Medical Society, the Fort Worth Academy

DR. C. C. GARRETT

of Medicine, and the Fort Worth Club of Internists. In medical school he was a member of Phi Beta Pi medical fraternity and Alpha Omega Alpha honorary medical fraternity. At the time of his death, he headed the medical section of the civil defense program in Fort Worth.

On November 17, 1932, in Fort Worth, Dr. Garrett married the former Miss Mary Jane Joyslin, who survives him. Other survivors include a daughter, Mrs. Jane Garrett Molpus, and a sister, Mrs. W. R. Sullivan, Dallas.

G. F. THORNHILL

Dr. Gabriel Felder Thornhill, Austin, Texas, died of coronary occlusion at his home, January 8, 1954.

Born in Navasota, March 31, 1890, the son of Dr. G. F. and Mary (Buckingham) Thornhill, Dr. Thornhill attended Paris high school. He received bachelor and master of science degrees from the University of Virginia, Charlottesville, and was graduated from New York Medical College, Flower and Fifth Avenue Hospitals, New York City, in 1919. He served an internship at Flower Hospital from 1919 to 1921. Continuing to practice medicine in New York for fourteen years, he was assistant attending physician at Fifth Avenue and Metropolitan Hospitals, head of the staff of the ear, nose and throat department of the Doctor's Hospital, consulting physician at Judson Health Centre, and instructor at Columbia University College of Physicians and Surgeons. He did postgraduate work at Metropolitan Hospital in New York.

A resident of Austin since 1936, Dr. Thornhill specialized in diseases of the ear, nose, and throat, being a diplomate of the American Board of Otology, Laryngology, and Rhinology. He had been state health director of the National Youth Administration, a member of the State Committee for Procurement and Assignment of Physicians, on the board of directors of Brackenridge Hospital, and a member of the medical staff of St. David's Hospital.

Dr. Thornhill was a member of the American and Texas Medical Associations through Travis County Medical Society, and a fellow of the American College of Surgeons. He had served as both president and secretary of his county society. He had been director and president of the Austin Chamber of Commerce and president of the Travis County Red Cross Chapter. He was a Rotarian, Mason, Shriner and Jester. He belonged to the American Legion and the Methodist Church. While at the University of Virginia, he was an outstanding athlete in golf, track, and baseball. In New York, he won the Metropolitan Golf Championship. He continued to be interested in golf, hunting, and fishing.

On June 10, 1926, Dr. Thornhill married the former Miss Weta Ingram in New York. She and a son, Gabriel Felder Thornhill, III, both of Austin, survive. Also surviving are his mother, Mrs. G. F. Thornhill, Paris, and two sisters, Mrs. George Robert Coleman, Amarillo, and Mrs. Clara Hammond, New York.

B. M. AVENT

Dr. Benjamin M. Avent, Rosebud, Texas, died November 17, 1953, after a long illness.

Born in Lafayette Springs, Miss., January 1, 1868, Dr. Avent lost his parents when he was a youngster and grew up in Texas. He attended school in Bartlett; the University of Alabama; and the old Memphis Hospital Medical College, Memphis, Tenn., from which he received his degree of doctor of medicine in 1897. After serving a preceptorship under a physician at Rogers, Dr. Avent set up his own

DR. B. M. AVENT

practice in Briary, Milam County. He then served the Baileyville and Barclay communities before locating in nearby Rosebud, where he had been in practice for well over fifty years, being city health officer for eighteen years and retiring from practice only last year.

Dr. Avent was elected to honorary membership in the Texas Medical Association in 1948 after being affiliated

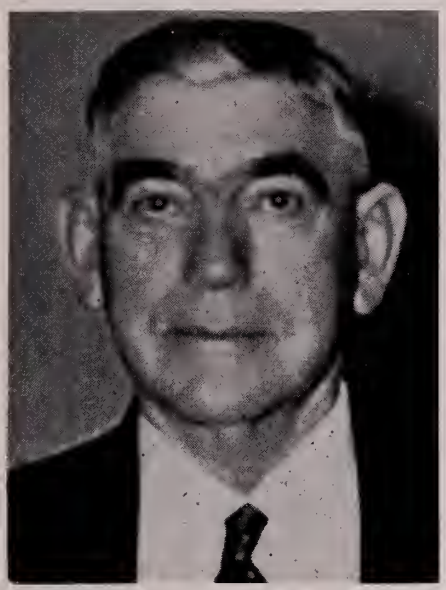
with the organization almost continuously since 1908. He was a member first through Milam County and more recently through Falls County Medical Society, and also belonged to the American Medical Association. He was a member of the Baptist Church and a Mason, recently receiving the Silver Button award of the latter order for a half century of service. He formerly was president of the Rosebud school board.

Survivors include Mrs. Avent; three sons, Dr. W. M. Avent, Waco; Hugh Avent, Greenville, S. C.; and Rhette Avent, Houston; four daughters, Mrs. L. A. Johnston and Mrs. H. M. Bennett, both of Houston; Mrs. E. H. O'Neal, Rosebud; and Mrs. Floyd Blakeney, Hobbs, N. M.

C. C. ANDERSON

Dr. Charles Cleveland Anderson, Venus, Texas, died in a Dallas Hospital, January 16, 1954, of coronary thrombosis.

The son of Hiram Winslow and Mary (Abel) Anderson, Dr. Anderson was born July 6, 1886, in Burnsville, Miss. He attended Oglesby public schools and the Medical Department of Tulane University of Louisiana, New Orleans, receiving his medical degree in 1913 from St. Louis College of Physicians and Surgeons. Dr. Anderson practiced medicine in Tishimingo and Greer Counties, Okla., before



DR. C. C. ANDERSON

locating in 1913 in Venus. For several years, Dr. Anderson was Venus' only physician. When in 1941 the one drug store closed, he also was for a number of years the town's only pharmacist.

A member of the American Medical Association and Texas Medical Association through Johnson County Medical Society, he was elected in 1940 to honorary membership in the state Association. He had been railroad surgeon for the Missouri Pacific Lines for thirty years. He was a Mason, being a Knight Templar and Shriner, and belonged to the Venus Lions Club. He also was a member of the Church of Christ.

Dr. Anderson served as president of the Venus school board and vice-president of the Citizens Bank of Venus for a number of years. He also was instrumental in obtaining several farm-to-market roads in his county.

On March 2, 1909, Dr. Anderson married the former Miss Leona Wilson in Whitney. She survives as do a son, Dr. H. M. Anderson, San Angelo; a daughter, Mrs. Peggy Wallace, San Angelo; two grandsons, Macky Anderson, San Angelo, and Billy Charles Roten, Venus; three brothers, Winslow Anderson, Dallas; Mason Anderson, Houston; and Jessie Anderson, Houston; six sisters, Mrs. F. A. Morris, Sr., Oglesby; Mrs. Hill Stewart, Lubbock; Mrs. W. E. Mize, Shawnee, Okla.; Mrs. A. C. Slade, Bismarck, N. D.; Mrs. John Nesbit, Houston; and Miss Woodie Mae Anderson, Houston.

L. G. AIDE

Dr. Lewis George Aide, linguist, writer, and physician of Bellmead (Waco), Texas, died December 12, 1953, of coronary thrombosis.

The son of Khalil and Barbara Aide, Dr. Aide was born in Maaser-El-Shouf, Lebanon, December 28, 1892. He came to the United States when he was 9 years of age and was graduated from Crosby High School at Waterbury, Conn. After serving two years in France with the United States Army, he worked with the American Red Cross in Europe

DR. L. G. AIDE

and the Middle East before returning to the United States in 1920. He entered Columbia University, New York, and obtained a medical degree from Long Island College of Medicine, Brooklyn, in 1927. After serving an internship at St. Peter's Hospital, Brooklyn, he practiced in that city for ten years, during which time he was vice-president of the Knights of Columbus, was president of the St. Nicholas Club, and organized and was president of the Democratic Club. In 1939 Dr. Aide moved to Texas, practicing for one year at Waelder and then becoming physician for the Veterans Administration Hospital in Denton. He was transferred to Waco to serve the Civilian Conservation Corps camp there and in Gatesville, and remained in Waco after he returned to private practice in 1942. He set up his offices in Bellmead, where he also established a weekly community newspaper, the *La Vega Citizen,* serving as its editor until a full-time editor could be employed. He was a member of the McLennan County Medical Society, Twelfth District Medical Society, Texas Medical Association, and American Medical Association; a captain in the Texas State Guard; a member of the Syrian-American Club of Waco; and a member of the Catholic Church.

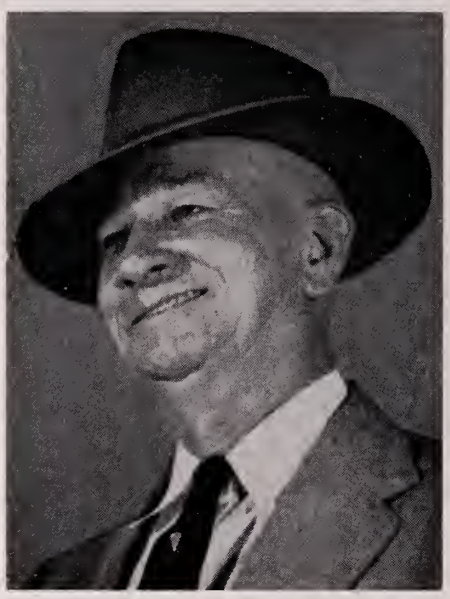
Dr. Aide spoke fluently Arabic, French, Spanish, and German, as well as English, and had translated poems, proverbs, and other works of literature from the original Arabic. He was himself a poet and had completed two novels at the time of his death. He also was interested in photography, woodworking, leatherwork, music, and amateur radio.

A son, Lt. Fouad K. Aide, Camp Gordon, Ga.; two brothers, Nick Aide, Brooklyn, N. Y., and George Aide, Orlando, Fla.; a sister, Miss Mathilde Aide, Bellmead; and a granddaughter, Miss Barbara Mathilde Aide, Austin, survive.

C. W. BORING

Dr. Clarence William Boring, Port Arthur, Texas, died in a local hospital January 5, 1954, of hypertension and coronary thrombosis.

A member of a well-known pioneer family, Dr. Boring was born in Homer, La., September 1, 1882, the son of James Wafer and Carrie (Edwards) Boring. He attended Opelousas public schools and was graduated in 1904 from Louisville Medical College, Louisville, Ky. After graduation, Dr. Boring interned at City Hospital in Louisville. For twenty-three years, Dr. Boring practiced in Breaux Bridge, La., where he established the Boring-Youngue Sanatorium in 1921. He was chief medical examiner for St.



DR. C. W. BORING

Martin Parish, La., draft board during World War I, and for Jefferson County during World War II. Dr. Boring had been coroner and county health officer of St. Martin Parish and city health officer of Breaux Bridge. He served as mayor of Breaux Bridge for twelve years, was a Mason and a member of the Methodist Church. He also was a member of the Louisiana State Medical Society and the Third Congressional District Medical Society.

After moving in 1927 to Port Arthur, he practiced there for more than twenty years. He was a member of the Texas Medical Association through Jefferson County Medical Society, being a member of the state Association almost successively since 1929. He was an honorary member of the county society and also an honorary member of St. Mary's Hospital staff, Port Arthur.

Dr. Boring, on November 7, 1908, married Miss Frank Stewart; to this union were born four sons. Mrs. Boring died in 1919. On April 14, 1923, he wed Miss Marie Cormier. They became the parents of a daughter, Carrie Marie, who died at the age of 6.

Dr. Boring is survived by his wife; four sons, Don and Jack Boring, of Port Arthur; John S. Boring of Baltimore; and C. W. Boring, Jr., of New York; three sisters, Mrs. E. V. Chauvin of Lafayette, La.; Mrs. Lee Wilson, Opelousas, La.; and Mrs. Wesley J. Miles of Crowley, La.; four grandsons; and a granddaughter.

A. J. EVANS

Dr. Andrew Jackson Evans, Mineral Wells, Texas, died December 10, 1953, following a six months' illness after suffering a cerebral hemorrhage on June 13.

Dr. Evans was born March 10, 1880, near Jacksonville, the son of Edmond C. and Mary Elizabeth (Denison) Evans. He attended old Fort Worth Medical College and in 1909 was graduated in medicine and pharmacy from the University of Louisville School of Medicine, Louisville, Ky.

DR. A. J. EVANS

Later he did postgraduate work in surgery at Mayo Clinic, Rochester, Minn., and Cooke County Hospital, Chicago.

Beginning his practice of medicine in Reece, where he also operated a drug store, Dr. Evans moved two years later to Caddo and then to Weatherford before locating in 1919 in Mineral Wells.

Dr. Evans belonged to the Texas Medical Association and American Medical Association through Palo Pinto-Parker Counties Medical Society. He was president of the county society in 1943. He also held membership in the Southern Medical Association and Thirteenth District Medical Society. He was a member and had been president of the staff of Nazareth Hospital in Mineral Wells. For many years, he was chairman of the board of stewards of the First Methodist Church of Mineral Wells.

Dr. Evans on March 8, 1905, near Tyler, married the former Miss Alvarine C. Phillips, who survives. Also surviving are two sons, A. Kenneth Evans and E. Cecil Evans, D. O.; two daughters, Mrs. G. L. Grantham and Mrs. F. J. Armstrong, Jr., all of Mineral Wells; a cousin, Miss May

Denison, who lived in the Evans home; a niece, Mrs. Mamie Patterson, Dallas, whom he reared as his own child; eleven grandchildren; and one great-grandchild.

B. L. JENKINS

Dr. Berry L. Jenkins, Clarendon, Texas, died January 11, 1954; he had not been well since suffering a stroke in May, 1953.

Dr. Jenkins was born January 4, 1867, at Dallas in a house on the present site of the Baker Hotel. He attended public school in Mansfield and old Mansfield College, and was graduated from Vanderbilt University School of Medicine, Nashville, Tenn., in 1891. After practicing in Ellis, Briscoe, and Parker Counties, at first under the supervision of a preceptor, he moved to Palo Pinto County, practicing there for almost twenty years. In 1910 Dr. Jenkins settled in Clarendon, where he lived until his retirement in 1941. He at one time was local surgeon for the Texas and Pacific Railway and for the Strawn Coal Company.

DR. BERRY L. JENKINS

A member for almost fifty years of the Texas Medical Association, Dr. Jenkins was elected to honorary membership in 1945. He belonged to Armstrong-Donley-Childress-Collingsworth-Hall Counties Medical Society, serving as its secretary for five years, and previously had belonged to Palo Pinto-Parker Counties society. He was a member of the Third District Medical Society and of the Presbyterian Church.

On June 12, 1894, Dr. Jenkins married the former Miss Maggie Buster of Weatherford. Mrs. Jenkins died in 1943. Survivors include two sons, Dr. Oscar L. Jenkins, Dallas, and B. L. Jenkins, Jr., Amarillo; two grandchildren; and two great-grandchildren.

C. B. BUCK

Dr. Charles Bentley Buck, Mercedes, Texas, died of coronary thrombosis in a Weslaco hospital December 20, 1953.

The son of Dr. Llewellyn A. Buck and Adelia (Bearce) Buck, Dr. Buck was born November 30, 1869, in Buckfield, Maine, a town named for his ancestors. He received his academic education at Peabody, Kan., and was graduated from old Kansas Medical College, Medical Department of Washburn College in Topeka, which is now the University of Kansas School of Medicine. He served an internship at Christ Hospital, Topeka. Beginning his practice in Abilene, Kan., in 1904, he moved his family to Mercedes, Texas, in 1907. He moved to the Rio Grande Valley after a visit to Corpus Christi, where he became intrigued by tales of the climate and the novelty of the development of the Valley's irrigation systems. Although he engaged in general practice, Dr. Buck had taken special work in anesthesiology in recent years. Forced into semiretirement by his age, he kept office hours until his last illness, which began a week before his death.

Dr. Buck was a member of the American Medical Association and Texas Medical Association through Hidalgo-Starr Counties Medical Society. He was elected an honorary member of Texas Medical Association in 1951. He was also a member of the McAllen Elks Lodge, a charter member of the Mercedes Rotary Club, and a member of the First Presbyterian Church in Mercedes. A veteran of the Spanish-American War, Dr. Buck served in the Philippine insurrection.

Dr. Buck is survived by a son, Robert M. Buck, and a daughter, Mrs. Martha A. McDougall, both of San Antonio, and a sister, Miss Lulu C. Buck, Mercedes, with whom he was living at the time of his death.

L. E. WILLIFORD

Dr. Louis Estes Williford, president-elect of Harris County Medical Society, died at his home in Houston, Texas, January 31, 1954, of coronary occlusion.

The son of Frank and Louise Estes (Hunter) Williford, Dr. Williford was born August 25, 1901, in Houston. He attended Houston public schools, and received academic and medical degrees, the latter in 1927, from Tulane University of Louisiana, New Orleans. He interned at Charity Hospital in New Orleans, and for a year was assistant professor of zoology and anatomy at Tulane. Except for a few years' military service, he had practiced in Houston since 1928.

DR. LOUIS E. WILLIFORD

Dr. Williford was a member of the Texas Medical Association through Harris County Medical Society and would have served as the society's president in 1955. He previously had been chairman of its committee on military affairs. A fellow of the American College of Surgeons and

International College of Surgeons, he also belonged to the Southwestern Surgical Congress and the Southern Medical Association. He served as a member of the board of trustees of the Houston Academy of Medicine and president of the Medical Alumni Association of Tulane University. He was for seventeen years chairman of the surgical staff at Memorial Hospital, Houston, being the youngest man ever to be appointed to that position when he took office in 1937. He belonged to the Houston Country Club, Chambers County Duck Club, and First Baptist Church. Dr. Williford was an enthusiastic sportsman, enjoying hunting and golf especially. He loved fine bird dogs and raised quail.

He was a veteran of World War II, having served with the Army Medical Corps overseas for twenty-seven months and rising to the rank of lieutenant colonel.

September 9, 1940, he married the former Miss LaRue Summit, who had been his secretary for a number of years. She survives as do a brother, Judge Frank Williford, and a sister, Mrs. Frank Hoffman, both of Houston.

J. G. SCHILLING

Dr. John Gaillard Schilling, Houston, Texas, died January 4, 1954, at his home.

Born March 15, 1885, at Cedar Bayou, Texas, Dr. Schilling was the son of Dr. Nicholas and Linna (Gaillard) Schilling. He received his preliminary education at Cedar Bayou public schools and was graduated from the University of Texas Medical School, Galveston, in 1909. He served an internship at John Sealy Hospital, Galveston.

Dr. Schilling practiced at Cedar Bayou for thirteen years before he moved in 1923 to Houston. During World War I, he served with the Army Medical Corps in France for sixteen months.

DR. JOHN G. SCHILLING

A member of the American and Texas Medical Associations through Harris County Medical Society, he was also a fellow of the American College of Surgeons. He was a member of the United States Committee of the World Medical Association and a founder member of the Postgraduate Medical Assembly of South Texas. He belonged to the Southern Medical Association, Association of American Physicians and Surgeons, and Texas Railway and Traumatic Surgical Association. He was a member of the staffs of Methodist, Memorial, and St. Joseph's Hospitals, Houston, serving at one time as president of the staff of Methodist Hospital and vice-president of the staff of Memorial Hospital.

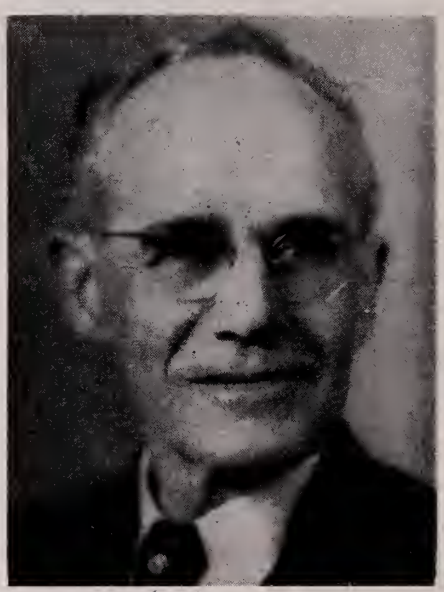
A member of the University of Texas Medical Branch Alumni Association, he also belonged to the Theta Kappa Psi medical fraternity. He was a member of the Houston Chamber of Commerce, Knights of Pythias, and Veterans of Foreign Wars. He also was a Scottish Rite Mason, a Shriner, and member of the Order of the Eastern Star. He belonged to the Presbyterian Church.

Dr. Schilling married the former Miss Fleda Mulligan of Crockett, November 6, 1924, in Houston. Survivors include his wife and one sister, Miss Annie Schilling, Cedar Bayou.

J. E. McCLUNG

Dr. John E. McClung, retired eye, ear, nose, and throat physician of Corsicana, Texas, died of leukemia November 4, 1953, in that city.

The son of Josiah and Sarah (Roberts) McClung, Dr. McClung was born March 5, 1875, in Winona. He received his medical degree in 1897 at the University of Tennessee College of Medicine, Memphis, and practiced in Winona for several years before moving in 1900 to Corsicana, where he settled. Dr. McClung did postgraduate work at the Uni-



DR. JOHN E. MCCLUNG

versity of Tennessee College of Medicine and in 1903 at the Manhattan Eye and Ear Hospital, New York. Later he was on the house staff of the Eye, Ear, and Nose Postgraduate Hospital in New York. The doctor retired in October, 1952.

A member of the Texas Medical Association for many years through the Navarro County Medical Society, Dr. McClung also was a member of the Masonic Order and several local civic clubs.

Dr. McClung's wife, the former Miss Jewel White, whom he married December 5, 1902, in Corsicana, died September 18, 1950. He is survived by two sons, Gerald McClung, Corsicana, and John E. McClung, Jr., New York; one daughter, Mrs. Henry Beckham, Waco; one sister, Mrs. Bess Edwards, and two brothers, Frank McClung and Till McClung, Winona; and four grandchildren.

President's Page

KNOW YOUR COMMUNITY

Doctors as individuals and county medical society members are influential in their communities. This position inculcates them with a special civic responsibility which in order to accept they must know their communities. They should know what facilities, services, and programs are being put to use in their communities and determine the part which can and should be played by the local medical societies for the best accomplishment of these efforts. The best health interest is served by "putting the doctor out in front" as the leader and principal speaker at forums and gatherings pertaining in any way to community medical care.

The Texas Medical Association has produced and distributed to county medical society officers a pamphlet called *Outline Guide, PR Activities for County Medical Societies.* One section of the pamphlet deals with planned participation in community affairs, stressing leadership by doctors in civic agencies dealing with any phase of medical care. Effective and strong community relations add strength to the internal structure of the society itself. You may wish to consider the following questions:

Does your society have an organized program to promote voluntary health insurance? Does it maintain active liaison with insurance underwriters in the city?

Do you have an entirely satisfactory blood bank program?

Do you maintain active liaison with such influential groups as the local Farm Bureau, the Chamber of Commerce, and the various effective trade and professional associations in the city? Does your woman's auxiliary extend this liaison into the federated women's clubs, school health programs, and parent-teacher associations? Could you secure resolutions, if necessary, in support of your views from these groups?

What about your liaison with the American Legion and the Veterans of Foreign Wars? What will be their views in regard to the American Medical Association's position on veterans' medical care?

Do you participate in a local rural health forum?

Has your society screened the sound community projects, and does it take part in a planned manner in those it considers worth while?

Many other projects could be enumerated, but these are mentioned to suggest that a planned committee study of projects, groups, and organizations that need medical leadership in your community is a logical starting point for county society participation.

The President's Page is the closest and most direct contact the President has with each individual member of the Texas Medical Association. I wish here to express my appreciation for having had the opportunity of serving as your President during the past year.

George Tunnell M.D.

PR diagnotes

MAJOR HEALTH LEGISLATION MOVING IN CONGRESS: American Medical Association's alert Washington Office currently reports that there is more action now in Congress on health legislation than at any time in the past few years. More than a dozen public hearings are in process, or scheduled for the immediate future. Hearings began on the administration's reinsurance plan on March 24. Other important administrative bills making progress on Capitol Hill are as follows: Omnibus Tax Revision (H. R. 8300) would, among other things, increase the amount of deductions allowed for medical expenses; it has cleared the House. American Hospital Association has urged that Hill-Burton Expansion (H. R. 8149, S. 2758) be dropped and the Hill-Burton act be amended to include nursing homes and rehabilitation centers. The bill has passed the House; Senate now considering it. Representatives of AMA and Department of Health, Education, and Welfare have been meeting with House committeemen to complete work on Reform of Public Health Grants (H. R. 7397, S. 2778). Senate hearings began April 13. Senate sub-committee hearings began March 30 on Vocational Rehabilitation Expansion (S. 2759). AMA's Washington Office maintains complete files on each bill; can furnish detailed information on request.

SOCIO-ECONOMICS AT ANNUAL MEETING: On the PR side of the annual meeting in San Antonio, May 3 through 5, are two able speakers. William Alan Richardson, editor of Medical Economics, will discuss, "What Makes the Doctor-Patient Relationship Tick" and "Better PR -- the Detour Around Socialized Medicine." Roger Fleming, secretary-treasurer, American Farm Bureau Federation, will speak at the final General Meeting Luncheon, Wednesday, May 5. Fleming, whose Farm Bureau has demonstrated admirable leadership in urging economy and conservatism in government, will discuss what the professions (business, industry, and agriculture) can do in this regard.

The Bexar County Medical Society is utilizing space contributed by San Antonio drug stores in weekly full page advertisements. The society uses drop-in ad space to stress medicine's contributions to San Antonians; one ad, for example, points out that San Antonio doctors provide 12 per cent of

their time to medical care in various clinics for which service they make no charge whatever.

The Memorial Library of the Texas Medical Association is distributing a series of unique bookmarks. They are available on request, and demand is heavy.

County medical societies may shortly expect improved liaison with the Association's central office, when new field secretary C. Lincoln Williston assumes his duties in April. Williston reports from former position as manager of the Office of Public Information of the University of Illinois.

AMA notes that the Houston Chronicle along with three Ohio newspapers deserves special credit for sound medical reporting. The Chronicle was cited for its series, "Versatile -- These Medics" by Elmer Bertelsen, staff science writer.

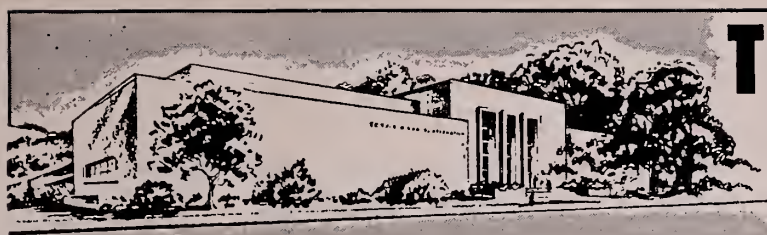
ON THE NATIONAL SCENE: New York State Medical Society advises effective way to handle complaints bobbing up frequently in letters to editor columns. Observed that much unnecessary controversy may be avoided as in New York counties medical societies' volunteering to investigate complaints received by editors in such letters prior to publication. Have found they can eliminate nearly all, and editors have agreed to print only those found to be justified.

North Carolina societies report use of the many AMA factual pamphlets, such as "A Doctor for You" and "Your Medical Dollar's Worth," as script material for local radio and TV shows. It's a tip for Texas societies which may be looking for such material. The pamphlets are available on request.

The Los Angeles Medical Association is distributing a two-page, printed folder prepared for a local insurance broker. The folder reports a total of 1,645,000 hours of free medical care provided each year by Los Angeles doctors. It clearly points out the staggering administrative costs involved if a government operated program were to replace the present free enterprise system under which this extensive medical care is encouraged.

TIP OF THE MONTH

Has your society begun a new PR project for 1954? If so, PR Diagnotes' readers would like to hear about it, so why not send in a brief report addressed to PR Diagnotes, Texas Medical Association. A newsletter depends on its friends, and your idea may well help others.



TEXAS State Journal of Medicine

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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Volume 50 **Austin, Texas, April, 1954** **Number 4**

ABLE SPEAKERS COMING

Seven guest speakers who together are able to discourse on the whole gamut of medical science, art, and practice will be among the chief attractions on the forthcoming program of the Texas Medical Association's annual session.

ROGER FLEMING

Most recent addition to the list of distinguished speakers to appear in San Antonio, May 3-5, is Roger Fleming of Washington, D. C., secretary-treasurer of the American Farm Bureau Federation, who will deliver the main address at the General Meeting Luncheon concluding the sessions of the Association and its Woman's Auxiliary. His topic, "Let's Get Together," reflects the fact that the independent American farmer and the equally independent American physician share some common problems and views.

Mr. Fleming began working in 1938 with the Iowa Farm Bureau Federation, the second largest state farm bureau, where he remained until 1948, when he became head of the Washington office of the American Farm Bureau Federation. His work in Iowa was interrupted by two and a half years in the United States Navy.

The other guest who is not a physician is William Alan Richardson, Rutherford, N. J., editor of *Medical Economics* since 1933. Mr. Richardson, an experienced newspaperman and financial editor, has lectured on medical economics at the Long Island College of Medicine and traveled extensively on all five continents, making a special study in 1949 of the National Health Service in Great Britain. He will discuss some of the problems of medical public relations with each of the two general sections, A (Medical) and B (Surgical).

Dr. Simeon T. Cantril, Seattle, who will speak to both sections on radiation therapy of certain tumors, has been director of the Tumor Institute of the Swedish Hospital at Seattle since 1938. Active during and since World War II in atomic energy projects, Dr. Cantril is associate professor of radiology at the University of Washington School of Medicine.

Formerly director of the Department of In-

ternal Medicine at the Bowman Gray School of Medicine of Wake Forest College at Winston-Salem, N. C., Dr. George T. Harrell, Jr., recently became dean of the University of Florida College of Medicine at Gainesville. Dr. Harrell was president in 1953 of the Southern Society for Clinical Research, is on the editorial board of *Medicine,* and is a member of the Commission on Chronic Illness. He will bring to Section A (Medical) the result of his research in metabolic problems, emphasizing myxedema and ACTH, cortisone, and hydrocortisone.

Two Denverites will participate in the San Antonio session. Dr. Harold D. Palmer, pathologist and medical director of the Children's Hospital of Denver and associate professor of pathology at the University of Colorado, is accomplished in pathology especially as it relates to pediatrics. He will appear twice on the Section A program. Dr. E. Stewart Taylor, head of the Department of Obstetrics at the University of Colorado School of Medicine, will discuss midforceps operations and endocrine treatment of gynecologic problems for Section B.

The seventh out-of-state speaker invited to take part in the annual session is Dr. Robert L. Sanders, senior surgeon of the Baptist Memorial Hospital, Memphis, and president-elect of the Southern Medical Association. With surgery of the gastrointestinal tract his major interest, Dr. Sanders was recipient in 1953 of the Mississippi Valley Medical Association's award for distinguished service in the teaching and practice of clinical surgery. Dr. Sanders is scheduled to contribute to a symposium on the gastrointestinal tract and to speak on cholecystic disease for Section B.

With the program for the 1954 session being arranged in two concurrent section meetings, it will be possible for more members of the Association to hear all of the guest speakers. Time for questions and answers also has been provided to permit local physicians to query the guest specialists on perplexing problems.

Although the contributions which Texas physicians will make to the scientific program should not be minimized, for some excellent presentations have been arranged, it is anticipated that the guest speakers will offer especially valuable hints to members of the Association, both in their formal addresses and in informal shoptalk throughout their stay in San Antonio.

Concerning the Right to Practice in Texas

It shall be unlawful for anyone to practice medicine, in any of its branches, upon human beings within the limits of this State *who has not registered in the District Clerk's office* of every county in which he may reside, and in each and every county in which he may maintain an office or may designate a place for meeting, advising with, treating in any manner, or prescribing for patients, *the certificate* evidencing his right to practice medicine, *as issued to him by the Texas State Board of Medical Examiners,* together with his age, post office address, place of birth, name of medical college from which he graduated, and date of graduation, subscribed and verified by oath, when, if wilfully false, shall subject the affiant to conviction and punishment for false swearing, as provided by law. The fact of such oath and record shall be endorsed by the District Clerk upon the certificate. The holder of every such certificate must have the same recorded upon each change of residence to another county, as well as in each and every county in which he may maintain an office, or in which he may designate a place for meeting, advising with, treating in any manner or prescribing for patients; and the absence of such record in any place where such record is hereby required shall be prima facie evidence of the want of possession of such certificate.

—Article 4498, Vernon's Civil Statutes, emphasis supplied.

ARE YOU ELIGIBLE?

A doctor who has practiced more than fifty years may feel that he has given all he has to offer to the profession, but this is not so. Even though he may be retired, a doctor who was practicing near the turn of the century still has much to offer his chosen profession. He remembers things happening years ago which may throw valuable light on the problems of

medicine today; he is a recorder of medical history whose firsthand reports should not be lost.

The Fifty Year Club, which any member of the Texas Medical Association who has practiced for fifty years is eligible to join, gives these doctors a chance to get together to reminisce of medicine and methods of treatment in the old days and to make plans for the days to come.

Organized in 1949 by Dr. W. M. Brumby, Houston, the club has no dues and no by-laws. The doctors who have been a part of this group are eager to include more of their colleagues when they meet for breakfast Tuesday, May 4, at 7:30 a. m. in the Gunter Hotel, San Antonio. Any doctor who is eligible should get in touch with Dr. L. H. Reeves, Fort Worth, who is in charge of the breakfast.

A HELPING HAND

While some of his fellow students from Baylor University College of Medicine, Houston, will be on their way to the Texas Medical Association's annual session in San Antonio, John H. Caskey of Waco will be serving in his official capacity as president of the Student American Medical Association. He and other representatives of SAMA's approximately 17,000 members, including students from the University of Texas Medical Branch at Galveston, Southwestern Medical School of the University of Texas at Dallas, and Baylor, will be participating in SAMA's fourth annual convention May 1, 2, and 3 in Chicago.

With a program geared to prepare its members as better students and later as better physicians, the meeting, including deliberations of the policy-making House of Delegates, is open to members of the medical profession, just as the sessions of the American Medical and Texas Medical Associations are open to interested medical students. Both medical students and the practicing doctors should realize the need for each group to see clearly and understand completely what the other is trying to do, for these students will join with today's physicians in comprising the medical profession of tomorrow.

A step in the right direction was the meeting of forty-nine medical students in Chicago in December, 1950, resulting in the organization of the Student American Medical Association and the establishment of its own *Journal,* both with the wholehearted approval and support of the American Medical Association. These students returned to their respective chapters with a constitution to go by and the enthusiasm necessary to gain interest on the local level.

Physicians of Texas were eager to offer a helping hand to the three local chapters. To promote a closer liaison with the future doctors of Texas, Medical Students' Day programs were instituted by the Texas Medical Association in cooperation with the Dallas, Harris, and Galveston Counties Medical Societies. To tighten the bond further, each senior medical student in Texas now receives the TEXAS STATE JOURNAL OF MEDICINE as a gift of the Texas Medical Association, and the Association helps send a delegate from each state SAMA chapter to the American Medical Association's annual session. Also, the entire senior class of the Texas medical schools has been extended a special invitation to attend the state meeting in San Antonio, with student delegates invited to represent the three medical schools in the House of Delegates meetings.

As a group, physicians are lessening the gap between medical students and practitioners, but each individual physician should show his interest in the young men and women who soon will be joining him in the profession. When called upon, he should speak before student groups, be willing to offer advice, share his practical experience on office procedures and the like, and at all times set an example that will add to the prestige of the medical profession.

MEMBERSHIP DIRECTORY PUBLISHED

By the time this JOURNAL reaches the physicians of Texas, they should be receiving the new directory of membership of the Texas Medical Association. Published and distributed by Group Hospital Service and Group Medical and Surgical Service, the Blue Cross and Blue Shield organizations in Texas, the directory was compiled from the 1953 membership list of the Association. It contains not only the names, addresses, and specialties of the physicians but also other pertinent information concerning medical services in the state. Every physician who was a member of the Association in 1953 and returned the directory information card to the central office should receive a directory by May 10. If his copy has not arrived by that date, he is asked to inform the Texas Medical Association, 1801 North Lamar Boulevard, Austin, and one will be sent him.

CURRENT EDITORIAL COMMENT

A CHALLENGE TO LEADERSHIP IN MENTAL HEALTH

Texas physicians cannot afford to ignore the 350,000 persons in this state who are mentally ill to the point of functional incapacity. Of this group 23,000 are completely incapacitated in hospitals, 30,000 are alcoholics, and 1,000 suicides occur annually in Texas. *One of every three* families has a patient sick enough to require hospitalization. Neither the general medical care of these patients nor their specialized treatment will be adequate unless all Texas doctors take an active interest in the operation of the state hospitals.

Improved and progressive professional practices do pay off. With better medical treatment in the state hospital system, a decrease in the average patient stay from 10.5 years in 1950 to 9.4 years in 1952 resulted in an estimated saving of $12,000,000. Aggressive programs can and do transform a tax-recipient patient into a tax-paying citizen.

The mental health movement, climaxed this year during the week of May 2 to 8, exists because of a growing public demand. The medical profession, in the form of Dr. Phillipe Pinel in 1791, took the lead in removing the shackles from the mentally ill and in establishing these illnesses as proper subjects of scientific inquiry and medical treatment. Medicine, because of its more comprehensive training and experience, is better qualified than any other professional group to spearhead further progress.

The serious competition from other groups is inadequately recognized. The existence of this competition is based on increasing demands from the people who are suffering. The public continues to insist that something be done one way or another, and the medical profession has not measured up to its responsibility in this particular area. Mental health problems belong with general health, for the mind and emotions of man cannot be separated from his body. Good treatment is possible only when these aspects are dealt with in relation to the entire human being. A significant question for medicine today is: Will we maintain our leadership through our own efforts and our own merit or will we turn over this leadership to other professional groups by default?

Adequate financial support coupled with politically untrammeled professional leadership and ingenuity would cut the present mental health problem in half without any basic advances in knowledge. The state spends a paltry $2 per day per patient under care, while it is well known that a minimum of $5 per day is necessary for good treatment.

Yet there are just as important and more basic approaches to the problem with which physicians must be concerned. The support for research in this field is appallingly inadequate; in fact only $4.15 is spent per patient under

treatment as compared to $28.20 for poliomyelitis, $26.80 for tuberculosis, and $27.20 for cancer. Despite these handicaps and within the limits of present knowledge, there has been remarkable practical progress; for example, the recovery and improvement rate for schizophrenic patients in seven states has risen from 33 per cent in 1914 to 56 per cent at the present time.

Preventive mental health services are likewise inadequately supported. In a survey of twenty-nine urban communities, one city in Texas spent only 4 cents per capita for such services; four other cities spent this much or less; twenty-four other communities spent more, up to 34 cents per capita. Medical participation in and support of the facilities we do have are gradually but definitely decreasing.

The single most important basic approach is the improvement of psychiatric teaching in medical schools—teaching geared to the broader practice of medicine rather than the specialty. It simply is not sensible, as was the case in 1948, to devote 4 per cent of the teaching time in the medical curriculum to psychiatry while from 30 to 50 per cent of patients seen in practice have important or predominant emotional or mental illness.

DON P. MORRIS, M. D.,
Professor of Neuropsychiatry,
Southwestern Medical School,
Dallas, Texas.

ORIGINAL ARTICLES

DIAMOX

New Oral Nonmercurial, Nontoxic Diuretic for the Treatment of Congestive Heart Failure

GEORGE R. HERRMANN, M. D.; M. RUTH BAXTER, M. D.; M. R. HEJTMANCIK, M. D.; and ALECIA R. MORAN, M. S., Galveston, Texas

THE treatment of patients with congestive heart failure and edema is an everyday job for the practitioner. The problems of the mechanism involved are only partially solved. The failure of the heart muscle probably begins in the abnormal chemistry of the myocardial cell incident to anoxia and to chemical and anatomic changes. The failure of propulsion of the blood results in imbalances and failure of the circulation. The train of symptoms and signs that follow this decompensation are probably the result of reduction of the blood flow through the hypothalamus, pituitary, adrenal, and renal capillaries. The excessive secondary retention of salt and water produces the classical picture. The mobilization and excretion of the edema fluid is the objective of most therapy. Increasing the cardiac output by rest in bed and the improvement of the cardiac tone by the direct effect of digitalis on the heart muscle cells often relieve dyspnea and edema early, but later salt restriction and diuretics are usually necessary.

Xanthines and organic mercurials and combinations of these have been the subjects of our clinical investigations of diuretics during the past twenty years in Galveston. At first we were interested in getting more effective diuretics, but we emphasized the need for less toxic diuretics. Novasural, Salyrgan, and combinations with xanthines such as Mercupurin, Mercuphyllin, Mercuhydrin, and Esidrone were followed occasionally by fatal toxic effects on the heart muscle. A sulfhydryl (monothiol) group then was added and Thiomerin was first released to us. Thiomerin was found to be nontoxic, so nonirritating that it could be injected deep, subcutaneously, and able to produce a brisk diuresis. A host of organic mercurial diuretics were developed for easier administration subcutaneously, by rectum, and orally, but

From the Cardiovascular Service of the University of Texas Medical Branch Hospitals.
Presented at the Universidad de Puebla, Semana Medica, October 5, 1953, Puebla, Mexico.
Supported by the Mid-Texas Twelfth District Heart Association Fund and H. H. Weinert Fund for Cardiovascular Research.

most of these have produced toxic or irritating side reactions and were inconstant in effect or unsatisfactory. Most of them have fallen into disuse, and many have been discarded.

We have always recognized that there has been a definite need for a safe and effective oral diuretic preparation. We were happy to have D. Dale Archer, M. D., and Rutledge Howard, M. D., of the Clinical Research Division of Lederle Laboratories come to Galveston and submit to us their new physiologic, oral, nontoxic, active, nonmercurial diuretic, Diamox, for clinical investigations. Previous studies had established the fact that this carbonic anhydrase inhibitor offered a different and definitely safer approach to the blocking of the reabsorption of sodium through the renal tubular epithelium than that accomplished by organic mercurials.

MODE OF ACTION

Diamox acetoazoleamide, carbonic anhydrase inhibitor 6063 was developed by the Stamford Chemotherapy Division of the American Cyanamid Company and Lederle Laboratories. It is 2-acetylamino-1,3,4-thiadiazole-5-sulfonamide, which is no longer antibacterial (fig. 1). The pharmacology and renal

CARBONIC ANHYDRASE INHIBITOR

SO_2NH_2 GROUP

Fig. 1. Diamox acetoazoleamide, Lederle 6063, 2-acetylamino-1,3,4-thiadiazole-5-sulfonamide.

and diuretic effects of Diamox have been thoroughly worked out by Pitts,[14] Maren,[12] Smith,[17] Friedberg,[3] and others. The imidosulfate group (SO_2NH) has been found to inhibit the carbonic anhydrase enzyme activity specifically and in all tissues. In mammals the carbonic anhydrase inhibitor stops the hydration of carbon dioxide in the blood cells, lungs, tissues, and renal tubular epithelium. With a drop in plasma carbon dioxide content there results a relative acidosis.

Diamox has been reported effectively to block the formation of carbonic acid in the cells of the tubular epithelium of the kidney. This interferes with the production of hydrogen (H) and bicarbonate (HCO_3) ions and the acidification processes, which conserves base. The converting of disodium phosphate (Na_2HPO_4) to monosodium phosphate (NaH_2PO_4) and sodium bicarbonate ($NaHCO_3$) and of amino (NH_3) to augmented ammonia (NH_4) releases sodium, which is excreted as well as monosodium phosphate and sodium bicarbonate.

Diamox, like ammonium chloride, potassium nitrate, or calcium chloride, produces a relative acidosis, but this is not the primary factor in Diamox diuresis. The relative acidosis is accompanied by the urinary excretion of fixed base and the reduction of serum bicarbonate. There is a resulting drop in the hydrogen ion concentration of the blood to 7.25 and carbon dioxide is lost through the lungs. The urinary sodium and carbonate output has been found increased with a decrease in the hydrogen ion concentration as a result of the inhibition of the carbonic anhydrase in the tubular epithelium. Urinary compensatory mechanisms such as augmented ammonia (NH_4) output tend to decrease the sodium and chloride output to some extent, but Diamox has shown little evidence of toxicity and seems to act physiologically.

CASES STUDIED

We have studied the clinical diuretic effects of oral Diamox therapy in 34 hospitalized patients and 23 clinic patients with congestive heart failure. All of these patients presented the classical symptoms and signs of failure of the circulation, dependent edema, and reliable criteria of heart disease, delay in arm to tongue Decholin time and increased systemic venous pressure.

The observations and evaluation of the status of the congestive failure patients and the possibility of toxic reactions were made by the medical resident physicians, Drs. A. P. Thaddeus, James Wright, Clyde Douglas, J. E. Johnson, W. L. Kenoyer, T. V. Rielly, J. S. Lowry, F. L. Sturrock, David Miesch, Virgil Lawlis, Robert Ulmer, O. E. Egbert, Luisa Duesberg, B. F. Montgomery, W. L. Lorentzen, James R. Oates, and Abdul Kerim. This study, as most of our clinical investigation, would not have been possible without their wholehearted cooperation and participation.

Hospitalized Patients

The hospitalized patients were usually in severe heart failure, which had increased in spite of adequate supportive and diuretic therapy. These patients were first stabilized over a twenty-four to forty-eight hour period on their previous digitalis dosage, low salt intake, and rest. Complete history, physical examination, body weight, routine laboratory studies, venous pressure, circulation time, and often blood volume studies were considered. Preliminary control blood studies consisted of measuring nonprotein nitrogen, carbon dioxide, serum proteins, chlorides, sodium, and potassium. A control twenty-four hour urine specimen was obtained and analyzed for sodium, potassium, and chloride content.

Diamox was administered generally in a dosage of

500 mg. each eight hours for 3 doses, then 500 mg. once daily for a week or two in the hospital, and intermittently or regularly for two to fourteen weeks in the clinic. During the first and second twenty-four hour periods after therapy was started, quantitative urinalyses were done for sodium, potassium, and chlorides; after forty-eight hours of therapy the blood studies of nonprotein nitrogen, carbon dioxide, chloride, sodium, and potassium were repeated. Intake and outputs were recorded as well as daily weights, and the extensive daily urinary and weekly blood chemical studies often were continued for ten to fifteen days.

Our patients were about equally divided between Caucasians and Negroes in the 34 hospital and the 23 outdoor clinic patients. There were more than twice as many males as females studied (table 1).

TABLE 1.—*Patients Receiving Diamox.*

	Hospital	Clinic
White	17	11
Negro	17	12
Male	25	16
Female	9	7
Total	34	23

As summarized in table 2, the types of heart disease in these patients were primarily coronary artery heart disease or hypertensive arteriolar disease, which were present twice as often as combined hypertensive

TABLE 2.—*Types of Disease and Ages of Patients Receiving Diamox.*

Types of Heart Disease	No. Patients	Age (Yr.)	No. Patients
Arteriosclerotic	18	20	2
Hypertensive	15	20-29	0
Arteriosclerotic and hypertensive	9	30-39	3
Rheumatic	5	40-49	17
Syphilitic	7	50-59	10
Congenital	1	60-69	9
Liver disease	2	70-79	13
		80+	3

arteriosclerotic coronary heart disease, syphilitic aortic heart disease, and rheumatic heart disease. There was only 1 case of congenital heart disease in failure, and this was in a middle aged man. Only 5 of the 57 patients in this series were under 40 years of age, and there were equal numbers in each of the decades thereafter from the fifth to the eighth decade.

The hospitalized patients were studied more extensively for two to four weeks. The urinary output volume increased in every case, from a minimum of 32 per cent to a maximum of 450+ per cent and an average of 160+ per cent. The weight losses were from 0 to 31 pounds with an average of 2.31 pounds during the first day, 1.93 pounds the second day and a total of 10.75 pounds for the first week. One patient continued to lose to a total of 60 pounds within two weeks.

The urine chemistry (table 3) showed the sodium excretion increased in each case from 16 to 722 per cent, with an average of 113 per cent. The potassi-

TABLE 3.—*Twenty-Four Hour Urinary Sodium, Potassium, and Chloride Excretion.*

	Na (Gm./24 hr.)	K (Gm./24 hr.)	Cl (Gm./24 hr.)
Before Diamox	.970	0.95	1.62
After Diamox	2.07	1.93	2.85
Average increase	113%	103%	76%

um excretion increased in 17 cases from 6 to 694 per cent, with an average of 103 per cent, but seemingly decreased in 3 cases. The chloride output increased from 6 to 929 per cent with an average of 76 per cent in 16 cases, and seemingly decreased in 4 cases. We believe that in some of our cases the total urine output volumes were not collected. This may account for the apparent decrease in a few cases of the potassium and chloride outputs.

Excessive sodium diuresis produced alkaline urine whereas excessive chloride diuresis produced an acid urine. The taking of the hydrogen ion concentration with nitrazine paper (Squibb) is a fairly practical method of determining the type of electrolyte losses.

The blood serum electrolytes showed on the average only moderate lowering (table 4). Low serum sodium levels developed in 2 patients, both of whom had been on 200 mg. per day sodium intake and had received Thiomerin in full dosage. It should be remembered that such patients are on the verge of electrolyte upsets from the slightest provocation as after even vomiting and diarrhea.

The blood chemistry studies and especially studies of electrolytes before and after Diamox in the hospitalized patients showed the greatest changes or drops in the nonprotein nitrogen and carbon dioxide

TABLE 4.—*Serum Electrolytes in 34 Hospital Patients on Diamox Therapy.*

	CO_2 (mEq./L.)	NPN (mg./100 cc.)	Cl (mEq./L.)	Na (mEq./L.)	K (mEq./L.)
Before Diamox	21.4	47.3	105.0	142.2	4.32
After Diamox	19.05	40.5	102.5	138.2	4.18

levels and in the shifts of the carbon dioxide combining power of the blood. In most instances there were reductions from —0.79 milliequivalents per liter to —9.9 milliequivalents per liter with an average of —3.62 milliequivalents per liter. There were 2 cases in which there was a rise in carbon dioxide content, and in these no diuresis occurred and the drug was presumably not absorbed. The averages are shown in table 4.

The serum sodium level was lowered in 17 cases

from —1 to —19 milliequivalents per liter with an average of —9.2, and rose in 7 cases from +3 to +20 milliequivalents per liter with an average of +8.8. The changes paralleled the diuresis.

The serum potassium level fell slightly in 12 cases from —.3 to —1.2 milliequivalents per liter with an average of —0.73 and rose slightly in 8 cases from +.1 to +0.85 milliequivalents per liter with an inordinate, probably erroneous change of +1.75 milliequivalents per liter in 1 case and, discounting this, an average of +0.29 milliequivalents per liter.

The serum chlorides dropped from a level of —4 to —84 milliequivalents per liter, with an average of —27.8, indicating a moderate loss of chlorides in most instances in which there was a diuresis. In the cases in which ammonium chloride was administered simultaneously Diamox failed twice and the chlorides rose.

The nonprotein nitrogen content of the blood was found lower after Diamox administration in 9 cases, dropping from —1 to —29 mg. per 100 cc. and averaging —13.8 mg. per 100 cc.; it was slightly higher in 7 cases, rising from +1 to +4 mg. per 100 cc. with an average of +2.5 mg. This evidence indicates that the renal function insofar as nitrogen waste excretion was concerned was little if at all affected, and slightly high levels were usually slightly reduced after Diamox diuresis.

The average clinical response in the hospitalized patients was considered excellent in 10 patients, good in 4, fair in 10, and poor in 6. There were no serious toxic reactions following the use of Diamox in these hospitalized patients other than severe nausea and vomiting in 2 patients.

Outclinic Patients

The outclinic patients were our pedigreed cases of chronic congestive heart failure that we have studied for years. They had been maintained in an ambulatory state on low-salt diets, daily digitalis or Gitalin dosage, and mercurial diuretic injections as required 1 to 3 times per week. Most of these patients have been instructed and trained to take care of themselves and are weighed by the special Heart Clinic nurse, Miss Hazel Son.

Twenty-three of these patients were taken off of their routine courses of mercurial and ammonium chloride weekly or twice or thrice weekly injections of Thiomerin (2 cc.) and put on 500 mg. of Diamox daily. In a few the daily dose of 250 mg. of Diamox was prescribed and failed. In 3 cases ammonium chloride was inadvertedly continued. Control determinations of nonprotein nitrogen and urinalyses were repeated at intervals of generally one week. Patients have been followed from one to three months on Diamox therapy.

In this study series of 23 outclinic patients with chronic congestive heart failure there were 11 Caucasians and 12 Negroes, 16 males and 7 females, with 7 in age group 40-49, 5 in 50-59, 3 in 60-69, 5 in 70 to 79, and 3 over 80 years of age.

The etiologic cardiac diagnoses were hypertensive cardiovascular disease in 9 patients, atheromatous diffuse coronary heart disease in 6, combined hypertensive and atheromatous coronary artery disease in 3, and syphilitic heart disease in 4 patients. There was 1 case of rheumatic but none of congenital heart disease with failure treated in this outpatient study.

Two outpatients experienced such severe vomiting after Diamox was administered that 1 had to be hospitalized. The other was given Diamox one week later without even nausea and with an excellent response. One patient complained of numbness and parasthesias; the drug was discontinued and no diuresis developed. In 1 patient the carbon dioxide dropped to 18 volumes per 100 cc. (8.2 milliequivalents per liter), but she tolerated this change well. No other toxic manifestations were noted. Two patients who had shown good response to Diamox in the first course at 500 mg. dosage seemed refractory after two months and began to gain weight. Two patients who had required Thiomerin (2 cc.) three times a week were maintained at their standard weight on Diamox, 500 mg. daily, alone. One patient could not be maintained on Thiomerin alone or on Diamox but responded well to the combination of the two drugs.

The loss in body weight for the first week in patients who responded ranged from 1.5 pounds to 14.5 pounds in 23 instances with an over-all average loss of 4.6 pounds in a week. One of the 3 patients who failed to discontinue ammonium chloride failed to lose any weight, another lost .5 pound, while the third had lost 1 pound in a week.

The clinical response in these outpatients with chronic congestive heart failure to Diamox was considered excellent in 11 cases, good in 6 cases, fair in 3 cases, and poor in 3 cases. Two of the patients with excellent diuretic results were refractory after two and seven weeks of daily Diamox therapy. The mechanism of this possible refractoriness has not yet been established. We shall continue to investigate this important observation.

SUMMARY

In the study of 34 hospitalized and 23 outclinic patients the new oral, nonmercurial diuretic Diamox was found to produce profuse occasionally, but usually moderate diuresis after 500 mg. every eight hours for 3 doses and then 500 mg. daily. A daily reproducible diuresis for six to eight hours after the

routine single daily dose of 500 mg. was produced. Diamox seemed to act physiologically.

A rise in urinary hydrogen ion concentration accompanied by a renal loss of sodium, potassium, and water and probably carbonates or a fall in urinary hydrogen ion concentration and chlorides might result from excessive diuresis. A moderate but satisfactory degree of diuresis often resulted with nothing more than a slight acidosis.

Patients on a 200 mg. per day sodium diet with or without carboresins are usually on the brink of hyponatremia hypopotassemia, and hypochloremia, and their blood may show drops to seriously low sodium, potassium, or chloride levels after severe vomiting or diarrhea as well as after brisk mercurial or Diamox diuresis. Ammonium chloride usually counteracts diamox diuresis and should not be administered before or with Diamox.

Blood and urine chemical and electrolyte studies carried out on most of these patients showed no evidence of any renal irritation effects of Diamox. The nonprotein nitrogen level usually dropped after diuresis and the slight rises noted were insignificant.

The urinary electrolyte shifts showed moderately, grossly correlating changes in the blood serum. The blood electrolyte patterns were grossly upset to the point of production of the syndrome of low serum sodium, hyponatremia, hypokalemia, or hypochloremia in 2 instances. Occasionally a fairly severe acidosis developed, but it has been well tolerated.

The electrolyte patterns in the urine were greatly altered by Diamox. There was usually a great increase in the output of sodium and water, usually also an increased potassium loss and a considerable chloride loss.

Further and more complete electrolyte studies should be carried out to establish firmly the electrolyte shifts. If vomiting, diarrhea, or paresthesia are induced by Diamox, the drug should be discontinued.

The ideal drug for the augmentation of urinary output of sodium has long been sought. We have found that Diamox seems to meet most of the important qualifications of an ideal drug or diuretic. Diamox is usually well tolerated, orally effective over relatively short periods of time, physiologically active, nonirritating, nontoxic, and with no significant side effects. On the other hand, the oral and rectal mercurial diuretics are and may be potentially dangerous, often irritating, and inconstant in action.

Our primary watchword must be absolute safety, and we must demand nontoxicity as more and more diuretics are being developed and submitted for clinical investigation.

The home use of the injectable (sulfhydril protected) mercaptomerins such as Thiomerin has been demonstrated in our clinic to be feasible. Yet this method is not without some danger and the inconvenience of injection. We therefore welcome this as a safe oral preparation in which the ease of administration is not fraught with the danger of high dosage of toxic drugs. Unfortunately 2 patients on continuous daily therapy for two to seven weeks seemed to become refractory or stationary or gained weight.

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The Institute of Industrial Health, University of Cincinnati College of Medicine, Eden and Bethesda, Cincinnati 19, is offering three-year fellowships in industrial medicine to physicians who are graduates of class A medical schools and have completed at least two years of hospital training.

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Clinical Studies of Dicurin Procaine (Lilly) and of SU-1775 (Ciba)

M. RUTH BAXTER, M. D.; M. R. HEJTMANCIK, M. D.; and G. R. HERRMANN, M. D., Galveston, Texas

PATIENTS with congestive heart failure and waterlogging edema are still and probably will be always major problems in cardiac therapy. Since the crux of the situation is abnormal myocardial cellular function, the ultimate solution must be directed at favorably influencing the chemistry of the heart muscle. Some present-day therapeutic efforts with digitalis and the coronary vasodilators are directed toward this accomplishment.

Control of the body electrolytes by restriction of sodium and use of diuretics is a major part of the treatment program. As more and more diuretics have been introduced, our interest has been centered on the development of safer, less irritating, and less toxic, rather than more powerfully active, drugs. To this end we first studied and introduced Thiomerin, in which a sulfhydryl monothiol group protected against acute mercury toxicity on the heart muscle.

We have given thousands of injections of Thiomerin without a single severe or serious reaction, and have taught 50 clinic patients to inject the drug subcutaneously at home two to three times a week and report back to the clinic weekly or every two weeks. In none of these patients have there been any severe reactions.

Even with the present armamentarium, development of occasional refractoriness to therapy and pain on injection in certain patients make it desirable to evaluate new diuretics as they are developed. We have tried the various oral and rectal mercurial diuretics and found none uniformly satisfactory in tolerated doses. The larger doses of mercurials are not without danger.

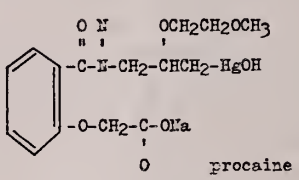
In the past eighteen months we have studied the therapeutic and side effects of two more organic mercurial compounds—Dicurin Procaine, sent to us by Eli Lilly and Company, and SU-1775, submitted by Ciba Pharmaceutical Products. These are both for subcutaneous administration.

Only patients with edema, generally due to chronic congestive heart failure, were selected for this study. They were first carefully evaluated, after reviewing the history, with physical examination, electrocardiogram, and routine laboratory studies, including urinalysis, nonprotein nitrogen content of the blood, and complete blood count. These examinations were repeated at frequent intervals throughout the study. The mercurial was given in 1 to 2 cc. doses subcutaneously, and a careful record was kept of the urinary output for twenty-four hours in all cases and in many cases for the following two twenty-four hour periods. Weights were obtained as often as possible to study the diuretic effect after each injection.

From the Cardio-Vascular Service of the University of Texas Hospitals. Supported in part by a grant from the H. H. Weinert Fund for Cardio-Vascular Research. Presented in part to the Texas Heart Association, Houston, April 27, 1953.

DICURIN PROCAINE (LILLY)

The structural formula of Dicurin Procaine is shown in figure 1. It contains 10 per cent organic mercurial compound as a complex procaine salt with 5 per cent theophylline, and each cubic centimeter



37 mg. Hg/cc.

FIG. 1. Dicurin Procaine.

contains approximately 37 mg. of mercury. It is furnished in 2 cc. ampules already in solution. One great advantage is its stability when stored at ordinary room temperature; it requires only protection from sunlight.

Study by other investigators[3] of the diuretic action in anesthetized dogs showed the diuretic potency of Dicurin and Thiomerin to be approximately the same. One group found the medial lethal dose of Dicurin Procaine in rats by intramuscular injection to be approximately 12.7 mg. of mercury per kilogram of body weight, and the medial lethal dose of Thiomerin to be approximately 18.7 mg. of mercury per kilogram.

Analysis of Patients.—A total of 264 injections of Dicurin Procaine was given to 52 patients, the number varying from 1 to 14 per patient. The majority of these were out-patients, 47 being seen in the Heart Clinic and 5 in the hospital. There were 32 males and 20 females, the number being equally divided between Caucasian and Negro. Three of the patients were in their thirties, 8 in their forties, 8 in

their fifties, 14 in their sixties, 15 in their seventies, while 4 were more than 80 years of age. All the patients had chronic congestive heart failure, the cause being hypertensive in 9 cases, arteriosclerotic in 21 cases, hypertensive and arteriosclerotic in 11 patients, rheumatic in 3 cases, syphilitic in 6 cases, and chronic cor pulmonale in 2 cases.

Reactions.—Of these 264 injections, 16 resulted in local reactions and 2 were accompanied by systemic reaction. The local reactions occurred in 9 of the 52 patients, and the 2 systemic reactions were experienced by 1 patient. Nine injections caused pain or tenderness lasting more than twenty-four hours, 6 caused subcutaneous induration, and 2 resulted in ecchymoses. The ecchymotic reactions all occurred in women, as noted in the studies by Best[1] and his group, but not all in elderly women as in his series. The local reactions were distributed as follows: 3 in 3 female patients with arteriosclerotic heart disease, 3 in 1 male patient with hypertensive cardiovascular disease, 2 in 1 female patient with arteriosclerotic and hypertensive cardiovascular disease, 2 in 1 male with syphilitic heart disease, 2 in 1 male with undiagnosed type of heart disease, and 4 in 2 females with rheumatic heart disease. One of these females had as well 2 systemic reactions, which will be described later.

Reactions in 3 of the patients were severe enough to necessitate the discontinuance of the drug, one at the patient's request because of subcutaneous nodules, which she had not experienced with injections of other diuretics. The other 2 cases will be described in detail.

CASE 1.—A.V.D., a 77 year old white woman with arteriosclerotic heart disease and chronic cardiac decompensation, had previously been well maintained for a long period on weekly Thiomerin injections, with no reactions. She was given 2 injections of Dicurin, which she tolerated well. The third injection was followed almost immediately by severe local pain and produced marked tender induration and ecchymosis. A fourth injection was given, and about two hours later an area of hyperemia and swelling about 5 cm. in diameter appeared. The patient had a low grade temperature elevation the rest of the day and that night, and a week later a large bluish residual about 10 or 11 cm. in diameter was still present. We skin-tested the patient with 0.1 cc. of Dicurin, and the skin test was markedly positive showing wheal formation with surrounding erythema. A skin test with procaine alone was negative.

CASE 2.—D. B., a 33 year old white woman, had rheumatic heart disease with chronic congestive failure. After her third and fifth injections of Dicurin she had systemic manifestations, similar on both occasions: she felt weak, had a hot, dry feeling in her throat, and felt as though she would faint. These symptoms lasted about an hour. Her skin test with Dicurin was negative. She had had no similar symptoms with many injections of Thiomerin.

In 4 of our patients, nonprotein nitrogen values later rose to pathologic levels, but other factors were causative and none of the high values could be ascribed to Dicurin. There was no instance of irritation of the kidney by Dicurin as shown by urinalyses after the injections.

Clinical Diuretic Results.—The diuretic effect of this drug was found to be satisfactory, the average urine output being 2,949 cc. during the first twenty-four hours following an injection, 1,658 cc. the second twenty-four hours, and 1,115 cc. the third twenty-four hour period. The average weight loss the first twenty-four hours in the hospitalized patients was 4 pounds; the second twenty-four hours, 0.8 pound.

SU-1775 (CIBA)

The structural formula of SU-1775 is shown in figure 2. It is an aliphatic compound with a sulfhydryl group and contains 25 mg. of mercury per cubic centimeter. In 1945 Volini[5] reported 3 deaths following intravenous administration of mercurial

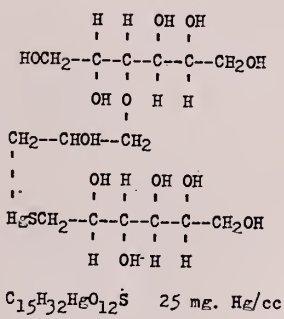


FIG. 2. SU-1775.

diuretics, 1 after Mercupurin and 2 following Esidrone. Esidrone was removed from the market in the United States, although it is still being used in Mexico. By the addition of the sulfhydryl group, the cardiac toxicity of Esidrone has been corrected and alleviated in SU-1775, as shown by electrocardiographic studies following intravenous administration in experimental studies, apparently with retention of the powerful diuretic effect.

Extensive animal experiments have been performed by other investigators[4] with SU-1775 with regard to cardiac toxicity, renal effects, and intracutaneous irritation. In these studies it has been shown to compare favorably with Thiomerin.

Analysis of Patients.—A total of 308 injections of SU-1775 was given to 60 patients, the number varying from 1 to 40 per patient. Of these 48 were outpatients and 12 were hospitalized. There were 39 males and 21 females, 29 being white and 31 being Negro. One patient was less than 29 years of age, 5 patients were in the 30-39 age group, 7 in the 40-49

group, 9 in the 50-59 group, 16 each in the 60-69 and 70-79 age group, while 6 were past 80 years of age. Most of the patients were edematous from chronic congestive heart failure, the cause being arteriosclerotic in 21 cases, hypertensive in 15 cases, arteriosclerotic and hypertensive in 8 cases, rheumatic in 4 cases, and syphilitic in 6 cases. One patient had heart failure which occurred a few weeks postpartum, the exact cause being unknown. Four patients had edema from portal cirrhosis and 1 from varicose veins.

Reactions.—Seven of the 308 injections were accompanied by local reactions, occurring in 5 of the 60 patients. There were no systemic reactions. Two injections caused pain or tenderness lasting more than a day, 5 caused subcutaneous induration, and 2 resulted in ecchymoses. Ecchymotic reactions were not limited to females in this series; 1 of the 2 patients was a male and the other a 33 year old woman. There were 2 local reactions in 1 male with hypertensive cardiovascular disease, 1 in a male with arteriosclerotic heart disease, 2 reactions in a male and 1 in a female with combination arteriosclerotic and hypertensive cardiovascular disease, and 1 local reaction in a female with rheumatic heart disease. None of the reactions was severe enough to cause the drug to be discontinued.

The nonprotein nitrogen content of the blood did not rise to pathologic levels during therapy in any of the patients. However, in 2 patients, both of whom had evidence of urinary tract infection both before and after the diuretic, the red blood cells in the urine rose from zero or occasional to 2 to 4 per high power field.

Clinical Diuretic Results.—The diuretic effect of this drug was found to be extremely satisfactory, the average urine output being 3,272 cc. during the first twenty-four hours following an injection, 1,631 cc. the second twenty-four hours, and 975 cc. the third twenty-four hour period. The average weight loss was 4.2 pounds the first twenty-four hours in the hospitalized patients and 2.4 pounds the second twenty-four hours. This is more of a diuresis than we have gotten in other diuretic studies[2] without ammonium chloride, and the amount of mercury in each dose is only about two-thirds of that in other mercurials.

DISCUSSION

From these preliminary studies with the two new mercurial diuretics, we do not feel justified in drawing any final conclusions. Only continued use over a long period in many patients could demonstrate superiority of any new product over the relatively safe and effective mercurials already on the market.

Dicurin Procaine appears to be an effective diuretic which has not produced renal toxic effects in our patients. It has the advantages of being dispensed in a stable solution and not requiring refrigeration. This is particularly valuable in self-administration at home and also saves time in the office. However, even in this small series, there has seemed to be an unduly high percentage of severe local and systemic reactions. We have not seen such reactions in several thousand Thiomerin injections and believe that these undesirable side effects may limit the use of Dicurin Procaine. Such severe reactions were not observed by Best and others[1] in 540 injections to 69 patients. However, these investigators noted a reaction occurred in about one-fifth of the patients, and 8.15 per cent of the injections. In our series local reactions occurred in fewer than one-fifth of the patients, and 6.8 per cent of the injections.

The reactions observed from SU-1775 were less frequent, and none was severe. They occurred in not quite one-tenth of the patients and 2.3 per cent of the injections. SU-1775 is an effective mercurial diuretic, well tolerated by the patient, and compared favorably to Thiomerin. This compound contains only 25 mg. of mercury per cubic centimeter in comparison to 37 mg. of mercury per cubic centimeter in Dicurin Procaine and 40 mg. of mercury per cubic centimeter in Thiomerin. In 2 patients with renal infection there was a slight increase in red blood cells in the urine following SU-1775, but no increase in nonprotein nitrogen. This may well not have been due to the diuretic, but more studies must be made before this point can be evaluated. SU-1775 is dispensed in a lyophilized form in 2 cc. ampules, which must be put in solution with distilled water immediately before using. It is stable for only a few days after being placed in solution. Its administration thus involves additional time consuming steps; however, this difficulty probably can be overcome by refinements in its preparation.

SUMMARY

The clinical effects of two new mercurial diuretics were studied in hospital and clinic patients over an eighteen month period.

Dicurin Procaine, a complex procaine salt with 5 per cent theophylline was effective in 264 injections given to 52 patients. However, it caused local reactions in 9 patients and 6.8 per cent of the injections, and systemic reactions in 1 patient and 1.9 per cent of the injections. In 2 cases reactions were severe. The average urinary output in the first twenty-four hours after injection was 2,949 cc. and average weight loss 4.0 pounds. Dicurin Procaine has the advantage of being dispensed in a stable solution and not requiring refrigeration.

SU-1775 is an aliphatic mercurial compound with a sulfhydryl group. In 308 injections given to 60 patients the clinical diuretic results were excellent. The average urinary output in the first twenty-four hours after injection was 3,272 cc. and average weight loss 4.2 pounds. Local reactions occurred in 5 patients and 2.3 per cent of the injections. There were no systemic reactions and the local reactions were not severe.

Neither diuretic produced any definite demonstrable signs of renal toxicity.

Further studies will be necessary before the place of these compounds in modern diuretic therapy can be determined. However, SU-1775 seemed to be nontoxic and more effective than other mercurials that we have studied.

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TREATMENT OF CYSTIC HYGROMA

JAMES A. MARTIN, M. D., Dallas, Texas

SINCE the first case of cystic hygroma was reported by Redenbacher in 1828,[1] there have been 250 or more additional case reports of this rather rare lesion in the world literature. Opinions as to proper treatment have varied greatly from one author to the next, and there is generally at present an inclination in favor of surgical excision. One often encounters the unqualified dictum that all such tumors are treated best by primary removal[3] and that they are radioresistant.[17]

The term cystic hygroma means "moist tumor" and implies an infiltrating multilocular tumor containing endothelial lined spaces and usually arising within the neck or axilla of a child. The cysts are usually thin walled with or without intercommunication and contain a serous or turbid fluid, having the consistency of lymph. Most popular among the theories of origin is that of embryonic sequestration of lymphatic channels from the primitive lymph sacs early in fetal life.[8, 11] This tissue apparently maintains its properties of growth and lymph secretion although isolated from the mother system, and endothelial fibrillar sprouts from walls of marginal cysts readily penetrate adjacent tissues. Lymphlike fluid produced within the fibrillae leads to the formation of cysts which enlarge, and eventually pressure atrophy within the walls of adjoining cysts may allow confluence and the formation of larger cysts. Adjacent tissues may be engulfed by the infiltrating process and destroyed by direct atrophy and fatty degeneration, thus accounting for the frequent finding of muscle, fascia, nerve filaments, and vascular structures within the walls of the tumor.[4]

Read before the Section on Radiology, Texas Medical Association, Annual Session, Houston, April 28, 1953.

Many hygromas are present at birth, whereas most of the remainder make their appearance within the first few years of life. Growth rate is often erratic and variable with some tumors which have remained small for some time abruptly increasing rapidly in size for no obvious reason. In other instances an increase in size may be associated with infection or alteration of intrathoracic dynamics, such as occurred in one of Figi's cases in which recurrence of a cervicomediastinal mass apparently was allied to the cough of pertussis.[2] The greatest majority of tumors have occurred in the neck from which they can extend superiorly into the floor of the mouth, cheek, and tongue or inferiorly beneath the clavicle into the axilla, into the mediastinum, or onto the chest wall. It is considerably less common to encounter isolated lesions within the mediastinum, axilla, or inguinal region. Secondary infection is by far the most drastic complication with secondary septicemia and toxemia accounting for a large percentage of fatal incidents regardless of the treatment employed. It is doubtful if fibrosis following sepsis accounts for spontaneous improvement in any but rare instances, and there is no justification for reliance on such a sequence of events for a possible cure.[5]

In spite of the lesion's infiltrating properties pain is seldom associated with a hygroma clinically, except rarely when there happens to be deep extension from the neck posteriorly to involve the brachial plexus. Mediastinal extension often produces tracheal and esophageal deviation, but only rarely are pressure symptoms associated. Isolated lesions in the mediastinum are generally asymptomatic and often are detected only by accident in an older age group by a routine chest roentgenogram or at autopsy. Fluid

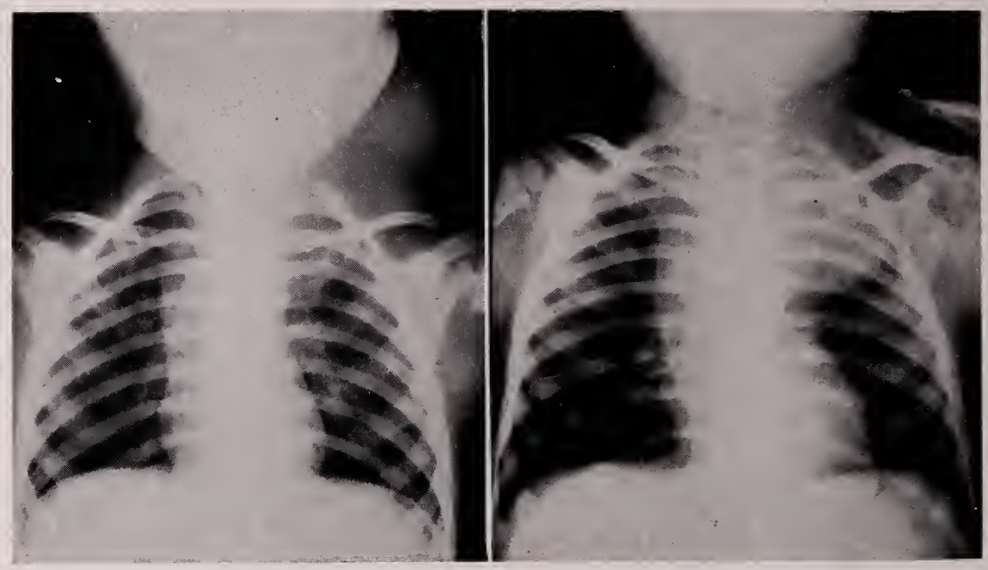

FIG. 1. A cervicomediastinal cystic hygroma. Pressure on the cervical component forced most of the mass into the chest. [From The Children's Medical Center in Boston. After Gross, R. E., and Hurwitt, E. S.: Cervicomediastinal and Mediastinal Cystic Hygromas, Surg., Gynec. & Obst. 87:599-610 (Nov.) 1948.]

contained within the cysts is usually not under pressure and clinically the tumor presents a consistency of semifluctuance without stretching of the overlying skin. In the neck one must differentiate this from thyroglossal cysts, branchial cleft cysts, lipomas, and hemangiomas. It has been said that a characteristic of hemangiomas is the "sign of emptying." One should remember, however, that pressure on a branchial cleft cyst can force it to empty into the retropharyngeal space,[16] and in one instance at least, pressure on a cervical hygroma has "emptied" the neck, so to speak, with reduction of most of the mass into the thorax (fig. 1). In the mediastinum an isolated tumor presents no pathognomonic radiographic changes and must be differentiated from other mediastinal masses including pericardial celomic cysts. In general, however, the proper diagnosis can be arrived at clinically without undue error whenever a cystic mass is apparent in the neck or axilla, fitting the general description previously given.

CLINICAL MATERIAL

Nine cases are presented in which semifluctuant cystic tumors of the head, neck, and axilla were treated primarily with irradiation. Of the children 6 were girls and 3 were boys. Some patients received radium applicator therapy, similar to the technique described by Figi, employing one or two 50 mg. capsules, having equivalent filtration of 1.5 mm. of brass and fixed to a balsam wood block so that treatment is administered at a distance of 2.0 cm. Other patients often received 200 to 220 kilovolt roentgen-ray therapy as a supplement or as the only treatment. It is possible that the small lesions limited to the cheek may not have represented true hygromas since reports of such lesions are relatively rare. Nevertheless, they were cystic tumors, apparently lymphangiomatous in nature, occurring in young children and not fitting well the general description of lipoma or hemangioma. There were 3 of these lesions, 2 of which regressed completely under treatment. The other lesions involved the neck or supraclavicular fossa and in one instance extended into the axilla. Seven of the 9 patients are considered to have responded satisfactorily to treatment, whereas the other 2 (cases 8 and 9) are classified as failures. Of the former group 3 required plastic surgical repair after treatment, in 2 instances to remove redundant skin folds, and in the third to excise small residual thick walled cysts. There is 1 case in which radiation produced an abnormality in development, the seriousness of which was predominantly of a cosmetic rather than functional nature. There were no deaths and no recurrences, and secondary infection was not a severe complication in any case.

CASE REPORTS

CASE 1.—S. K., a 26 month old girl, had a slow-growing tumor of the left side of the neck, first noticed by her parents when she was 2 months old. In the two weeks preceding admission of the child to the clinic, the tumor for no apparent reason grew rapidly and doubled in size, without producing any pressure symptoms. At the time of initial examination on February 3, 1951, it was observed to be a large semifluctuant cystic mass, extending from the mandible to the clavicle and crossing the midline anteriorly. Some bluish discoloration of the lower portion of the mass suggested recent bleeding (fig. 2). External radium treatments were given to the upper portion of the tumor, using a 50 mg. applicator at a 2 cm. distance, with a fourteen hour exposure to each of seven adjacent areas over its

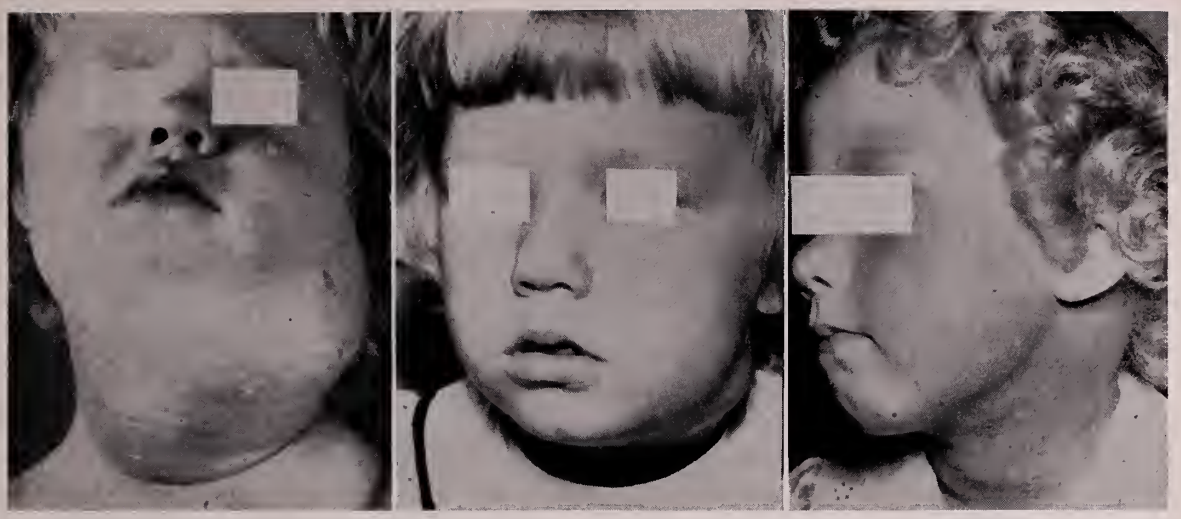

FIG. 2. Case 1. *Left.* A 26 month old girl with a large semi-fluctuant hygroma in the neck. *Center.* The same child seventeen months later showing marked reduction in size of the tumor following irradiation. *Right.* Final result one month later, shortly after excision of small residual thick-walled cysts.

surface. The tumor showed only minimal shrinkage over the next four month period, and on June 2, fractionated roentgen-ray therapy was initiated through a single lateral 10 by 10 cm. field, and a total dose of 1,800 r (air) was delivered in seven days. Other factors were 200 kilovolts, focal surface distance of 50 cm., and filtration of 0.5 mm. copper and 1.0 mm. aluminum. Following this there was considerably more reduction in size, such that only 2 small isolated cystic lesions remained seven months later. Each of these was treated in January, 1952, through a circular cone, having a 7 cm. diameter, with a dose of 1,200 r (air) delivered to each area in five days. Further shrinkage took place gradually over the next six months. During this interval some transient enlargement of the upper cyst occurred concomitantly, with a fever following multiple mosquito bites, but the lesion promptly was reduced in size again following penicillin therapy. On July 7 the remaining cysts were excised and described as being thick walled without recognizable lining and containing hemorrhagic fluid. The patient recovered promptly from this operation and has remained well.

CASE 2.—D. B., a 4 month old girl, was initially seen on October 10, 1932, with a soft cystic mass arising in the right lower part of the neck and measuring about 5 inches in length and 4 inches in diameter (fig. 3). This had been present since birth and had not undergone any change in shape or size, nor had it caused the child any obvious discomfort. Two 50 mg. radium capsules in a pack were applied, at a 2 cm. distance, for fourteen hours to each of three areas over the tumor on each of three consecutive days. Over a three month period the mass was reduced in size by about one-half. On February 13, 1933, a single fourteen hour application to the center of the tumor was given with the same pack. Six months later the tumor was reduced to a flat structure, encased in a sac of loose skin, and a final single fourteen hour application was administered. The patient was seen again seventeen years later, at which time it was noted she had remained well without recurrence of the tumor although the overlying skin still hung in rather unsightly folds. At present, she is under the care of a plastic surgeon and has recently undergone preliminary excision of the major portion of the skin sac.

CASE 3.—B. L., a 6 weeks old boy, was originally seen on December 23, 1946, with a large cystic mass measuring roughly 7 by 8 cm. in the right side of the neck (fig. 4). This tumor had been present, without remarkable change in size, since birth and did not produce any obvious embarrassment to adjacent structures. Fractionated roentgen-

FIG. 3. Case 2. *Left.* Appearance of a cervical hygroma at the time of the patient's initial treatment in 1932. *Center.* The same patient as seen in 1950 showing complete regression of the tumor leaving redundant skin folds in the area. *Right.* The appearance in 1953 shortly after initial plastic procedures were started.

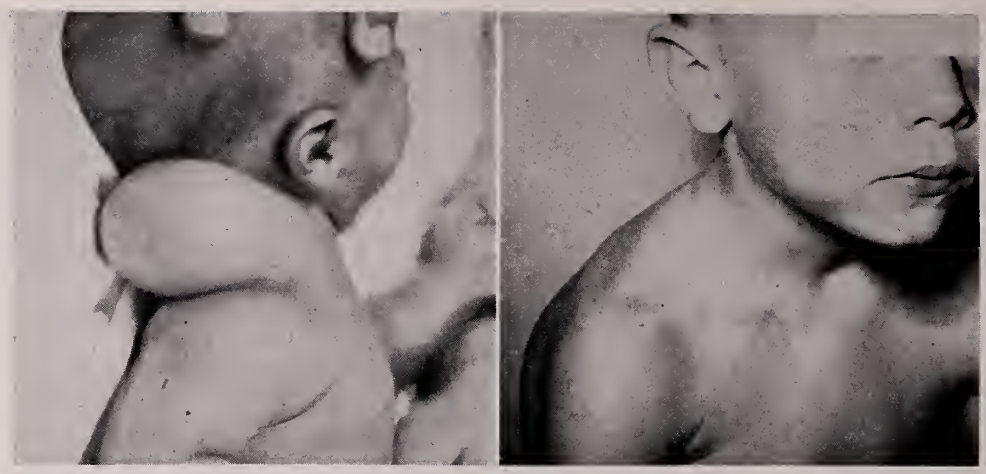

FIG. 4. Case 3. *Left.* A large hygroma in the right side of the neck of a 6 week old infant. *Right.* Six years later the tumor had completely regressed and the excess overlying skin folds had been removed surgically.

ray treatment was administered, cross-firing through two tangential 10 by 10 cm. fields and delivering in twelve days 1,032 r (air) anteriorly and 1,040 r (air) posteriorly. Other factors were similar to those in case 1. Over the next three months slow shrinkage was noticed, and at the end of that time the mass was considered to be one-third of its original size. On March 27, 1947, a second, shorter series was administered to the residual mass, employing the same treatment factors, and delivering 900 r (air) in five days through a round cone 7 cm. in diameter. One month later only a small remnant of the tumor could be felt within the overlying skin folds, and the patient was referred to a plastic surgeon for excision of this excess skin. This was performed in October, 1947, and the wound healed without consequence. The patient was last seen March 7, 1953, a little more than six years following his initial treatment, with a tiny area of induration beneath the lower extremity of the surgical scar but no evidence of recurrence.

CASE 4.—W. G. C., a 3 year old girl, was admitted to the clinic on January 6, 1930, nine months after a puffy tumor was first noticed over the left temporal region. Clear fluid was aspirated from the mass, but it continued to increase slowly in size and eventually extended over the cheek into the neck beneath the ear without causing her any discomfort. The upper portion of the lesion measured 1.25 inches in diameter, and the lower portion was 3 inches across. Heavily filtered 100 mg. radium packs were applied at 2 cm. to each of four areas over the tumor, for fourteen hours each, and this was repeated ten days later. Three months later the mass was reduced to a diameter of 2 inches, and the therapy was repeated. There was continued reduction in size, and with 2 more smaller applications the mass was found reduced to a small cyst ten months after the first consultation. The patient was last seen in April, 1953, at the age of 26 years, with only slight fullness of the left side of the face, with no disability and no visible asymmetry of development.

CASE 5.—B. A. S., a 5 year old girl, was referred to the clinic on May 31, 1937, with cystic masses in the right axilla and supraclavicular fossa. The axillary lesion was observed six months after birth, but the supraclavicular mass was first noticed eight months before this visit when

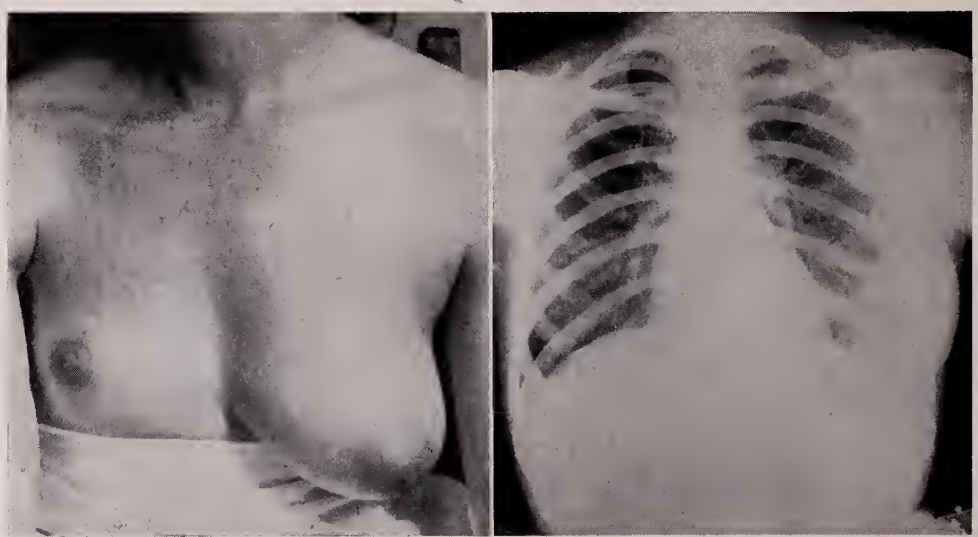

FIG. 5. Case 5. *Left.* Considerable reduction in the amount of subcutaneous tissue about the right shoulder girdle and delayed development of the right breast about sixteen years after irradiation therapy to a hygroma of the axilla and supraclavicular fossa. *Right.* Chest roentgenogram of the same patient showing shortening of the right clavicle.

its rapid increase in size became obvious. Partial excision of the axillary lesion was performed two weeks previously, and a histologic diagnosis of cystic hygroma obtained on a mass of tissue described as being the size of a man's fist. The residual axillary mass measured about 2.5 inches in diameter, while the palpable supraclavicular mass was 1.5 inches across. Roentgen-ray treatment was given through a single anterior 15 by 15 cm. field covering both areas and including most of the right pectoral region. A total dose of 2,000 r (air) was delivered in eight days, employing 220 kilovolts, 50 cm. focal surface distance, and a filter of 0.8 mm. tin, 0.25 mm. copper, and 1.0 mm. aluminum. In a period of two months both lesions regressed, leaving only a single movable 1.0 cm. node, which persisted unchanged low in the axilla over the next four years and to the present. The patient was not seen again until April 11, 1953, at which time she was well, without evidence of recurrence, but exhibited evidence of retarded development of the right shoulder girdle and breast, undoubtedly late results of irradiation therapy (fig. 5). There was no associated functional or psychic disability.

CASE 6.—J. H., a 4 month old girl, was originally seen on July 20, 1931. About two months previously her mother first noticed asymmetry of the child's face, and a 2 inch soft tumor was discovered in the left cheek. A single fourteen hour application of the 100 mg. pack was given, and two months later a second application of a 50 mg. pack was made for fourteen hours. The patient is now married and the mother of a healthy infant. There is no evidence of a cyst in the left cheek, and the skin texture is good. Roentgenograms of the mandible show a symmetrical bony development and average dentition.

CASE 7.—C. C., a girl, was first seen at the age of 18 months, with a soft cystic mass, measuring 2 inches in diameter, in the left parotid area. The patient had been under a dermatologist's care for several months for a tumor within the lower lip which had responded well to carbon dioxide snow. On April 20, 1942, a 100 mg. radium pack was placed over the tumor of the cheek for fifteen hours. About five months later the tumor was reduced to a single cystic area measuring .75 inch in diameter, and a second radium application was given with the above applicator for sixteen hours. The patient was last seen March 14, 1953, at which time the mass had completely disappeared. The overlying skin was soft and elastic, and development of the face and teeth had been symmetrical.

CASE 8.—B. L., a month old boy, was originally seen on May 5, 1936, with a soft cystic mass in the left side of the neck. This mass had been observed at birth as "lemon-sized" but since then had enlarged itself fourfold and extended down over the back. A 50 mg. radium pack was applied at 2.0 cm. for fourteen hours to each of four areas over the lesion. Re-examination in two and a half months revealed little change, and the same application was applied to each of two areas. After another interval of three months there was no significant change, and the treatment was repeated to two areas with sixteen hour applications each. On February 6, 1937, a 100 mg. applicator was placed for twelve hours to each of two areas, again without producing any appreciable effect upon the tumor. One year and three months after the initial visit a total dose of 2,400 r (air) was administered in nine days through a single posterior field over the mass employing roentgen rays at 200 kilovolts and treatment factors as in case 1. The child's family then moved, and it has not been possible to determine his subsequent course or present status.

CASE 9.—W. R. D., Jr., was seen on January 27, 1948, at the age of 15 months, with a cystic soft tissue mass within the right cheek slightly narrowing the right palpebral fissure and partially obliterating the right nasolabial fold. This lesion was first observed about forty-eight hours after birth and was described as diminishing slightly in size within the next two months but not changing appreciably afterward. Roentgen-ray therapy was administered through a single lateral 10 by 10 cm. field, with an air dose of 1,450 r delivered in seven days. Treatment factors were the same as in case 1. The lesion was slightly smaller when seen two months later but had increased again in size at the final visit seven months after treatment. The child has not been seen since, but a member of the family states the tumor is still present, although somewhat smaller than when first seen. He apparently has had one episode of superimposed infection within the last year requiring hospitalization but readily controlled with penicillin.

CONCLUSIONS

It appears rather shortsighted to say that only one method of approach to a problem is reasonable, when several are tried and available. It has been established that a number of cystic hygromas are remarkably radiosensitive,[2,7,12,13] but this does not imply that irradiation is the best attack in all instances. Likewise, it has been proved that even the infiltrating tumors of the neck and mediastinum can be eradicated successfully by one or more skillful surgical procedures with or without the use of sclerotics in destroying the endothelium of nonresectable fragments.[5,6,7,16] Incomplete removal, however, invites recurrence, and a difficult operation implies a certain rate of complication and mortality. Exponents of surgery have quoted the figures of Figi[2] pointing out the mortality of 7 out of 13 patients, but they have overlooked the fact that these deaths were from secondary infection in children considered inoperable and that all other patients benefited by radium treatment. Those supporting radiation therapy, on the other hand, might quote the figures collected from the literature by Dowd[1] in which surgery accounted for 40 cures while allowing 39 deaths. It is easy to overlook the fact that these deaths were also generally from sepsis in an era before bacterial chemotherapy was available.

Objectively speaking, I believe that the drawbacks of surgical attack include the difficulties of adequate dissection in the infiltrating lesions and thus the possibility of incomplete removal and later recurrence or the possibility of inadvertent damage to vascular and nervous structures. Of less frequent importance are the chances of postoperative sepsis and mortality. A small localized and easily excised lesion might be treated surgically by preference and a good result obtained in a relatively short time. The isolated mediastinal lesion is primarily a surgical problem due to the present limitations in its preliminary diagnosis.

The major drawback of radiation therapy is that the response is relatively slow and the treatment and follow-up periods are likely to extend over a number of months. Occasionally, surgery must be performed at the end of a treatment course anyway, in the form of plastic repair or excision of a remnant cyst or cysts and as a form of treatment in a tumor which proves to be radioresistant. There is usually, however, little real hazard in performing these plastic procedures. Theoretic objections to radiation stem from disastrous experiences with growth irregularities in the past when radiation was given indiscriminately over growth centers. Oddly enough, there is a significant void of any such reports in the literature concerning cystic hygroma although it is likely that longer follow-up reports in some instances might disclose a few growth irregularities that have previously escaped detection. The danger of secondary infection apparently will not be the serious problem it once was before chemotherapy was available.

SUMMARY

In spite of some general opinion that the treatment of cystic hygroma is exclusively a problem of surgery, it is a fact that many if not most of these tumors are radiosensitive to a remarkable degree. A small series of cases treated primarily with irradiation and followed for adequate periods of time has shown a most satisfactory response in the majority of instances with no mortality. Infection was no problem in any case, and there were no recurrences in those lesions successfully treated. Careful planning in treatment technique can be done in such a way as to obviate possible damage to growth centers. This approach to treatment is of definite value and should be considered carefully along with surgery weighing the advantages and drawbacks of each method when selecting the wisest plan of attack in any individual situation.

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ABSTRACT OF DISCUSSION

DR. DEAN JONES, San Antonio: Dr. Martin has dealt with this subject fully and adequately and obviously has perused the literature on the subject rather extensively. I believe he has considered all of the possible disadvantages of radiation therapy of these lymphangiomas, but some of these will stand further emphasis.

Practically all of these cases are treated in infancy so that the whole lifetime is ahead of the patient. This allows ample time for all the possible late sequelae of irradiation to develop. In view of the rather high dosages used I would expect some of these people to develop atrophic skin changes in later life and occasionally skin malignancy to ensue. Dr. Martin has encountered little developmental disturbance but one case did have underdevelopment of the breast on the side of the treated lesion.

It seems evident from the case studies that the roentgen beam has been a worse offender in producing undesirable sequelae than has the use of radium. This is to be expected in view of the physical characteristics of the two modes of irradiation. The inverse square law is a potent protective factor in the use of radium applicators at a distance of 2 cm. from the skin surface. Relatively little radiation reaches the deeper structures and even the skin effects are likely to be of lesser import.

Worthy of note is the fact that lesions of this group are rarely seen in adults, and this suggests that there must be a natural tendency for such lesions to regress. Indeed some authors have stated that such spontaneous regression does ofttimes occur. Such a statement may be found in Boyd's textbook of pathology.*

These considerations are called to your attention merely as a note of caution. It is well to keep in mind that this is a benign lesion, subject to spontaneous regression, and that radiation in early life may and does lead to undesirable late changes which can exceed in seriousness the original disease.

Now allow me to get back into the good graces of my colleagues by saying that Dr. Martin has shown, and I agree, that there is a place for radiotherapy in the treatment of lymphangiomas and that we need not yield the treatment of cystic hygroma entirely to the surgeon.

*Boyd, W.: *Surgical Pathology, ed. 6, Philadelphia, W. B. Saunders Company, 1947.*

SELF EXAMINATION OF THE BREASTS
A Suggestion in Technique

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THE importance of self examination of the female breast cannot be overemphasized. It is estimated that 18,000 women die annually in the United States as a result of breast cancer. One of every 25 adult women can be expected to develop this disease.

It is agreed that the best prospect for further improvement in therapy of breast cancer lies in earlier recognition. Shimkin and associates[6] expressed the belief that if all patients experienced delay of less than one month from apparent onset of breast cancer to definitive treatment, a five year survival of 60 per cent could be achieved. Haagensen[3] estimated that more than 90 per cent of women who develop breast cancer discover their tumors themselves and expressed his conviction that instruction of women in self examination of the breasts offers the best hope of improvement in control of breast cancer. Education of the public by means of motion pictures and articles in the lay press is directed toward this objective and is obtaining results. It is becoming commonplace for a patient to report the discovery of a mass in her breast directly after seeing an article or film dealing with this subject.

The American Cancer Society has emphasized the importance of early diagnosis and has issued films and monographs for the instruction of the profession as well as the lay public. It is insufficient for the physician merely to advise his female patients to conduct periodic self examination of the breasts; he is obligated to give careful and detailed instruction in the steps to be carried out in order that this self examination may be performed effectively. These steps are outlined and illustrated in the monograph written by Haagensen[2] for distribution to physicians by the American Cancer Society and also are demonstrated in motion picture films issued by this society for both lay and professional instruction.

An indication of the effectiveness of the film for lay instruction may be gained from the report of one Iowa county[1] where it was shown to 1,280 women more than 35 years of age. Of this group, 120 subsequently underwent complete physical examination; 32 of the group were found to have breast lesions necessitating biopsy, of which 6 were malignant. In Texas, the M. D. Anderson Hospital for Cancer Research has prepared a pamphlet[5] illustrating the methods of self examination of the breast; this is available to physicians for distribution to patients.

From the Department of Surgery, Southwestern Medical School of the University of Texas.

HELPFUL MANEUVER

My attention was directed recently by chance to a maneuver which subsequently has proved to be of material aid in the detection of masses in the breast. A patient was seen because of a firm axillary mass which was suspected to arise from breast carcinoma, but the primary tumor eluded detection on each of several examinations. Immediately prior to operation, while the breast was being washed with soap, it was noted that the primary tumor, which had theretofore escaped detection, could be felt as the soapy hand glided without friction across the surface of the breast.

This idea is by no means new in principle. Haagensen, in his monograph, advised that "when palpation of the breast is carried out in warm weather and the skin is moist, a little talcum powder on it diminishes friction and may add to the accuracy of tactile perception." The origin of this technique, which often has been employed by me to advantage, is ascribed by Haagensen[4] to Dr. George Semken of New York.

Although this maneuver may be of occasional help to the physician, its chief importance lies in its adaptation to self examination by the patient herself. Careful questioning frequently will disclose that a tumor was first detected by the patient during the course of her bath. This is probably due not so much to any unusual thoroughness in palpation at this time as to the frictionless gliding of the hand over the soapy surface. Since the erect or sitting posture of the patient in the shower or bath is not the optimum one for the detection of lumps in the breast, examination while bathing should not supplant the periodic examination in the recumbent position carried out according to prescribed techniques. It is a worth-while supplement to the usual methods, however, and one which the patient should be encouraged to carry out at frequent intervals.

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NOTES ON THE SURGERY OF BREAST TUMORS

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IT IS the purpose of this paper to call attention to the importance of the breast in the feminine economy, to stress the virtues of a thoughtfully planned surgical approach to lesions of that organ the exact character of which must be determined, and to review briefly the several steps of radical mastectomy. A consideration of plastic procedures, purported to elevate sagging structures or to trim them down to normal (or desirable) size is beyond the scope of this effort, which concerns itself essentially with the surgery of tumors.

The breasts are anatomic structures which in these latter days have assumed an importance far in excess of their original function of lactation. Poets, painters, and sculptors of all ages have paid homage to them. The breasts are woman's badge of womanhood, the external and visible evidence of her sex, often her most beauteous feature, sometimes her greatest asset in the game of life, and ironically enough, sometimes too her greatest liability. Budding in maidenhood; ripening gracefully in the teens and early twenties; magnified and glamorized by Hollywood, the sweater girls, and the resort advertisements; capitalized by dames of the Dagmar and Irma class; borne with pride and dignity by young matrons; propped, supported, and uplifted by women of middle years; and endured by elderly females as more trouble than they are worth, these structures seem designed by nature to command attention and therefore must be of paramount concern in the calculations of most women.

Constantly changing as the fires of ovarian activity wax and wane, the breast is often the site of tumors, benign or malignant, the treatment of which is surgical removal. And because the breast is such an essential part of feminine charm, cosmetic considerations are of prime importance and deserve the studious attention of all who would aspire to perform such surgery.

For the time being, then, we are specialists in breast surgery. The indications for operation are clear. The patient is on the operating table. She has a tumor of the breast. It is time for the incision. Where and how shall we make it?

INCISIONS

Let us assume that the lesion to be removed is in all probability benign and that our objective is local excision of the tumor with minimal disturbance of the contour of the breast. The site of the growth determines the site of the incision, and a consideration of the normal tension lines of the skin (Langer's lines) should determine the direction of the incision. When possible, incisions should run parallel to Langer's lines if the least noticeable scar is to be obtained. A radial incision may be used medial to the nipple but is seldom indicated elsewhere. Tumors in the upper, outer, and lower quadrants rate a marginal incision. Lesions near the nipple and not too deep or too large can be attacked through an incision in the areolar margin with almost invisible scars. If the existence of a lesion is in doubt, exploration can be carried out through a marginal incision with the exploring finger in the loose tissue underneath the breast. When simple mastectomy is indicated, a transverse elliptic approach is the operation of choice.

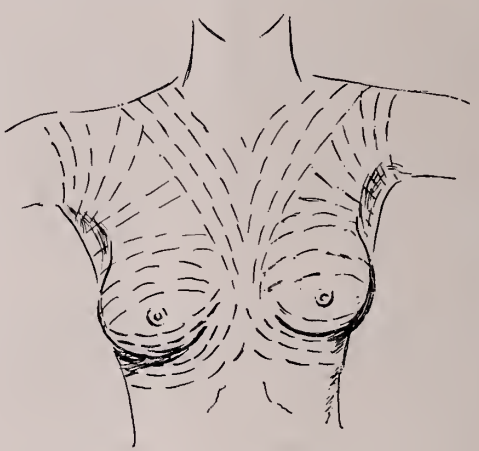

FIG. 1. Drawing of female chest showing Langer's lines.

With careful and considerate technique, pain is negligible and serum formation need not occur. There is little disability, and the patient is restored to her pristine charm with no deformity or distortion of outline.

In recent years, thanks largely to the educational effort of the American Cancer Society, patients are increasingly alert to the menace of cancer and present themselves with smaller tumors, the true nature of which can be revealed only by the finality of the microscope. The apparently benign lump we have taken out on frozen section may prove malignant. If we are wise, the patient has been prepared for this eventuality and has given the green light for the more extensive operation if that should be nec-

Read before the Section on Surgery, Texas Medical Association, Annual Session, Houston, April 29, 1953.

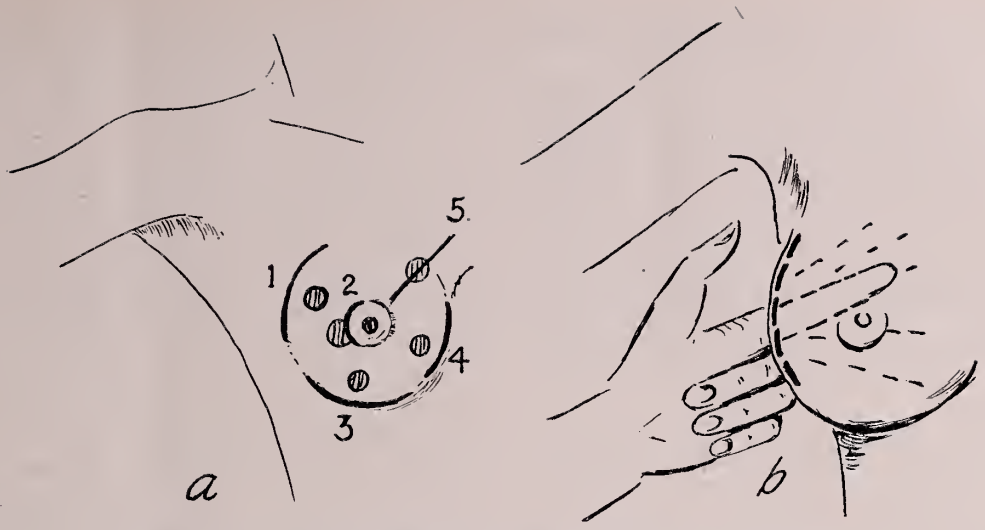

FIG. 2. Incisions for benign lesions of the breast.
a. *1, 3,* and *4:* marginal incisions for peripheral lesions; *2:* incisions in the areolar margin for central lesions; *5:* radial incision for medial lesions.
b. Exploration of the breast through a marginal incision, with a finger in the loose tissue underneath.

essary. Excision biopsy followed by surgery a few days later does not materially affect adversely the subsequent course or prognosis.

The idea of the futility of radical surgery is increasingly prevalent, but unless we accept it, the radical operation remains the most effective treatment for cancer of the breast. The several incisions for radical mastectomy include those described by Halsted, Willy Meyer, Kocher, Greenough, Warren, Stewart, and Rodman. At least twenty-eight different incisions have been described. Which one we should use may be governed in large part by the location of the growth and by the habit of the operator. It is unwise to try to make any one incision apply to all cases. Improvisation is one of the tricks of our trade. The man with the knife should use the incision which will best enable him to excise enough skin in the vicinity of the lesion, give him ready access to the peak of the axilla, and yet provide the most comfortable closure. Regardless of the incision chosen, primary closure may be impossible and resort to supplementary skin grafting may be necessary.

DISSECTION

Once the incision is made, the operation proceeds along fairly stereotyped lines, designed to remove thoroughly the breast and its environs. The surgeon may elect to detach the breast from the chest wall before he attacks the axilla. There is more logic and less bleeding in proceeding first with dissection of the axilla. The surgeon visualizes the pectoralis major muscle, the lower margin of which is his first landmark after he gets through the skin of the axilla. It is well to carry the dissection posteriorly and laterally until the anterior margin of the latissimus

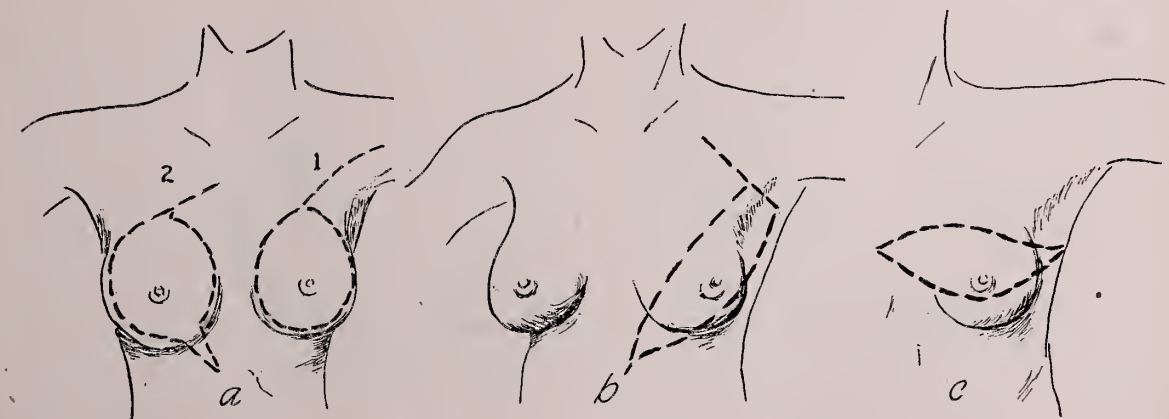

FIG. 3. Incisions for radical mastectomy.
a. *1:* Halsted incision; *2:* incision of Kocher.
b. Incision of Rodman.
c. Transverse incision of Stewart.

dorsi muscle is encountered, marking as it does the lateral limit of the axillary dissection. The lower two-thirds of the pectoralis major is isolated and divided near its tendinous insertion into the humerus and reflected medially and downward. This exposes the pectoralis minor muscle and beneath it the costocoracoid membrane, which the operator already has visualized in his mind's eye. The pectoralis minor is divided near its insertion into the coracoid process and reflected downward, and the costocoracoid membrane is incised thus exposing the contents of the axilla.

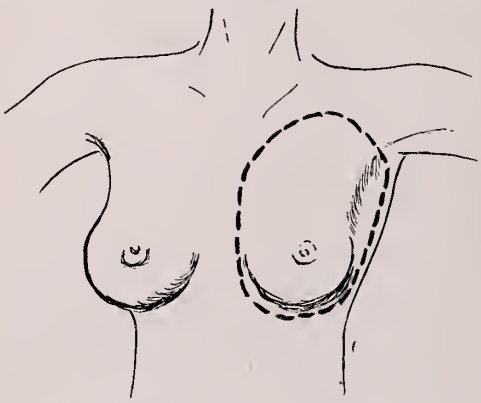

FIG. 4. Area of dissection in a radical mastectomy with any type of incision.

Dissection of the axilla then is carried out, beginning at its peak where the axillary vein emerges from the chest, and clearing that vessel of tributary veins and gland-bearing tissue from above downward and from within outward. At the outer extent of this dissection are encountered the subscapular vessels and thoracodorsal nerve and just beyond them the margin of the latissimus dorsi. The mass of gland-bearing axillary tissue with the pectoral muscles is reflected downward, leaving the axillary vein and subscapular artery, vein, and nerves, and exposing the muscular walls of the axilla, including the long thoracic nerve of Bell.

Removal of the breast is the next step, and this is done with more rapidity and ease from the margin of the latissimus dorsi muscle medially to the sternum, leaving the reflection of the sternal part of the incision to the last. This completes the dissection, and left exposed are the chest wall with the long thoracic nerve, the denuded axillary vein, the subscapular nerves and vessels, the latissimus dorsi and subscapular muscles, and perhaps the upper origins of the rectus abdominis muscle.

Closure of the skin completes the operation, usually with a drain to the axilla and a pressure dressing. Closed drainage with a catheter, recently suggested, may offer a better solution for an annoying problem. Free use of the arm is encouraged. Serum formation is the rule rather than the exception but usually ceases in one to three weeks. Swelling of the arm is a common sequela but need not be disabling. Excellent prostheses minimize the deformity and salve to some extent the psychic insult of losing the breast. Disability is of relatively short duration considering the enormity of the operation.

SUMMARY

A thoughtful and considerate approach is recommended in breast surgery with emphasis on the cosmetic result. Common incisions are reviewed with special reference to the several steps involved in radical amputation of the breast.

1226 Pennsylvania Ave.

ABSTRACT OF DISCUSSION

DR. ROBERT F. SHORT, Dallas: Dr. Thomason's paper contains a great deal of information, all of which I adhere to closely. I do wish to state that any tumor of the breast

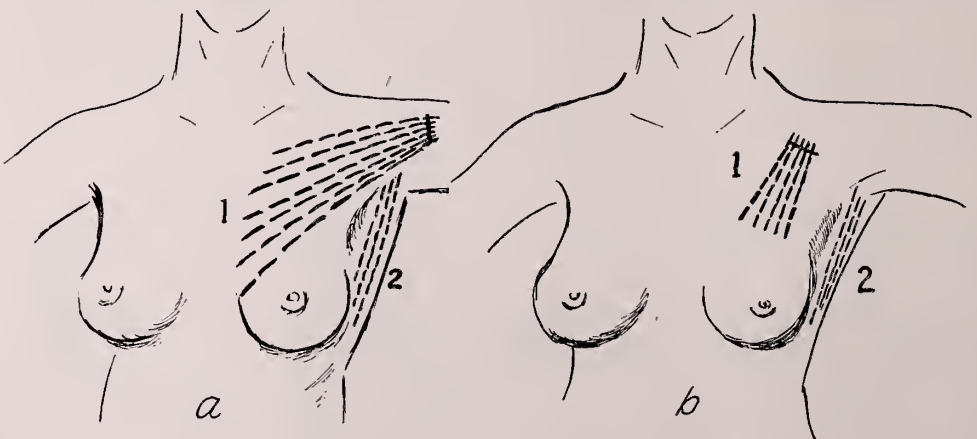

FIG. 5. Landmarks in dissection. *a—1:* pectoralis major muscle; *2:* latissimus dorsi muscle. *b—1:* pectoralis minor muscle; *2:* latissimus dorsi muscle.

that is painful is practically never malignant. A malignant breast almost always is found accidentally, with no pain attributable to it.

Dr. Thomason has described closely the technique in a radical resection of the breast. I have found that if there is present in the apex of the axilla one node, called Halsted's node, the outcome usually is fatal. If glands are in the axilla, I frequently resort to radiation therapy, although I am still at loss to say whether this is of value.

For pressure dressings I use flat rubber sponges employing at time an Ace bandage, which will give total pressure and eliminate a great deal of the serum exudate.

Treatment of Malignant Bladder Tumors

GRAYSON CARROLL,* M. D., F.A.C.S., St. Louis, Missouri

THE treatment of malignant bladder tumors depends on the location of the lesion and the depth of the infiltration into the wall of the bladder.

All tumors of the vault of the bladder may be segmentally resected. Tumors overlying or involving one ureter may be segmentally resected, transplanting the ureter into another portion of the bladder. Lesions found on the floor of the bladder about the trigone or bladder neck are the most serious and pose the greatest problem.

The papillary tumors invading only the most superficial layer, usually having a small base, are easily diagnosed and treated by cystoscope; although they have a tendency to recur or reimplant, the prognosis in this type is favorable. Those showing infiltration into or beyond the muscle layers have a much poorer prognosis and require a carefully planned type of therapy, usually radical. All types of tumors may infiltrate deeply, but the pedunculated sessile types usually infiltrate the deepest. They may be of transitional or epidermoid type.

The diagnosis as to the depth of the infiltration is the real problem. Broders' classification, grading malignancy group 1, 2, 3, and 4 by the microscopic appearance of the cells and their arrangement, is helpful but not determinate. The cystoscopic appearance is extremely helpful, since the large sessile or pedunculated bases with ulcerated and necrotic surfaces are usually deeply infiltrating.

The greatest diagnostic aid is the biopsy specimen which is removed transurethrally either with the electrical cutting loop or the Lowsley rongeur. This tissue should include practically all the layers of the bladder even at the risk of penetration, and the pathologist should be advised to report the depth of penetration in relation to the muscular layers.

The third valuable aid is the bimanual palpation of the tumor under deep anesthesia, preferably spinal anesthesia, with the hand pressing down forcibly over the lower part of the abdomen against the finger in the rectum in the male and in the vagina in the female. It is remarkable how distinctly some of these tumors can be palpated in this way. Immobility of the bladder or thickening laterally suggests deep infiltration.

PROGNOSIS

Jewett's work is accepted as a criterion for prognosis. He studied 80 cases to determine the effect of depth of mural infiltration on five-year results after complete extirpation of the primary growth. Thirty-nine patients had simple cystectomy and 41 segmental resection. Of 19 patients with tumors which infiltrated less than halfway through the muscularis, 14 lived from five to fourteen years without recurrence or metastasis, whereas only 2 of 61 with deeply invading tumors survived five years. Only 10 per cent of patients with superficially infiltrating tumors died with evidence of extension, as compared with 85 per cent of those with deep tumors.[4]

Another interesting observation which affects prognosis and treatment was the finding of Fletcher Colby, who stated:

> Radical lymph node dissections were performed recently on 39 patients. In none of seven patients without invasion of the bladder muscle were the pelvic lymph nodes positive for cancer. Of 32 patients with tumors which invaded the muscle, 47% had positive pelvic lymph nodes.[2]

TREATMENT OF INFILTRATING TUMORS

The early enthusiasm experienced with cystectomy and the diversion of urine by implantation of the ureters in the rectosigmoid has waned somewhat. The operative mortality has been greatly reduced and the immediate unsatisfactory features have been overcome, but the late results in many cases have not been favorable. Complications of transplanting the ureters into the rectosigmoid may be classified as (1) leakage of urine at the operative site, provoking peritonitis or abscess formation; (2) constriction of

This study made possible at St. John's Hospital by a grant from the Olin Foundation.

**Associate Clinical Professor, Department of Urology, St. Louis University.*

the ureter at the site of the anastomosis, resulting in hydroureter and hydronephrosis; (3) recurrent pyelonephritis caused by regurgitation of infection from the rectosigmoid; and (4) positive ascending pressure from the intestine.

The late results from this procedure include hyperchloremic acidosis in which the blood chlorides are persistently elevated and the carbon dioxide combining power is low. There is often a high nonprotein nitrogen level and high urea nitrogen. The patient has nausea, weakness, loss of appetite, loss of weight, and a general feeling of malaise. This is the result of reabsorption of the sodium chloride and the ammonium chloride from the urine in the intestine, and the renal failure which disturbs the tubular function. A low salt diet with administration of an alkali and frequent evacuation of the urine in the rectosigmoid will tend to correct this imbalance. However, this corrective procedure becomes less effective as renal failure proceeds.

Various procedures have been devised to overcome these objections. Elmer Hess, of Erie, Pa., recently has carried out on several patients with a tumor occupying one side of the bladder the procedure he describes as follows:

In the male, if the tumor is in one-half of the base of the bladder we take out the prostate and a large cuff of the bladder holding the tumor, ligating the ureter on that side, and then reimplanting the ureter into the small segment of bladder which we leave behind which, as a rule, carries the other ureter with it, and we sew this around a suprapubic tube. We then take a cone of bladder and sew it down to the posterior urethra, with a retention catheter in it, the same as we do when we do a total prostatectomy. We have on one occasion removed the entire base of the bladder, ligated both ureters, and reimplanted both ureters into the fundus of the bladder and resewn the fundus of the bladder down to the urethra where it has been severed. We have had good results with that.

In women, we do exactly the same thing, except that we take out the third of the urethra, bladderwise, instead of removing the whole urethra.[3]

Retaining the bladder and at least one of the ureteral orifices in most instances preserves the normal function. Dr Hess has stated that the patients are comfortable and continent, but the long-term results are not yet available. He has utilized the frequently observed fact that only a small amount of bladder tissue is needed to restore normal capacity and function.

Dean Sauer of St. Louis University, in an effort to avoid the infection caused by the reflux of fecal material and the reabsorption of urinary electrolytes by the colon, establishes a permanent midsigmoidal colostomy for complete diversion of the fecal stream and implants the ureters into the distal sigmoid colon after closure of its proximal end, thus using the rectum as a substitute for the urinary bladder. Seven cases have been treated in this manner with no evidence of electrolytic imbalance or pyelonephritis.[5] This procedure may prove of considerable value in avoiding the late sequelae of cystectomy but does resign the patient to a permanent colostomy.

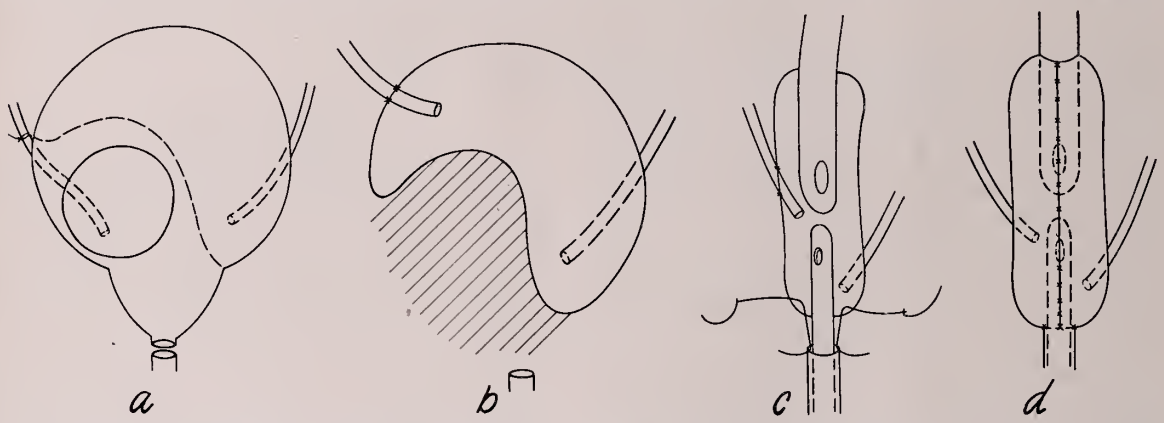

FIG. 1. The Hess procedure for treatment of infiltrating tumor of the bladder retains a small amount of bladder tissue, transplants ureters as indicated, and retains the external sphincter. It is a modified segmental resection.

Eugene M. Bricker utilizes an isolated segment of the terminal ileum with its mesentery intact as a urinary reservoir. This is accomplished by cutting a segment of the ileum, reestablishing the continuity of the gastrointestinal tract by end-to-end anastomosis and inserting the ureters into the segment of the ileum which is closed at one end and brought out as a colostomy on the lower right abdominal wall. A Rutzen bag is used as an external urinary reservoir.[1] Infection and back pressure are avoided by this method, but the patient has the inconvenience of the Rutzen bag, and electrolytic imbalance rarely occurs. This is demonstrated by a case so treated by Dr. Hollo, chief surgeon of Frisco Hospital, and me. Complete pelvic evisceration was performed for a rectal tumor which had invaded the prostate and

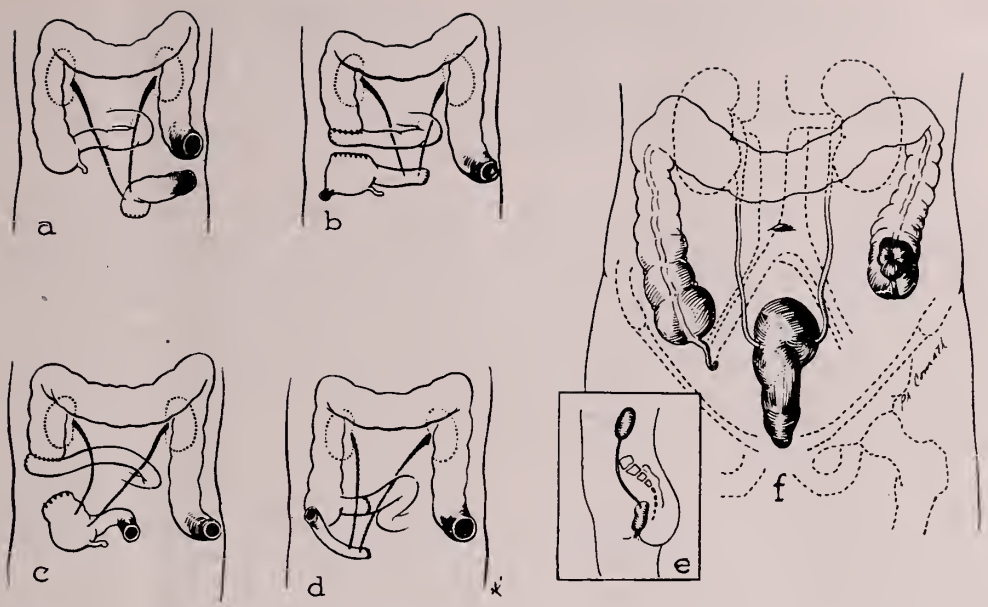

FIG. 2. The Sauer-Melick procedure for bladder tumor utilizes the excluded rectosigmoid colon for the bladder, transplanting ureters in it. A colostomy diverts the fecal stream. (After Sauer, D.: Paper read at the Interim Conference of International College of Surgeons, St. Louis, April 1, 1953. Illustrations *e* and *f* were published in Kinman, L. M.; Sauer, D.; Houston, V. T.; and Melick, W. F.: Substitution of Excluded Rectosigmoid Colon for Urinary Bladder, A.M.A. Arch. Surg. *66*:531-537 [April] 1953.)

bladder. A colostomy to divert the fecal stream was made on the lower left side of the abdomen and an isolated segment of the lower ileum was made for the diversion of the urine with an ostium on the left lower part of the abdomen. The chlorides gradually rose to as high as 750 mg. per 100 cc. of blood, and the carbon dioxide combining power dropped to 20 volumes.

From the findings of Fletcher Colby in which such a high percentage of the infiltrating tumors showed metastasis into the pelvic lymph nodes, it appears that a complete cystectomy is not sufficient, but evisceration of the pelvic fascia and lymph nodes is indicated. Even this is not curative in the deeply infiltrated group. This is borne out by a report of W. F. Whitmore and Victor Marshall of 53 pelvic exenterations performed at New York Hospital between June, 1948, and May, 1951. Lymph node metastases were found in one-third of the patients. Eight out of these patients showing metastasis were dead from return of the cancer, strongly suggesting that this may not be the solution to the problem in these markedly infiltrated cases. Seven out of 23 patients with infiltration beyond the muscle but no metastasis are well, and 9 out of 14 patients with infiltration into but not beyond the muscle are well. This may be the answer to the problem in this group.[6]

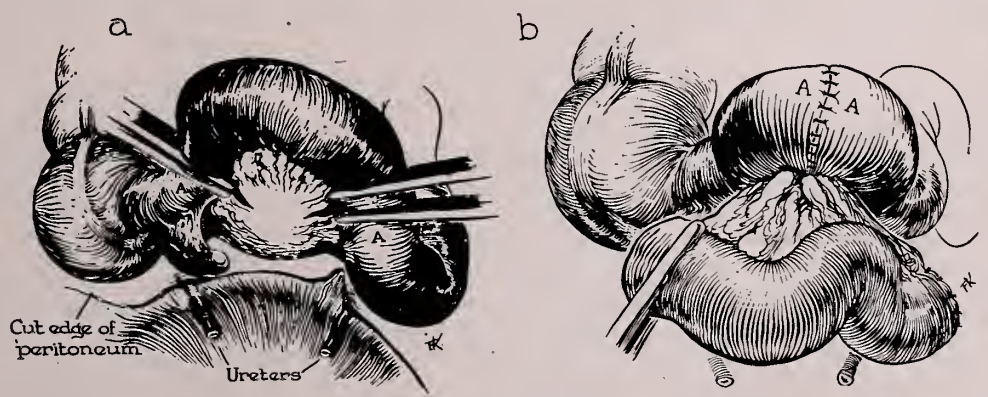

FIG. 3. The Bricker procedure for bladder tumor utilizes an isolated segment of ileum, transplanting ureters in it, and providing a urinary colostomy and end-to-end anastomosis of the gastrointestinal tract. A fecal colostomy is performed if rectum also is removed. (After Bricker, E. M.: Bladder Substitution After Pelvic Evisceration, S. Clin. North America *30*:1511-1521 [Oct.] 1950.)

The free use of blood transfusions, antibiotics, and improved operative skill have greatly reduced the operative mortality in these radical procedures.

SUMMARY

The proper method of diagnosis of bladder tumors in respect to prognosis and treatment has been discussed, emphasizing that the depth of infiltration of the tumor is the criterion which determines the prognosis and treatment. The biopsy specimen taken through all layers of the bladder and bimanual palpation under anesthesia afford the best methods.

The various surgical treatments are presented, with a critical analysis of the results.

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3. Hess, E.: Personal Communication, March 12, 1953.
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ABSTRACT OF DISCUSSION

DR. B. W. TURNER, Houston: Today the concept of cancer of the bladder obviously is more advanced than it was twenty years ago. We who care for these patients know that we have yet to discover the cure that all are seeking. The past two decades have brought many new methods and ways of controlling this dreaded disease, mostly through radical measures that enable urologic surgeons to remove totally the lesion or lesions whereas in the past such was impossible.

Tumors of the bladder are to be graded by their cellular groupings and their depth or penetration into the bladder wall. This may be considered the number one factor in the handling of these cases. The location of tumors of the bladder is considered the number two factor. I have tried to simplify the classification of bladder tumors into as few groups as possible and have used the following classification: Papillary, squamous cell, adenocarcinoma, transitional cell, and undifferentiated type.

In the treatment of bladder tumors the small papillary group of the superficial type may be destroyed by simple fulguration. The type that has not penetrated to the serosa may be resected by the transurethral approach to the best advantage, unless it is located in the dome area where in most cases segmental resection is the choice procedure.

In the highly malignant types, deeply penetrating the walls of the bladder and invading or penetrating the serosa, radical cystectomy is indicated unless the process has extended to the retroperitoneal glands and gland dissection is not considered feasible. In cases in which cystectomy is indicated, with or without gland dissection, the procedure is preceded by ureterosigmoid anastomosis, and in my hands the Cordonnier technique, with or without modification, has been the choice procedure. Both operations are done at the same time unless the condition of the patient renders it unsafe.

Lesions of the dome or side walls of the bladder, unless they are superficial and small and papillary in type, are cared for by segmental resection. Lesions on the base of the bladder may be resected by the transurethral route unless they penetrate too deeply to be resected beyond the tumor extension; then cystectomy must be employed.

I care for about 75 per cent of tumors of the bladder by the transurethral route. I do not employ any type of radiation as I am of the opinion that it has not helped as I once thought it did and that time has proved almost all bladder tumors to be radioresistant.

I wish to emphasize a few points in the examination of patients:

1. A careful cystoscopic survey of the entire bladder wall should be made, using the observation lens with the bladder filled to near capacity. Then with the panendoscope the posterior and bulbous urethrae should be studied. The panendoscope is not a cystoscope, and the bladder mucosa cannot be properly visualized through it.

2. A specimen of tissue of all suspicious lesions should be removed for biopsy.

3. A bimanual examination should be made in an effort to detect superficial or deep glands, fixation, induration, thickening of the walls, and so forth.

4. It is necessary to employ routine follow-up examinations in all bladder tumor cases, including bone and chest roentgenograms as well as cystoscopic examination.

5. An unfortunate sequence of bladder tumor is that symptoms usually come late; if we urologists are to find more bladder lesions, we must spend more time examining the bladders of patients subjected to routine cystoscopic study.

WHARTON NURSES' HOME RECEIVES AWARD

The Josephine Traylor Brooking Memorial Nurses' Home, for which ground was broken in Wharton early in February, won an award in an architectural design competition conducted by *Progressive Architecture.* Architectural firm planning the building, the first to be erected for the Gulf Coast Medical Foundation in a proposed medical center adjacent to Wharton County Junior College, is Fehr and Granger of Austin.

The nonprofit medical foundation contemplates erection of a 100 bed hospital and other buildings in the new center. Arrangements already have been made for training of vocational nurses at the junior college, and these students will stay in the new home now being constructed.

Physical Medicine Contest Scheduled

An essay in the field of physical medicine and rehabilitation by a medical student, intern, resident, graduate student in preclinical science, or graduate student in physical medicine and rehabilitation will be eligible for a cash award of $200, a gold medal, and a certificate. The contest, sponsored by the American Congress of Physical Medicine and Rehabilitation, closes June 1. Inquiries may be addressed to the congress, 30 N. Michigan Avenue, Chicago 2.

Doctors in Alcoholics Anonymous

The fifth annual International Group of Doctors in Alcoholics Anonymous will meet in Akron May 14-16. Doctors, Mayflower Hotel, Akron, Ohio, may be written for information and reservations.

TUMOR SEMINAR

Conducted by

Lauren V. Ackerman, M. D., St. Louis, Missouri

THE Ninth Annual Tumor Seminar of the San Antonio Society of Pathologists was held at Brooke Army Hospital, Brooke Army Medical Center, Fort Sam Houston, Texas, November 1, 1952.

The meeting was opened by Col. Carl J. Lind, Jr., MC, chief of Laboratory Service, Brooke Army Hospital, who introduced Major Gen. E. A. Noyes, MC, commanding general of Brooke Army Medical Center; Major Gen. Martin E. Griffin, MC, commanding general of Brooke Army Hospital; and Dr. A. O. Severance, secretary-treasurer of the San Antonio Society of Pathologists. Colonel Lind honored Dr. B. F. Stout as the originator of this society, its president for many years, and the backbone of the society. Credit for work on the seminar was given to Capt. Francis J. Sullivan, administrative officer who organized the mechanics of the assembly, and to Mrs. H. A. Watson and Mrs. A. C. Krukowski, who type and edit the proceedings of the seminar for publication. The photographs were prepared in part by Mr. Henry Marasco of the photography section. Capt. Robert E. Kellenberger was the pathologist responsible for organizing, preparing, and coordinating all details between contributors, Dr. Ackerman, and many others. Monetary support was given by the American Cancer Society and the South Central Region of the College of American Pathologists. The slides were prepared by the M. D. Anderson Hospital for Cancer Research in Houston under the direction of Dr. William O. Russell.

Dr. Severance introduced Dr. Lauren V. Ackerman of St. Louis, who is professor of surgical pathology and pathology at Washington University. The first case then was presented.

CASE 1

Diagnosis.—Carcinoma with excessive mucin production.

Contributor.—Dr. Lauren V. Ackerman, Washington University School of Medicine, St. Louis.

History.—A soft, reddish, gelatinous lump measuring 2.5 cm. in diameter was excised from the breast in a 57 year old woman. There were no palpable regional lymph nodes and no history of discharge from the nipple.

Submitted diagnoses.—Adenocarcinoma (mucinous, colloid, and so forth), 31; intraductal papilloma, 6; intraductal carcinoma, 2; intraductal adenoma, 1; fibroadenoma, 1; tumor of skin appendage origin with sebaceous elements, 1.

Dr. Ackerman: In this case almost everybody believes that this was a mucinous or colloid type of carcinoma. There were 2 diagnoses of intraductal carcinoma. I think the carcinoma was far beyond the ducts so that this designation could not be used.

This tumor is composed of small nests of well differentiated tumor cells separated by lakes of mucin. This is a carcinoma of the breast which has a characteristic gross appearance. Grossly the tumor is soft, often rather demarcated, and frequently gelatinous and somewhat currant jelly–like in appearance. This gross appearance with apparent encapsulation is often misleading to the surgeon. However, these tumors are true carcinomas and must be treated by radical mastectomy. They have a somewhat better prognosis as a group than the usual carcinomas of the breast, for they appear to grow more slowly and metastasize in a lower percentage. The mucin arises from the epithelial cells of the tumor rather than from a degeneration of the stroma (fig. 1). If the tumor metastasizes to a lymph node, the mucin is also present, which is further evidence of origin from the tumor cells. This type of carcinoma with excessive mucin production is in contrast to the rare carcinoma of the breast in which the mucin is confined to the cytoplasm (so-called signet ring type). This type of carcinoma of the breast has an extremely poor, if not hopeless, prognosis in all cases.[1]

Radical mastectomy was done on this case on September 26, 1951, and the regional axillary lymph nodes, 17 in number, showed no evidence of tumor. The patient was last seen on March 10, 1952, and showed no evidence of recurrence.

Dr. A. O. Severance, San Antonio: I have heard it said by some that colloid or mucoid carcinoma of breast does not metastasize to axillary nodes. I have thought they can metastasize occasionally.

Dr. Ackerman: I feel that the type of tumor demonstrated has a tendency to grow slowly and will have metastasized at the time of operation in a low percentage of instances. I had a patient who had a carcinoma of this type with only one lymph node involved; lesions in the lung and bone developed but grew very slowly. The patient died about four years after the tumor metastases were recognized.

CASE 2

Diagnosis.—Breast, intracystic papilloma.

Contributor.—Col. A. M. Richmond, MC, Fourth Army Area Medical Laboratory, Fort Sam Houston.

History.—The patient noted a lump a few days prior to admission. There were no clinical signs of infiltrating tumor. A mass of solid tumor inside a thick-walled cyst was found at surgery. The wall of the cyst was not perforated at the operative procedure.

Submitted diagnoses.—Intraductal papilloma, 23; carci-

noma, 8; cystadenoma, fetal adenoma, and so forth, 7; sclerosing adenosis, 2; cystosarcoma phylloides, 1.

Dr. Ackerman: I think most of you have believed this was benign. Only 8 believed it was carcinoma, so the majority are with me.

Dr. Hugh Grady of the Armed Forces Institute of Pathology made the following comment: "The critical questions in this case are (a) is the primary tumor malignant and (b) do the two isolated nests of tumor cells in lymph nodes constitute metastasis, or do they represent tumor emboli which have been extruded from the main tumor mass by mechanical manipulation incidental to examination and operation, but which are not destined to implant in the substance of the node, survive, and grow autonomously? Neither question can be answered unequivocally. Most observers are reluctant to consider the primary tumor malignant on purely histologic criteria. The findings in the lymph nodes are not conclusive evidence of metastasis in the stage at which they are observed; speculation as to their probable fate is beyond the realm of empirical science."

Sections show a mass of tumor within a fairly thick-walled cyst. The individual cells are forming acini, and many of these acini are lined by apocrine cells with prominent pink cytoplasm. In other zones there are papillary projections supported by connective tissue vascularized cores. These lesions vary in cellularity. In some areas there are rather prominent aggregates of cells. In such cellular, apparently growing areas, mitotic figures are not uncommon, but they are normal mitotic figures. In the breast parenchyma surrounding this lesion there are a few nests of cells within apparent lymphatics. These cells do not appear abnormal. The tumor within the thick-walled cyst is well supported by connective tissue stroma, and there are no areas of necrosis (fig. 2).

The tumor was well differentiated and well supported by connective tissue stroma, and there is no necrosis (fig. 4). These findings are all against the diagnosis of a malignant tumor. The fact that there are few nests of tumor cells in the surrounding lymphatics does not necessarily indicate that this is a malignant neoplasm. I suspect that it could occur because of trauma to the tumor, perhaps from examination or at the time of operation. Apparently this patient had a radical mastectomy. An axillary lymph node shows a nest of tumor cells within a peripheral sinus (fig. 3). These tumor cells are uniform in appearance and look like the cells seen within the lymphatics of the breast. Their presence within this peripheral lymphatic is not evidence to me of malignant change but merely suggests that tumor reached the lymphatics and was carried to the regional lymph node. I do not believe that it would have the capacity to continue to proliferate, grow in the node, or distantly metastasize. This, naturally, is a personal opinion and cannot be proved. If you say that it is malignant tumor within the peripheral sinus with capacity to grow replacing the lymph node and metastasize, I cannot disprove this statement either. However, tissue such as endometrium also can break into lymphatics and be transposed to distant areas. This does not make the endometrium malignant. I feel that all that was indicated in this patient was local excision of the lesion. This lesion is certainly not a cystosarcoma phylloides because that lesion shows malignant changes in the stroma and there are no changes in the stroma of this tumor.

Dr. A. O. Severance, San Antonio: What percentage of intraductal papillomas do become malignant?

Dr. Ackerman: I have never seen a single one with this pattern become malignant.

Dr. Severance: Given this same case once more in your laboratory, you're looking into the microscope, you're seeing those patterns in the lymphatics, would you say leave the patient alone or do a radical?

Dr. Ackerman: I would just leave it as is. I would say no further treatment is indicated.

The follow-up report said that the patient had had roentgen-ray therapy which was completed on July 22, 1952. I think all of us would be in agreement that roentgen therapy given to a patient with these equivocal findings would be contraindicated, because roentgen therapy, if it were given to cure cancer, has considerable morbidity. I have seen 2 patients during the past two years with extreme irradiation effect in the lungs sufficient to cause symptoms necessitating pneumonectomy.

Dr. W. R. Mathews, Shreveport: When do you recommend irradiation in mammary cancer?

Dr. Ackerman: Let us say that you select for surgery the patients who are truly operable. Then, if you have a surgeon who knows how to do a radical mastectomy, the percentage of local recurrences on the chest wall and axilla is around 10 per cent. If you irradiate the chest and axillary areas, you are irradiating a wide area in which there is only a 10 per cent chance of local recurrence. If the tumor recurs in the immediate area of the breast, it will appear in the anterior mediastinum or within the supraclavicular area. How can we predict which cases are going to have tumor in those areas? Dahl-Iverson did supraclavicular biopsies on an appreciable number of cases, and in the patients who had axillary lymph node metastases one-third had supraclavicular lymph node metastases. In another group of patients who had tumor arising in the central quadrant or the inner quadrant of the breast, Hanley was one of the first routinely to do a biopsy on the anterior

mediastinum, and in those patients with tumors in the central or inner quadrants the percentage of those with mediastinal lymph node involvement was up as high as 40 or 50 per cent. Finally, if a patient has a tumor in the outer quadrant of the breast and the axillary lymph nodes are negative, in practically no instance will the supraclavicular or the anterior mediastinal lymph node areas be involved.

So, let us take that information and try to decide about roentgen-ray therapy. In the first place it would not be rational to give roentgen therapy to the patients who had a tumor in the outer quadrant and had no evidence of lymph node metastasis. I think it would be rational to give roentgen-ray therapy to those patients who had axillary lymph node involvement or who had tumors arising in the central or inner quadrant. And I would say that the therapy should be directed not to where the tumor is not, but to an area where the tumor is, which would be in an area extending up along the anterior mediastinum in an arch involving the supraclavicular area. That is the procedure which we are now following at Washington University except that we have set it up as a problem which statistically will take us perhaps ten years to find the answer. In other words, we have thrown out our cases that arise in the outer quadrant and have negative axillary lymph nodes (average number found 27). Then we have taken two groups, those that arise in the central or inner quadrant and those that arise in the outer quadrant and have lymph nodes involved. Then we have taken those two series and alternated the cases in those two groups so that in each of those two groups half of them receive irradiation and half of them do not. We are routinely doing biopsies of the second and third interspaces on those cases merely for the record. The lymph nodes found often measure no more than 5 mm. or the surgeon tells us, "I am sorry, but I was unable to get any lymph nodes for you." Yet, we block that material and lymph nodes are not only there but they are involved. We take the material which we receive from those spaces and subserial section it, and that often gives us increased information. Another way of handling that problem is Dr. Cushman Haagensen's method.[13] McDonald[22] biopsies the breast, anterior mediastinum, and supraclavicular area first. If the anterior mediastinum and/or supraclavicular area show cancer, then that patient is no longer operable and is placed in the group for irradiation therapy.

Dr. William W. Tribby, Memphis, Tenn.: How would you treat a carcinoma of the breast which, when first seen, is inoperable but responds so well to irradiation that it becomes operable? I have seen radical mastectomy done under these circumstances.

Dr. Ackerman: I have also seen patients with advanced inoperable cancer, with extensive skin edema, fixed axillary lymph nodes, and satellite skin nodules. I have seen irradiation given under these circumstances and have seen the whole area become very soft. I have seen the satellite skin nodule disappear, and then I have seen a surgeon examine the patient and say, "Well, this patient who was inoperable before is now operable." Those circumstances, in the cases with which I am familiar, resulted in stirring up of the fire; those patients developed metastases and died in a relatively short period of time after the operation was done. Perhaps there might be cases which did not follow that course, but I just happened not to have seen any.

I think the reasoning for that is in what happens to the patient with cancer of the breast that responds to roentgen-ray therapy. If the patient has skin edema, satellite skin nodules, that means the lymphatics are blocked by tumor. The reason why surgery is contraindicated is that no matter how wide the surgeon makes his skin incision, he will always be cutting through involved lymphatics. So, when he finishes he will have removed most of the tumor, he will have stirred up the fire, he perhaps will have increased the volume of tumor in distant areas, which on a theoretical basis may speed up the growth of the lesion so that the patient will die in a shorter time. In no instance in my experience have I ever found a case subjected to thorough irradiation that did not have evidence of viable, healthy looking cancer in the primary tumor and/or the regional axillary lymph nodes. I think that what irradiation does to a breast cancer is to kill some of the cells, but there are always some of the cells that are very hardy; they are not affected by the irradiation, fibrosis occurs, and the tumor is locked up for variable periods of time. For that reason I feel that irradiation therapy as such is an excellent palliative method of treatment, but I have not seen any of the cases which Dr. Tribby talks about that have done well.

CASE 3

Diagnosis.—Breast, cystosarcoma phylloides.

Contributor.—Dr. A. O. Severance, Baptist Memorial Hospital, San Antonio.

History.—The patient, a 41 year old woman government employee, noticed a lump in the breast one week prior to operation. There was no history of trauma. A rounded, firm, irregular tumor 3 by 4 cm. was felt in the left breast 3.5 cm. above the nipple, not attached to skin or fascia. No axillary nodes were palpable. Clinical impression: fibroadenoma.

The tumor, measuring 3.5 by 3 by 2.8 cm., was embedded in a mass of adipose tissue measuring 8 by 5.5 by 3.5 cm. It had a somewhat nodular surface, was well demarcated, and bulged on cut section. This cut section was

slightly shiny and showed pink lobulated tissue. Between the lobules were irregular branching narrow clefts.

Submitted diagnoses.—Cystosarcoma phylloides, 18; fibroadenoma, 7; chronic cystic disease, 4; localized fibrosis, 3; sclerosing adenosis, 3; sarcoma, 3; intraductal carcinoma, 1.

Dr. Ackerman: I feel that a surgeon who palpates a breast lesion, even though he has great skill as a palpater, will be right in only about 80 per cent of the instances in appraising a single lump. So, I do not believe that any dominant lump ever should be left in a breast on the basis of a clinical impression. I think that a surgeon who has a background in surgical pathology (naturally I think all surgeons who are doing any major surgery should have a background in surgical pathology) should be able grossly to appraise correctly about 80 per cent or so of the breast lesions. I think that under certain circumstances, given a surgeon with an extensive background, he might proceed with a radical mastectomy on merely the gross impression. However, in any case in which there is any doubt as to the appraisal of the lesion, it would be imperative that frozen section be done. I think that the pathologist should be able to decide on frozen section in a high percentage of the lesions. I do not consent to do a frozen section on a papillary lesion because I am afraid I might call it cancer, for intraductal papillomas of the breast are often highly cellular. If the surgeon gives it to me I say, "Thank you. I will see you tomorrow." Usually he says, "Why is that?" and I say, "Well, I am afraid if I did this frozen section I might call it malignant and probably I would be wrong." Usually it turns out that the lesion is benign. I feel that it does no harm if the pathologist does wait for the permanent sections.

Microscopically there are well-defined acini in this case which are uniform in appearance, and there are some areas of intracanalicular growth. In such zones the epithelium is thinned. There are a few areas in which apparent squamous metaplasia has occurred. In still other areas the stroma has become hyalinized and relatively acellular. In some zones the stroma has become highly cellular, made up of large masses of cells with great variation of their nuclei, and showing many mitotic figures, some of them abnormal.

To me this is a classic example of a tumor which is known as cystosarcoma phylloides of the breast. These tumors have had innumerable names. They show all gradations from benign to highly malignant. In the benign form some pathologists feel that the correct designation is giant intracanalicular adenofibroma. The epithelial elements are the passive elements, and the stroma shows the malignant changes. The decision as to proper treatment is important. These tumors are often inadequately treated by local excision and often locally recur. However, metastases to regional lymph nodes is distinctly uncommon. We reported a case with metastases to the regional lymph nodes of the sarcomatous element.[7] In Treves' study[41] of 77 cases, he felt that 36 of the group were malignant. However, metastases were clinically demonstrated in only 9 cases and were microscopically proved in 6. In all instances the malignant element in the metastases was sarcomatous, and in only 1 case was there metastastic involvement of a lymph node. Distant metastases to the lung was the commonest site. In a given case simple mastectomy should be done including the underlying pectoral muscle. If the tumor is unequivocally malignant, I would be in favor of a radical mastectomy in spite of the low chance of involvement of the regional lymph nodes.

Dr. F. P. Bornstein, El Paso: Would you comment on occurrence of lymph node metastases in fibrosarcomas and leiomyosarcomas?

Dr. Ackerman: All I can say is that I have seen metastases to lymph nodes in both of these tumors. I have not seen lymph node metastases in leiomyosarcomas of the uterus, but I have seen lymph node metastases in leiomyosarcomas of the stomach, and I have seen lymph node metastases on several occasions of fibrosarcomas of the soft tissues. So, I know they do occur but in a relatively low percentage.

Dr. L. J. Manhoff, Jr., San Antonio: What are your criteria for the histologic differentiation of intraductal papilloma and papillary adenocarcinoma?

Dr. Ackerman: Papillary carcinoma per se to me is an extremely rare neoplasm, and intraductal papillomas are relatively common. An intraductal papilloma is usually a small lesion, but at times it can be of fair size and at times it can grow within a cyst. Usually there is no evidence of any necrosis within the epithelial cells. The individual cells are uniform and often there may be apocrine epithelium; usually the tumor is well supported by connective tissue stroma. At times these tumors are highly cellular and at times they appear to be within the surrounding connective tissue, but cells within the surrounding connective tissue may simply mean that the tumor has been so cut and blocked that this is a false impression. I am not frightened by the cellularity of the lesion or its apparent invasion in the surrounding tissue. The papillary carcinomas of the breast are rare.

Sometime ago an article appeared which emphasized the prominence of bleeding as a sign of cancer of the breast. The inference from reading this article was that if there was bleeding from the nipple, there was cancer in a high percentage. I am sure that if you read just the conclusions that would be the inference. However, if you broke this group

down you would discover that if you excluded palpable cancers of the breast that had invaded the nipple and Paget's disease involving the nipple, and you included only cases in which there was a nonpalpable mass or small mass, the incidence of bleeding would be, I think, only 2 per cent.

A pathologist sent me two slides, for I had told him that I thought intraductal papillomas practically never, if ever, became malignant. In this instance a tumor of the breast was first diagnosed as benign, and then it recurred and was diagnosed as malignant. Therefore, it was considered that an intraductal papilloma had become a cancer, a papillary carcinoma. The first sections to me were unequivocally malignant, and the lesion therefore was a papillary carcinoma from its inception.

In 2 cases that have occurred during the first part of my stay at Washington University one patient came back with a recurrent mass in the breast and the other came back with a recurrent mass and metastases. In both of those instances the tumor of the breast had first been reported as a benign papillary tumor. Both of those tumors were of fair size, both of them were papillary, but in contrast to intraductal papilloma, the cells lining these papillary projections were malignant cells. There was also layering and loss of polarity, atypical mitotic figures, and rare areas of necrosis.

We have just seen another remarkable incidence of papillary carcinoma in which a man for ten years had in the region of the breast a palpable mass which was becoming steadily larger. Removal of that lesion showed a papillary cancer with invasion of the surrounding tissue; the entire tumor was a papillary tumor with layering of the cells and atypical cells lining the papillary projections.

Dr. Fred Stewart at the Memorial Hospital sees only a rare example each year in a group of say 700 breast cancers. But to me they are distinct from intraductal papillomas and represent slowly growing cancers which are malignant from the beginning.

Dr. Wilson G. Brown, Houston: Have you ever seen an adenocarcinoma occur in a fibroadenoma?

Dr. Ackerman: I have seen a single example of adenocarcinoma occur in a fibroadenoma. I have reported the sections. The entire tumor was cut at various levels and the cancer was entirely within the neoplasm.[3]

Dr. M. L. Trumbull, Memphis, Tenn.: Would you comment on management of bleeding nipple cases with no palpable underlying mass?

Dr. Ackerman: It is my feeling, as I have indicated, that when you have that situation you usually have a benign intraductal papilloma. It is the opinion of the surgeons with whom I am associated that if you examine that patient frequently, you will always be able to find a palpable mass and that all that is necessary is quadrant removal of the mass. You will find in almost every instance a benign intraductal papilloma. If you did such an operation and had an unexpected finding of cancer, I believe that no harm has been done to the patient and that radical mastectomy can be done. I think that some of the confusion about intraductal papillomas has occurred in chronic cystic disease, for you often see microscopic evidence of a little papillary proliferation, and I think that that is what is meant by some people when they say there are multiple papillomas throughout the breast. I think that all this means is that chronic cystic disease, with all the variations in its pattern, may have microscopic papillary proliferation, which is common in contradistinction to gross single intraductal papillomas. I think also it is difficult to get away from the follow-up of Drs. Haagensen and Stout's group of patients with intraductal papillomas which have been treated conservatively. This group never developed cancer, and in only a small percentage did recurrence appear.

Dr. William W. Tribby, Memphis, Tenn.: What does the word *phylloides* mean?

Dr. Ackerman: This is a term applied to a tumor which on section shows a lobulated leaflike appearance.

Dr. P. A. B. Cunningham, Galveston: Would you please give us your definition of *malignancy?*

Dr. Ackerman: I have never known how to define malignancy.

Dr. Cunningham: Have you seen other such benign metastatic deposits in lymph nodes from either a breast tumor or any other tumor?

Dr. Ackerman: As I have indicated, I fortunately have never recommended radical mastectomy for what I would call a benign intercystic papilloma. Therefore, I have never had the opportunity of examining axillary lymph nodes. In a case of thyroid tumor with tumor cells floating in the lymphatics or of parathyroid adenoma with tumor cells floating in the lymphatics, nobody will do a neck dissection, so I have not seen that happen. My experience is zero from that standpoint. However, if you had a highly cellular benign tumor and handled it roughly during surgery, I would not be surprised if tumor cells were pushed into the lymphatics and the lymphatics would then carry them on to the lymph nodes, where they would die because they do not have the power of invasion.

CASE 4

Diagnosis.—Brenner tumor.
Contributor.—Dr. H. J. Schattenberg, San Antonio.

History.—The patient, aged 38, had had menorrhagia and metrorrhagia for the preceding four years. An ovarian tumor could be palpated. Hysterectomy was performed. The uterus, tubes, and cervix were normal. One ovary contained an ovoid tumor measuring 2.5 by 3 cm. which was solid and golden yellow. The other ovary was normal. The endometrium was thickened, with glands in the proliferative phase.

Submitted diagnoses.—Brenner tumor, 23; granulosa and theca-cell tumor, 5; arrhenoblastoma, 3; thecoma, 3; theca-cell tumor, 1; dysgerminoma, 1.

Dr. Ackerman: I am happy to see that the majority are with me because I suffered with this tumor. I certainly entertained the diagnosis of granulosa and theca-cell tumor seriously. I do not believe that I could put it into the group of masculinizing tumors. I see no evidence of, say, interstitial cells; I see no areas of tubular formation; and I do not see any of the patterns which we conventionally associate with the arrhenoblastomas. I do not feel there is any resemblance to dysgerminoma because a dysgerminoma is a tumor which on cut section looks like brain tissue but microscopically exactly resembles a seminoma with large nuclei and prominent nucleoli without any fibrous background. So, my diagnosis on this case is a Brenner tumor.

The tumor is apparently well encapsulated and made up of two types of tissue. There are nests of cells with uniform nuclei and pink cytoplasm separated by a rather cellular stroma. The stromal cells are uniform with somewhat spindle-shaped nuclei. The reticulin stain demonstrates abundant reticulin in the stroma but no reticulin in the epithelial-like cells.

The gross description of the endometrium suggests that the neoplasm of the ovary was an estrogen-secreting tumor. Usually with such a tumor there is also hypertrophy of the myometrium. The pattern of this tumor suggests that it could be a mixture of thecal and granulosa cells. Both of these elements have a similar origin from the ovarian mesenchyme. These cells do not have the pattern of the estrogen-secreting Sertoli cell tumors demonstrated by Teilum.[39] Sometime ago McKay[23] demonstrated histochemically that there were reactive materials present in the theca cells of the thecomas and in the theca-like cells of the granulosa-cell tumors. He wrote: "From these and other considerations it seems likely that the thecal component of granulosa-cell tumors, rather than the tumor cells themselves, is concerned in hormone production. One case of a nonestrogenic or 'pure' granulosa-cell tumor is reported." The fibrous elements do not have the hyaline plaques of the thecoma, and most important, there is no sudanophilic material present. The collections of epithelial-like cells do not have the pattern of granulosa cells and, most unusual, are grouped in small nests. These focal collections of cells fit best with the Brenner tumor. The Brenner tumor arises from Walthard cell rests. At times central change occurs in the middle of these cells with pseudomucinous change. On one occasion I have seen a pseudomucinous tumor associated with a Brenner tumor. It is of considerable practical importance to separate a Brenner tumor from a granulosa-cell tumor, for the Brenner tumor is invariably benign and the granulosa-cell tumor is often malignant.

Dr. Leo Weiss, Dallas: Have you ever stained Walthard cell rests for mucin? If so, was the reaction positive?

Dr. Ackerman: I have never done that; however, I think that is an excellent idea. I may say that in the Walthard cell rests that I have seen, I have never seen the pseudomucinous areas in them. Have you, Dr. Weiss?

Dr. Weiss: No, I have not.

Dr. J. A. Carroll, Galveston: How often do you see nonfunctioning granulosa-cell tumors of the ovary, and should not those which do function be called thecomas?

Dr. Ackerman: That is a good question because it has been demonstrated histochemically that probably the estrogen-secreting elements come from the thecal areas; that was demonstrated by Doctor Hertig and his co-workers.[23] They have seen nonfunctioning thecomas, and I am sure there must be nonfunctioning granulosa-cell tumors because unless you have theca-cell elements probably you will not have function. But the two are so intermingled that I am not sure that this rigid separation is necessarily indicated. From a practical standpoint, however, if you have a granulosa-cell tumor, you probably have a malignant neoplasm, at least potentially so, and with a thecoma, although there have been rare cases reported of malignant change occurring, such cases are rare indeed.

CASE 5

Diagnosis.—Soft tissue of neck, benign cyst of uncertain embryonic origin.

Contributor.—Dr. P. T. Flynn, Austin.

History.—A 43 year old white woman, on a routine physical examination October 1, 1951, was found to have a 3 by 7 cm., oval, slightly nodular, nontender mass beneath the lower right third of the sternocleidomastoid muscle. The mass was movable and not attached to the trachea. At the time of operation the muscle was split just above the clavicle and a 5 by 4 by 4 cm. oval cystic mass was found sharply circumscribed with a bosselated surface that was fairly adherent to the jugular vein. The mass was carefully dissected and removed in toto without rupture. Upon cut section the mass was cystic and readily collapsed. It was filled with a light green, creamy, homogeneous material which was fairly adherent to the lining. There were

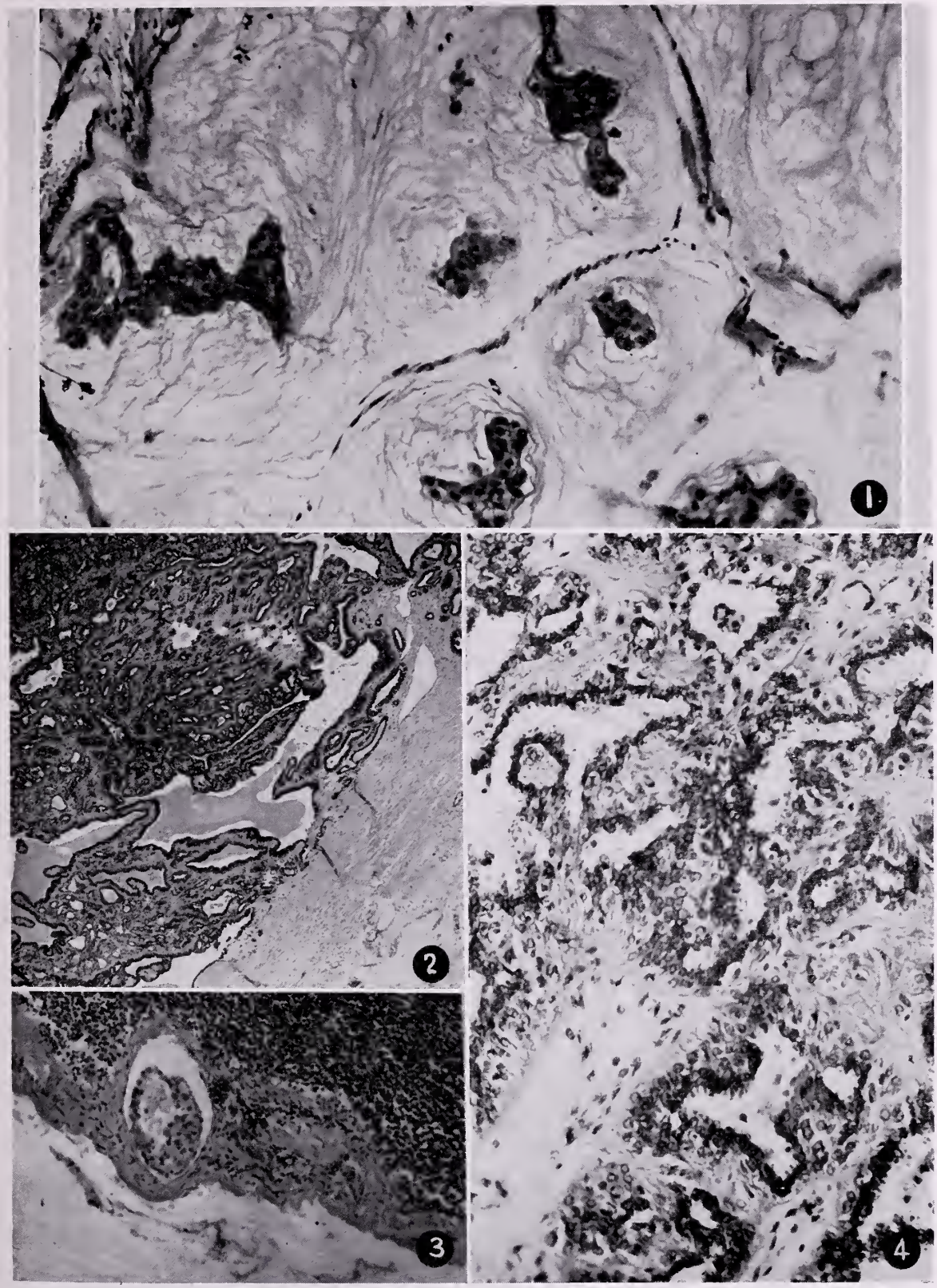
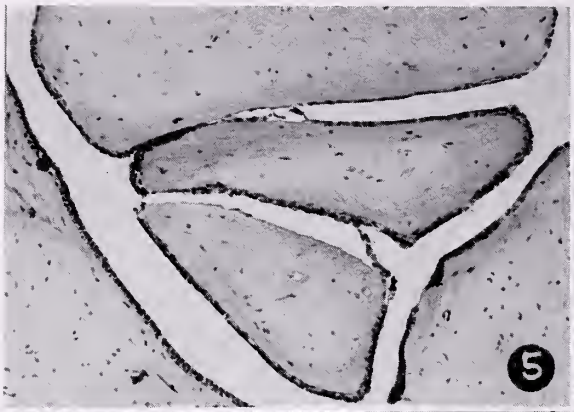


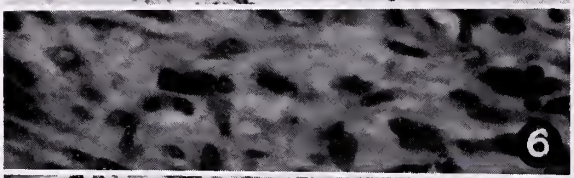
FIG. 1. Case 1. Carcinoma with excessive mucin production. Note lakes of mucin between tumor cells. x 230.

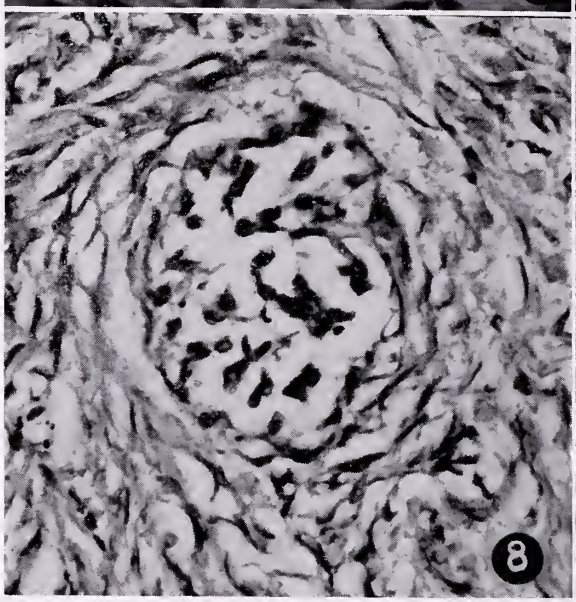
FIG. 2. Case 2. Intracystic papilloma of breast demonstrating its well defined pattern and encapsulation. x 30.

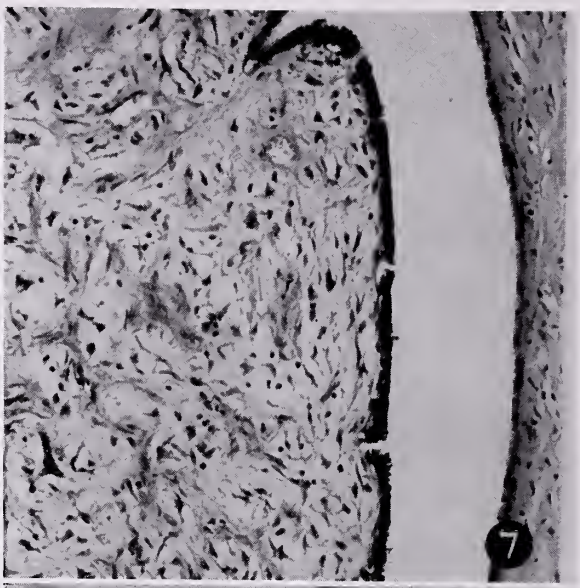
FIG. 3. Case 2. Cluster of tumor cells in peripheral sinus of axillary lymph node. x 105.

FIG. 4. Case 2. Detailed photomicrograph showing uniformity of cells and supporting connective tissue framework. x 230.









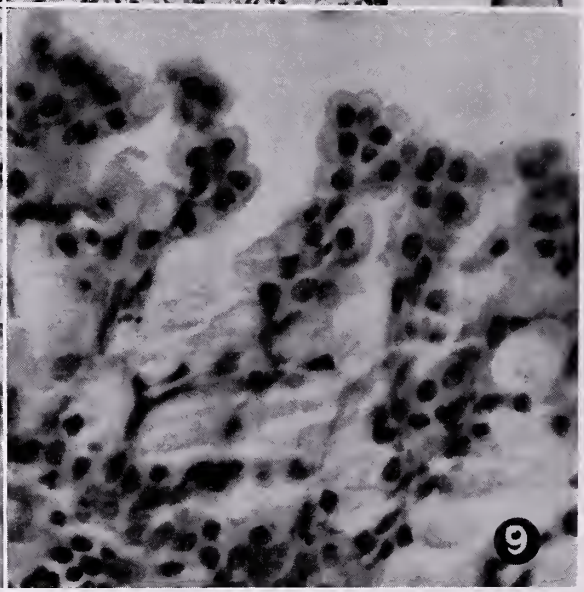


FIG. 5. Case 3. Typical intracanicular area of benign proliferation in cystosarcoma phylloides. x 30.

FIG. 6. Case 3. Sarcomatous area in stroma with pleomorphism and mitotic activity. x 300.

FIG. 7. Case 3. Photomicrograph showing cellularity of stromal background. x 120.

FIG. 8. Case 4. Small mass of cells characteristic of those observed in a Brenner tumor. x 343.

FIG. 9. Case 5. Mucin secreting cells lining cyst. x 475.

FIG. 10. Case 6. Hürthle-cell carcinoma with large uniform cells with little or no mitotic activity. Tumor thrombi were present. x 600.

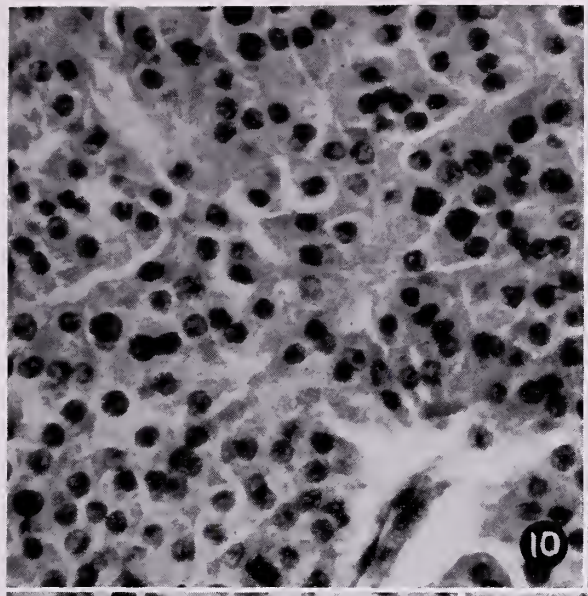
FIG. 11. Case 7. Mass of malignant reticulum cells within a lymph node. Note prominent nucleoli. x 900.

FIG. 12. Case 9. Chronic granuloma with foreign body giant cell and inflammatory infiltrate. x 600.

FIG. 13. Case 10. Giant-cell tumor. Note typical multinucleated giant cells. The stroma is of only moderate cellularity. x 600.

FIG. 14. Case 11. Chorioadenoma destruens (invasive mole) with chorionic villus. Note the sharp demarcation between the cells and villus. x 30.

FIG. 15. Case 12. Malignant schwannoma. Note the cellularity and relative uniformity of the nuclei. x 650.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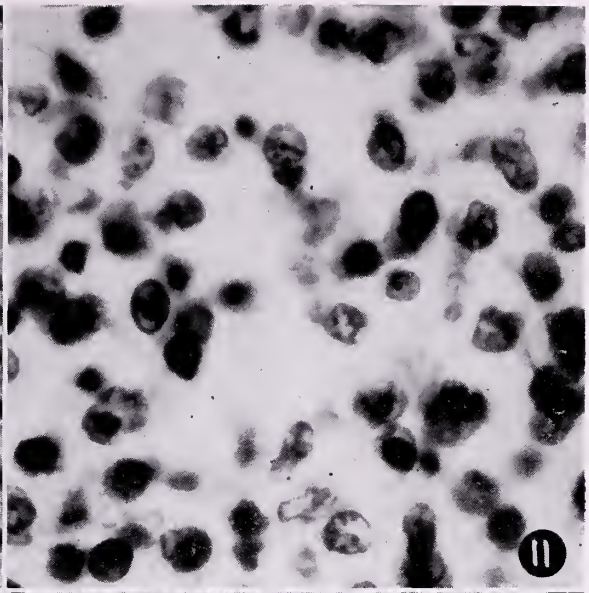
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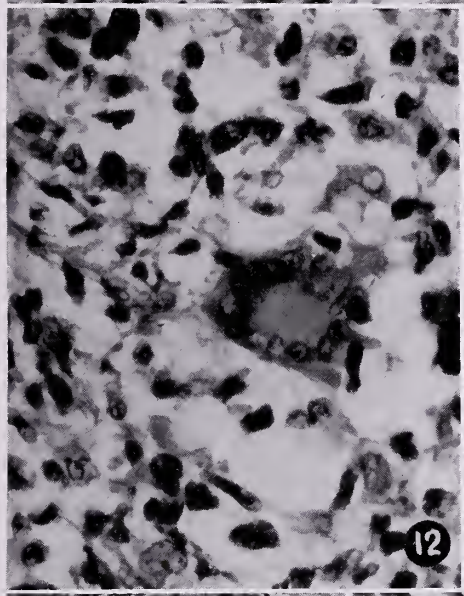
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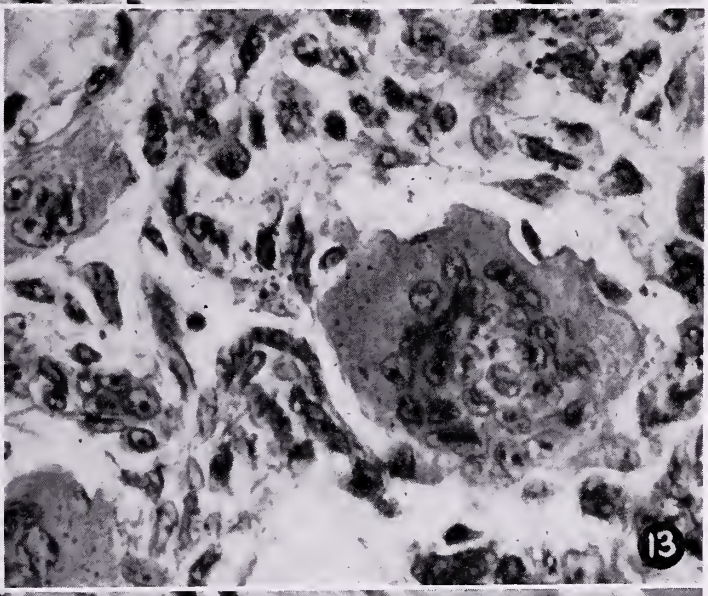
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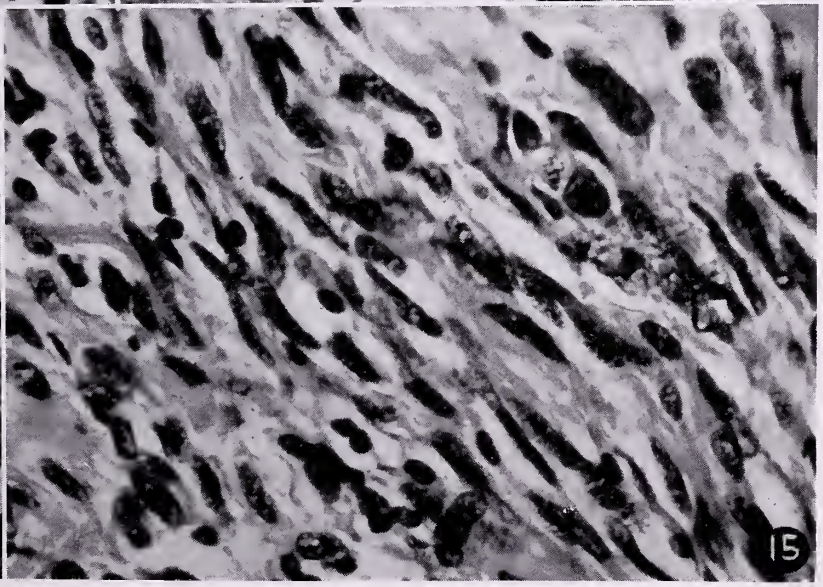
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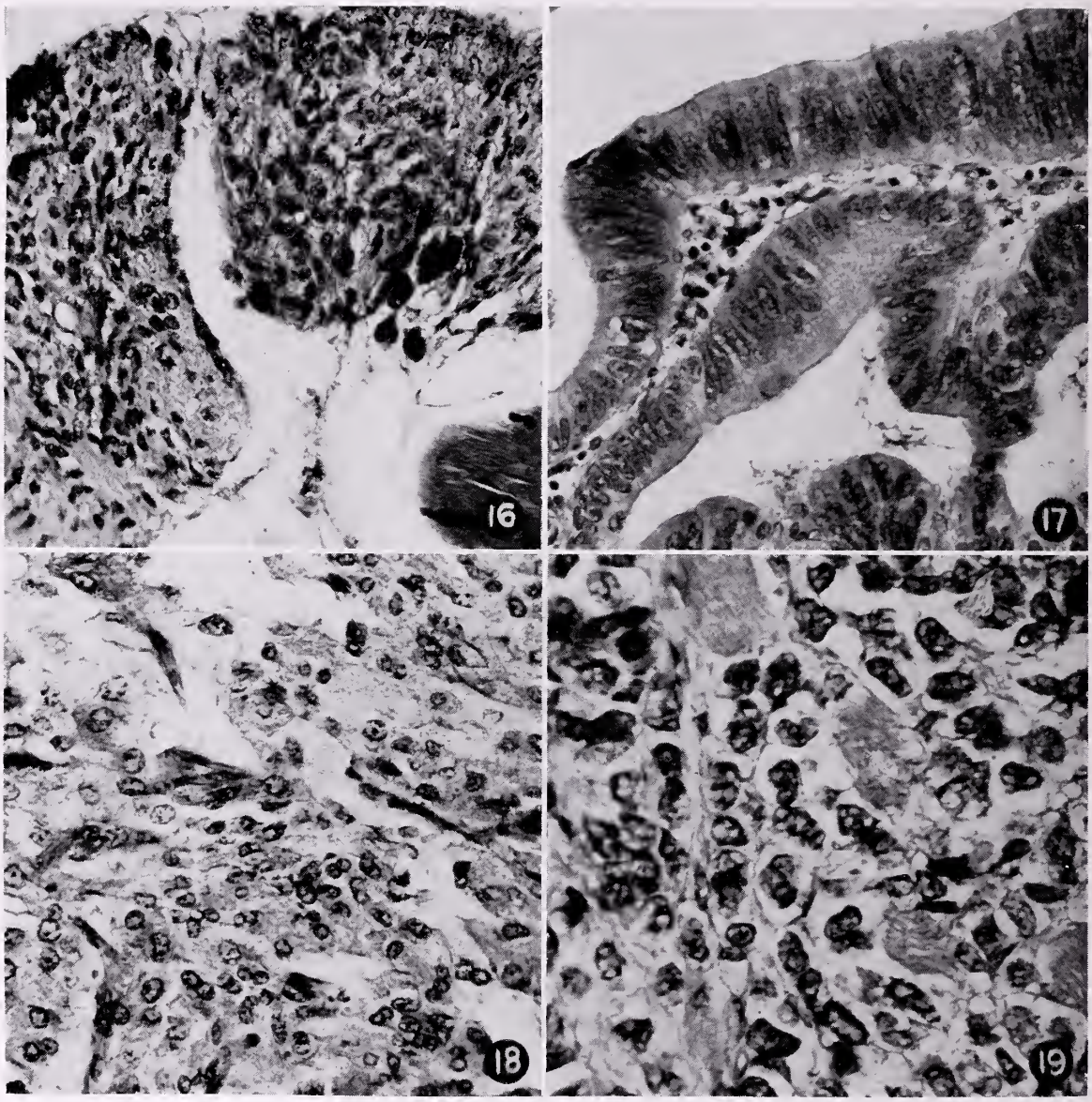

FIG. 16. Case 13. Neurofibroma (? malignant schwannoma) showing a relatively cellular zone with melanin pigment. x 514.

FIG. 17. Case 14. Neoplastic glands with infolding, layering, and loss of nuclear polarity. x 343.

FIG. 18. Case 15. Neoplastic cells arranged in small nests surrounded by blood vessels. x 343.

FIG. 19. Case 16. Reticulum-cell sarcoma with large cells with prominent nuclei. x 514.

numerous small papillary processes projecting into the lumen.

Submitted diagnoses.—Branchial cleft cyst, 24; papillary cystadenoma lymphomatosum, 14; muco-epidermoid cyst, 3; carcinoma, 3; syringocystadenoma papilliferum, 2.

Dr. Ackerman: Well, everybody finally worried their way down to a branchial cleft cyst; at least the majority did, and I can readily see why this diagnosis was made.

The lesion is made of epithelial cells which are squamous in nature and also mucus secreting as shown by the mucin stain. These cells are accompanied by lymphoid tissue which often shows germinal centers. No normal salivary gland, thyroid, or thymic tissue can be seen. Thymic cysts and cysts of the parathyroid (third and fourth branchial arches) have been seen in this area. Thyroglossal cysts are usually in the midline although rarely they have been reported away from the midline.[44] They may show mucus-secreting cells. This is certainly not a papillary cystadenoma arising from the salivary gland. Salivary gland tissue is not present and aberrant salivary gland tissue does not occur in this area. Furthermore, tumors of that nature do not contain mucin-secreting cells and the lymphoid tissue is clothed by oxyphil cells. This could be a branchiogenic cyst from the third branchial arch. I believe this lesion must be classified as a benign cyst of embryonic origin.

I think I should read part of a letter from Dr. A. P. Stout. Dr. Flynn sent this case to Dr. Stout, and he had a little trouble too. He made a study first of the cases of papillary cystadenoma lymphomatosum, and he found 43. Forty-one of those were in the parotid and 2 were in the submaxillary gland, and as I have indicated, there may be some question about those. Judging from the comments of Thompson and Bryant,[40] the tumors described in the submaxillary gland were possibly in that portion of the parotid gland which extends forward to overlap the posterior pole of the submaxillary gland. He had none in lymph nodes. Dr. Stout wrote: "Coming now to the histologic appearance of your tumor, the evidence is conflicting. First, if this is a cystadenoma lymphomatosum in a lymph node, we should be able to recognize it as a lymph node. This I cannot do. I see follicles but I can recognize no sinuses either marginal or elsewhere. In regard to the epithelium lining the cavities it is stratified columnar nonciliated." He does not know what is in those vacuoles, and I think that to some extent is the key to the diagnosis in this case. He said if he were in favor of the growth being a cystadenoma lymphomatosum, the cells in the basal layer have intracellular bridges and he has never seen that in a cystadenoma lymphomatosum. So, he said, "against a branchial origin is the fact that it is a papillary adenomatous growth, and I cannot find records of any such tumors arising from branchial elements." He really was not certain of the diagnosis and cast his vote for this being a unique example of a branchial papillary cystoadenoma of the lateral neck.

CASE 6

Diagnosis.—Thyroid, Hürthle-cell carcinoma.

Contributor.—Dr. Lauren V. Ackerman, Washington University School of Medicine, St. Louis.

History.—A 43 year old white woman had had a history of goiter for eighteen years. Eight years before a thyroidectomy was done and in the past three years she had noticed again gradual enlargement of her neck. A firm, irregular, nodular mass about 8 by 12 by 6 cm. was palpable just to the right of the midline of the neck in the area of the right lobe of the thyroid gland. The basal metabolic rate was +1 per cent.

Submitted diagnoses.—Hürthle-cell tumor, malignant, 16; thyroid carcinoma, 14; Hürthle-cell tumor, benign, 5; thyroid adenoma, 4; parathyroid carcinoma, 3; parathyroid adenoma, 2.

Dr. Ackerman: I never would blame anybody for calling this lesion benign because you can call it malignant only on the basis of invasion of the capsule and/or involvement by tumor thrombi within the veins. Fourteen called it cancer. Five put it in the parathyroid group. I can say that this is not parathyroid carcinoma on the basis of the microscopic changes. In the parathyroid carcinomas, of which I have now seen 4 or 5 cases, there are a trabecular pattern, mitotic figures, and no oxyphilic cells. Of course, I am talking about functioning parathyroid cancer. If you wish to call this nonfunctioning parathyroid cancer, the same things I said before would apply. As to the adenoma, this easily could be designated as an adenoma if you found no evidence of blood vessel invasion or invasion of the capsule. I do not diagnose malignant changes in an adenoma unless I see such invasion or such evidence of vein invasion.

This tumor of the thyroid is well differentiated, made up of uniform cells, with uniform nuclei. The cytoplasm is prominent and bright pink. The tumor forms masses of anastomosing tumor cells separated by blood vessels. True tumor thrombi within veins are present. These cells are Hürthle cells, and they can form distinctive tumors. However, these cells are often seen in thyroid glands of myxedema, exhaustion atrophy, and Hashimoto's struma and in thyroids previously subjected to roentgen rays.[11] This tumor is a Hürthle-cell tumor because of the character of the cells with the bright pink cytoplasm. It was large, well encapsulated, and tan colored. My section and some of the sections from the seminar also show true tumor thrombi within the veins. It was diagnosed as a Hürthle-cell carcinoma because

of invasion of the capsule and because of tumor thrombi within the blood vessels.

Frazell[10] reported 4 cases of Hürthle-cell cancer and Chesky[6] reported 25 cases. These tumors occurred in about three-fourths of instances in females with an average age of around 50 years. Often there was a fairly long clinical history, and grossly the tumors were frequently rather large, grayish-brown or tan. Grossly blood vessel invasion was not too rare and lymph node metastases were not infrequent. Microscopically there is apparently some correlation between the more differentiated tumor and a long clinical course. If osseous metastases are present, blood vessel invasion is invariably found. It is possible that in the case under discussion bone metastases may occur in the future. It seems possible that from reports of these cases the initial treatment of this rather rare variant should be radical. The decision as to whether radical neck dissection should be done must depend on the findings in an individual case.

The date of surgical excision in the present case was August 18, 1948. The patient was given postoperative irradiation. The opposite lobe was removed September 22, 1949, and no tumor was found. On October 28, 1948, a pea-sized subcutaneous nodule close to the previous operative scar was noted. This nodule gradually increased in size. Three nodules of tissue were removed on April 19, 1951. These were in the soft tissue of the neck and some of the tumor cells were apparently within the superficial cells of the veins. About June, 1950, a nodule seen in the lung was thought to be a metastasis. The patient was last seen August 19, 1952, with persistent tumor still present in the subcutaneous tissue. She was in good general condition. A roentgenogram taken at that time showed innumerable metastases.

Dr. Wilson G. Brown, Houston: What percentage of Hürthle-cell carcinomas are associated with hyperthyroidism?

Dr. Ackerman: As far as I know, none. I think few thyroid cancers are associated with hyperthyroidism; if hyperthyroidism is present, usually it is not related to the presence of the cancer. That is an important aspect because you may get a patient with hyperthyroidism and microscopically you may have an extremely hyperplastic gland with papillary enfoldings which scare you. Dr. William A. Meissner from the Lahey Clinic has seen patients with such prominent hyperplasia that the hyperplastic elements had extended beyond the capsule of the thyroid and had grown into the surrounding muscle. In a patient with extreme hyperplasia, Graves' disease, even if the hyperplastic elements extend beyond the capsule, that is not necessarily evidence of malignant change.

Dr. John H. Childers, Galveston: What have been your experiences with cases of carcinoma of thyroid gland receiving radical neck dissection prior to clinical appearance of metastases?

Dr. Ackerman: That is a good question. I have practically no experience with that. I would say, however, that in the consideration of radical neck dissection you have to take note of the type of tumor. In the first place, the undifferentiated cancers you will not be able to cure anyway, no matter what you do, and in the tumors that exactly resemble normal thyroid their spread is usually through the blood vessels. This question would apply, I think, to one of the commonest tumors, the papillary carcinomas of the thyroid gland. When you see patients with those tumors, you more frequently see a metastasis in a lymph node without evidence of a tumor in the thyroid, than a tumor in the thyroid without evidence of involvement of regional lymph nodes. The life history of papillary carcinomas is very long; I know of a doctor's wife in St. Louis who has been living for twenty years with this tumor. So, it is going to be difficult to evaluate any form of treatment, whether it be roentgen-ray therapy or immediate radical neck dissection. I do know there have been a few cases subjected to operation in the St. Louis area in which the regional lymph nodes have not been palpable and in some of those cases metastases have been found. I think that there would be a number of instances in which you would not be able to palpate the regional involved lymph nodes. Usually these patients are young. Often they are females, and if you do a radical neck dissection on a female without palpable lymph nodes, there is going to be a protest. Recently Dr. Charles Eckert devised a procedure in which he divides the sternocleidomastoid muscle and does the radical neck dissection. He does that on the basis that we have never seen direct invasion of the sternocleidomastoid muscle by a papillary tumor. So, if you had a papillary carcinoma localized apparently in a lobe of the thyroid gland, I would not argue too strongly with anybody who would want to do a radical neck dissection, although I would not know whether the number of times you would find regional involved lymph nodes would warrant that procedure. I do not believe anybody has answered that question.

Dr. C. D. Fitzwilliam, Fort Worth: Do you consider venous invasion an absolute indication of malignancy in a tumor of endocrine glands?

Dr. Ackerman: I will only say this, that I think there is a certain parallelism between the islet-cell tumors, parathyroid tumors, tumors of the adrenal cortex, and thyroid neoplasms. I have noticed in all

of those tumors that it is not unusual to have cells free-floating within the vessels, and in the follow-up of the parathyroid tumors, about which I have the most information, that finding is not significant. Whenever tumor thrombi such as we demonstrated here are present, I would say that that is a significant finding and might indicate a fair chance the patient might get into trouble in the future. I think that when I see tumor thrombi I should classify the lesion as malignant. There are 2 cases of islet-cell tumors that I know about. One was a case reported by Dr. Whipple in which an islet-cell tumor with venous tumor thrombi was resected and then more than five years elapsed before a metastasis appeared in the liver. We have a case of islet-cell tumor with tumor thrombi in the veins in which after a five-year period tumor appeared in the liver and caused the death of the patient. We have another patient with a cortical tumor of the adrenal with tumor thrombi in whom after about two years metastases appeared in the lung. I think if you just have a few cells floating in the vessel, I would write it down in the report, but that would not be an indication to me of something bad that is going to happen.

I would like to know if anyone in this audience has any tumors of any of those organs in which the only finding of malignancy was a few cells floating in the veins and in which after a period of time metastases appeared? Well, that is good; it makes me feel better to know that your experience has not been different from mine.

Col. C. J. Farinacci, Denver, Colo.: What would be the procedure of choice in handling of thyroid nodules: (a) frozen section or not and (b) if malignant, hemithyroidectomy alone or with radical neck dissection?

Dr. Ackerman: We have finally evolved this procedure at Washington University. If you have a single nodule in the thyroid gland in a patient who does not have evidence of hyperthyroidism, there is a considerable chance that that thyroid nodule may be cancerous—that chance runs from 1 out of 10 to 1 out of 4, according to whose statistics you are quoting. If you have a single nodule, it can be cancer, a benign tumor, or an adenomatous nodule, and nobody can tell you what it is. This patient that you are talking about I assume has no palpable lymph nodes. If the surgeon explores that thyroid and he finds that the nodule is confined within the substance of the thyroid, that is one thing. If he finds it growing outside in the muscle and you take a frozen section of the tissue in the muscle, then the diagnosis can be made easily. But if the lesion is in the substance of the thyroid, I do not see how frozen section is going to help. I think that the surgeon can excise that nodule either by hemithyroidectomy or by an adequate margin of thyroid tissue and then it will not matter what the diagnosis is. The decision will be only whether or not to do a radical neck dissection. I do not believe it is necessary to make that decision at that moment. So, that has been our procedure. On the contrary, I think it is wrong for a surgeon, given a single nodule in the thyroid, to decide it looks benign and to enucleate it because it is much easier than doing a hemithyroidectomy. This is all right if it proves to be benign, but if it is cancer, you have spread cancer over the entire operative field.

Dr. J. I. Mossberger, Denver: Would you please comment on the origin of the Hürthle cell?

Dr. Ackerman: The Hürthle cell to me is not a special cell. It comes from the thyroid and as I understand it there are no interfollicular cells. These oxyphilic cells are often seen in the thyroids of patients with myxedema, exhaustion atrophy, and Hashimoto's struma, and in thyroid previously subjected to roentgen-ray therapy. I think that the Hürthle cell as such is a cell that comes from the thyroid itself.

CASE 7

Diagnosis.—Lymph node, cervical; reticulum-cell sarcoma.

Contributor.—Dr. A. O. Severance, Baptist Memorial Hospital, San Antonio.

History.—The patient, a 55 year old housewife, was admitted to the hospital in October, 1951, for intense pain in the back radiating into the right leg. She also complained of gradually increasing weakness and moderate weight loss for the past year. In 1948 she had had a hysterectomy, the indication for which was unknown. Results of the pathologic examination of tissues removed was unknown. At that time (1948) a moderate anemia and marked leukopenia was noted. Red blood cells numbered 3,720,000 per cubic millimeter; hemoglobin was 11.5 Gm.; white blood cells were 1,750 (polymorphonuclear leukocytes 41 per cent, lymphocytes 59 per cent). Since that time every blood count has shown leukopenia, the leukocytes varying from 1,000 to 2,600. The differential was approximately the same, and showed a persistent relative lymphocytosis (up to 72 per cent lymphocytes) and occasional relative monocytosis (up to 25 per cent monocytes). The anemia became more severe, and a low count of red blood cells 1,970,000 and hemoglobin 7.1 Gm. was recorded in September, 1951. Repeated blood transfusions had a moderate effect, and the red blood cell count was brought up to 2,700,000. Liver and spleen were not palpable. A roentgenogram of the spine showed old compression fractures of the second and fourth lumbar segments. The question of metastatic bone involvement from a carcinoma of the thyroid gland was raised because the patient had a nodule in the thyroid. This nodule clinically did not appear as a malignancy. A bone marrow specimen was interpreted as indicative of severe hypoplastic anemia. The patient had no fever. After her discharge from the hospital the condition of the patient deteriorated rapidly, and in December, 1951, the liver became palpable 1 cm. below the costal margin and the spleen 3 finger-breadths

below the costal margin. The patient also developed a low grade fever. She died December 23, 1951, with signs of cerebral hemorrhage.

Submitted diagnoses.—Malignant lymphoma, 16; leukemia, 7; Hodgkin's disease, 7; reticuloendotheliosis, 7; inflammatory node, 1; myeloid metaplasia, 1; metastatic carcinoma, 1; histoplasmosis, 1; hypersplenism, 1.

Dr. Ackerman: I think that malignant lymphoma is always a good diagnosis and I will be frank to say that I use this as a diagnosis at times. I am in agreement with Custer[9] that the giant-cell lymphoma may become lymphosarcoma or may have the blood picture of lymphatic leukemia. I am in agreement that Hodgkin's sarcoma, reticulum-cell sarcoma, and monocytic leukemia are closely related and the exact breakdown is not necessarily indicated. I have not seen giant follicle lymphoma become Hodgkin's disease. Neither have I seen Hodgkin's disease become leukemia. If you have histoplasmosis, usually you get granulomatous areas; whenever I have missed a case of histoplasmosis, I see the organisms in every lymph node section I look at for quite a while afterward. The only way I avoid overdiagnosing the lesion is to keep handy a section which shows unequivocal histoplasmosis. Of course, you may have peripheral manifestations with histoplasmosis, usually in the form of granulomatous lesions which suggest Boeck's sarcoid without evidence of the organism, and you often find those organisms in the bone marrow and adrenals. I think this could be classified perhaps as a malignant reticuloendotheliosis. I think whether you call it that or whether you call it reticulum-cell sarcoma does not make too much difference.

Section of the lymph node showed complete obliteration of the architecture and replacement by cells with prominent nuclei, prominent nucleoli, and pink cytoplasm. Mitotic figures are common; some of these figures are abnormal. These tumor cells often show phagocytosis, and tumor is extending beyond the capsule into the perinodal fat. There is some variation in the cellular infiltrate. There is no evidence of acinar formation and the cells are not growing in sheets such as you see in a carcinoma. There are also no Reed-Sternberg cells. We would therefore be left with the diagnosis of reticulum-cell sarcoma.

There is close relation between monocytic leukemia, Hodgkin's sarcoma, and reticulum-cell sarcoma. The malignant cell of Hodgkin's disease is the reticulum cell, and when Hodgkin's sarcoma becomes highly undifferentiated, I am unable to distinguish between Hodgkin's sarcoma and reticulum-cell sarcoma. Monocytic leukemia has a rather typical clinical onset, is usually acute, and is associated with hemorrhagic phenomena and involvement of the lymph nodes and other organs, particularly those of the reticuloendothelial system. There is also another variant in which there may be diffuse involvement of bone, liver, and spleen, which you might label as malignant reticulosis. Mycosis fungoides with its long clinical duration and formation of skin nodules often terminates with visceral involvement by reticulum-cell sarcoma. What determines the form of the malignant process arising from reticulum cells is, of course, unknown. These variations remind me of the variable picture which may be present in tumors originating in plasma cells.

This patient died and had infiltration in many organs including the kidney, which shows the same type of infiltrate. Some of these cells, which I believe are reticulum cells, show evidence of phagocytosis. Evidence of phagocytosis in a cell does not mean it is not a tumor cell. I have seen phagocytosis by reticulum cells in reticulum-cell sarcomas of bone. This, however, is a very diffuse process.

We will go ahead with the next case and leave the discussion for both cases.

CASE 8

Diagnosis.—Brucellosis with extreme hyperplasia of the reticuloendothelial cells.

Contributor.—Dr. A. O. Severance, Baptist Memorial Hospital, San Antonio.

History.—The patient was a 10 year old boy whose youngest brother had one lung removed when he was 9 years of age. There was no history of familial diseases. The patient's birth and feeding habits were normal. He had always been "shaky," he was left handed, and his family thought he was just "nervous." At the age of 4 he drank raw milk in Oklahoma.

The first admission to the hospital was for fever, muscle aches, and backache. Physical examination showed pale skin and occasional cyanosis, palpable cervical lymph nodes, tremor in the hands, and ulcerative pharyngitis. The patient ran a febrile course in the hospital and was discharged as improved with a final diagnosis of brucellosis.

The second admission to the hospital, three months after the first, was for cough and severe respiratory distress, anorexia, pedal edema, and "lumps" in the neck. Physical examination revealed an ashen-colored cyanotic child who appeared extremely irritable. A lump of about 2 by 1.5 cm. was visible and palpable on the mid forehead. There was a bluish swelling across the bridge of the nose. Ankles and abdominal wall showed 3 plus edema. The heart was questionably enlarged; sounds were indistinct with murmurs. The lungs were filled with harsh rales. The liver was 3 fingers below the costal margin, and the tip of the spleen was palpable. Anterior and posterior cervical nodes were markedly enlarged.

The patient ran a septic type of temperature while in the hospital. Symptoms regressed under strenuous therapy, but returned and the patient ran a downhill course and died twenty-five days after admission to the hospital and four months after onset of the symptoms.

Serial roentgenograms of the chest showed evidence of congestion and perihilar infiltration. Skull roentgenograms were negative.

Red blood cells varied from 4,920,000 to 2,650,000. White blood cells varied from 5,300 to 2,350 with a slight shift to the left. Studies of the urine were negative except for an occasional pus cell and hyaline cast. Agglutination

test results were as follows: typhoid H and O and paratyphoid A and P, negative; Proteus OX19, negative; brucellosis titer 1:320, 1:320, 1:80. Spinal fluid tests were negative. Bone examination showed suppression of segmented and stab cells, stimulation of myelocytes and nucleated red cells; no leukemia was evident. Lymph node biopsy suggested Letterer-Siwe disease.

Submitted diagnoses.—Leukemia, 9; reticuloendotheliosis, 9; malignant lymphoma, 8; brucellosis, 5; Letterer-Siwe disease, 4; Hodgkin's disease, 2; granuloma, 2; myeloma and plasmacytoma, 2.

Dr. Ackerman: Again, I think leukemia, reticuloendotheliosis, and malignant lymphoma are good diagnoses, and I think this lesion falls into this group.

It seems apparent with the passage of time that the diseases given the names eosinophilic granuloma, Hand-Schüller-Christian disease, and Letterer-Siwe disease are interrelated. Lipid deposits are not present within the cells except in chronic lesions. Eosinophilic granuloma is usually restricted to those cases in which there is a single bone lesion. However, I have seen such cases with single bone lesions on two occasions progress to the clinical picture of Hand-Schüller-Christian disease, and I am particularly suspicious of such a progression when there is a single bone lesion in a very young child. So, the age of the patient seems to bear some relation to what you get. The criteria for Letterer-Siwe disease have included an acute fatal course occurring in a child, (this patient was a little bit old, 10 years), skin lesions, enlargement of the spleen and liver, hemorrhagic diathesis, generalized lymphatic enlargement, progressive anemia, usually a normal leukocyte count, localized skeletal tumors, and proliferation particularly in the spleen, liver, lymph node, thymus, skin, and bone marrow. The typical cells are usually large, measuring 30 to 50 microns; they may be irregular, round, oval, or polyhedral; nuclear membrane is distinct; phagocytosis is not unusual and it was present here. This case to me is not classical Letterer-Siwe disease because of the age of the patient and the absence of skin changes. However, such cases have been reported previously, and I do not think we have to restrict our diagnosis to the criteria I mentioned. I see no reason why we cannot have certain variations, and I have shown you these lymph nodes of a Hand-Schüller-Christian disease and Letterer-Siwe disease which have great similarity. As a matter of fact, if I got a lymph node or a lesion with, let us say, eosinophilic granuloma in Hand-Schüller-Christian disease, I would be hard put to it to make the clinical diagnosis. I think I would have to have the clinical findings.

The section shows that the architecture of the lymph node has been destroyed. The principal cell present is a rather large cell with a vesicular nucleus and fine chromatin. The cytoplasm is pink and often the cells are rather large. Mitotic figures are few in number. The process extends beyond the node into the perinodal fat. No Reed-Sternberg cells can be identified, and there are no true granulomatous areas.

It would be tempting to diagnose this lesion as Hodgkin's disease because of the obliteration of the architecture, the extension of the process into the perinodal tissue, and the mitotic figures. Against this diagnosis, however, is the fact that these cells are well-differentiated reticulum cells. I suspect that cytoplasmic fat is absent. I therefore believe that this case falls into the group of nonlipoid reticuloendotheliosis.

Now I would like to have Dr. Severance review the findings.

Dr. A. O. Severance, San Antonio: These 2 cases are from a series of 5 cases of malignant reticulosis which my resident, Dr. Robert Hausman, collected from the files of the Baptist Hospital over a five-year period. They were all much alike in the clinical picture and in the microscopic and gross findings at autopsy. The bone marrow was completely necrotic in some areas.

At the autopsy these 2 or 3, I cannot remember now but I think 2, vertebrae in that first case of a 55 year old woman were yellow and necrotic, and Dr. Hausman and I were worried about a metastatic tumor. The patient had a nodule in the thyroid and clinically by roentgen ray it was diagnosed as metastasis to the vertebrae. However, microscopically, as you saw, there was no carcinoma there; it was just necrosis. The cells in the bone marrow nearby, however, around the areas of necrosis were similar in appearance to those in the lymph node and in the spleen, and even the liver showed a few of these scattered cells in the sinus areas. Dr. Hausman and I interpreted these cells like Dr. Ackerman as reticulum cells. The typical phagocytes showed red cells and nuclear fragments. The distribution of these cells in the lymph nodes and other organs of the body were as you saw, and even that little aggregation in the kidney. This is still a 55 year old woman. How to interpret this case?

The history was of some two and one-half years' duration, the patient gradually going downhill, transfusions and other supportive treatment giving only temporary relief. The reason for the diagnosis of malignant reticulosis in contrast to a possible diagnosis of reticulum-cell sarcoma was that the cells did not seem to form aggregates. They seemed to have a diffuse infiltrating pattern like you would expect in leukemia. In fact, Dr. Hausman's theory on malignant reticulosis may be different to that of others. His theory is that malignant reticulosis is in fact a malignant manifestation similar to leukemia and is

a leukemia of the reticulum cells. That is perhaps why it has such a pecular distribution. The cells individually do appear to be malignant cells of reticulum type. They show scattered mitoses, and they do vary in size and shape.

Now, the second case, the little child, had a much more rapidly fatal course. We were worrying about leukemia in that child until we did a biopsy of a lymph node, and with our previous experience on some of these other cases we switched over from the tentative idea of leukemia which the clinicians were worrying about to a form of malignant reticulosis which in this child, we thought, we could call Letterer-Siwe type. The bone marrow in this child did not have areas of necrosis like that of the 55 year old woman. It was a bone marrow that showed some suppression of the granulocyte as did the other bone marrow. In the bone marrow aspiration study, I thought that we were dealing with just suppression of the granulocyte series, and in one case a suppression also of the nucleated red cells, but I saw increased numbers of cells that I labeled as monocytes. Dr. Hausman thinks I was calling monocytes something he would have called reticulum cells, but since he did not see the bone marrow he could not say for certain. He reviewed some 200 articles in the European literature and abstracted these articles and incorporated some of them into his thesis.

Dr. Ackerman: I am in agreement with Dr. Severance. There is little in the English literature about this entity, although there are articles in the European literature and the English literature.

Col. C. J. Lind, Fort Sam Houston: Harold Downy, who was really a histologist rather than a hematologist, in the 1930's was interested in the reticulum cell and reviewed the literature pretty well. I think you will find something in his handbook on this entity of reticuloendotheliosis. We had several cases that seemed to run quite a gamut from this into more or less a sarcoma type picture, and we all thought that they were frankly malignant lymphomas in a broad sense.

Dr. Ackerman: I have left my discussion in this case, for I feel that it illustrates the way an error can be made in this lesion. I believe that the correct final diagnosis is brucellosis.

Dr. Lowbeer, a recognized authority,[20, 21] reviewed the sections on case 8 and felt this was an unequivocal instance of brucellosis. He cited that this 10 year old child had been exposed to raw milk ingestion and on three occasions there had been serum dilutions for brucellosis and agglutination from 1:80 and 1:320. Clinically, there was persistent leukopenia with relative lymphocytosis associated with high intermittent fever. This is characteristic of brucellosis but not of Letterer-Siwe disease in which neutrophilic leukocytosis is common. Negative cultures do not speak against brucellosis because the organisms are notoriously difficult to culture. In the lymph nodes and spleen there was tremendous proliferation of reticuloendothelial cells which was diffuse in lymph nodes and spleen and focal in liver, lung, and bone marrow approaching neoplastic proportions. Dr. Lowbeer quoted many references illustrating the tremendous reticuloendothelial cell proliferation which can occur in brucellosis. Brucella organisms are intracellular parasites which are destroyed by some macrophages but manage to survive in others. In summary, he stated, "This patient certainly had brucellosis as well as a universal proliferation of the cells of the reticuloendothelial system of hyperplastic and perhaps dysplastic, but questionably neoplastic proportions. The relationship between the brucellotic infection and a powerful stimulation of the reticuloendothelial system has been established; and therefore this case presents one of subacute or chronic brucellosis causing—in a young child—a universal stimulation of reticulum cells of almost neoplastic proportions."

CASE 9

Diagnosis.—Skin, back; chronic granulomatous process, etiology unknown.

Contributor.—Dr. J. M. Moore, Santa Rosa Hospital, San Antonio.

History.—A 55 year old man five years ago had a large, elevated lesion on the thigh which was excised. The area of excision was skin grafted. Two years ago a large, irregular lesion appeared on the back. This was elevated, reddish blue in color, and showed evidence of ulceration. This was subjected to biopsy.

Submitted diagnoses.—Mycosis fungoides, 25; nonspecific infections, 7; lymphosarcoma, 5; leukemia cutis, 3; melanoma, 2.

Dr. Ackerman: There are a few with me but not many. I think we would all agree that this is not a melanoma. It would be unusual to have leukemia as a single nodule. I would think of lymphosarcoma, whenever it involves the skin, as having pretty homogeneous replacement by tumor cells.

The surface of the epidermis is almost completely ulcerated and all areas are replaced by an infiltration which shows numerous giant cells. There is also, however, a rich infiltration of reticuloendothelial cells, plasma cells, and unidentified cells. Mitotic figures are fairly abundant. No Reed-Sternberg cells can be identified.

In the first place there is no evidence that this is a squamous or basal-cell carcinoma. Neither is there any evidence of malignant melanoma. We are concerned primarily whether this is some inflammatory process or a neoplastic process. In favor of inflam-

mation is the large number of giant cells, plasma cells, and occasional eosinophils. If this is a neoplasm, it must be a malignant lymphoma. Against malignant lymphoma is the presence of numerous giant cells. These giant cells are the type seen in foreign body reaction and often several are found together. There is considerable foreign body material within these giant cells. Also the cells present show excessive reticuloendothelial proliferation and many plasma cells. Mitotic figures are infrequent.

The clinical history is not that of mycosis fungoides. Mycosis fungoides usually is preceded by skin changes and then progresses to nodules and finally may become disseminated reticulum-cell sarcoma. Naturally we would like to be able to see the previous skin lesion. I heard this patient has developed another nodule. Is that correct?

Audience member: That is correct.

Dr. Ackerman: Where is the other nodule?

Audience member: It is in the region of the previous nodule.

Dr. Ackerman: Previously there was another lesion excised. Have you ever been able to get hold of those sections?

Audience member: No, we have not.

Dr. Ackerman: If this is mycosis fungoides, this is a very peculiar history. Perhaps we have missed it. I am sure that the follow-up of this case is going to be the determining factor in the diagnosis, and this is the type of case in which I think it is so important.

CASE 10

Diagnosis.—Soft tissue, leg; giant-cell tumor (probably malignant).

Contributor.—Dr. P. T. Flynn, Austin.

History.—The patient is a 27 year old Latin-American woman. On March 3, 1948, four years before the present admission, roentgen ray showed a large area of irregular bone destruction measuring 9 cm. in length and 6 cm. in width, involving the lower end of the femur and the entire lateral condyle. There was a definite expansion of the bone anteriorly, laterally, and posteriorly with an abrupt break in the cortex along the lateral aspect. Some bone was present in this area of destruction, giving it a faint silk-bubble appearance which was in favor of a giant-cell tumor. The break in the cortex was more suggestive of osteogenic sarcoma. At operation March 13, 1948, there was found cystic degenerative bone with space filled with blood clots. The area was subjected to thorough curettage. The pathologic diagnosis was giant-cell tumor. The patient was discharged April 16.

The patient developed a recurrent tumor of the left lower femur, and on December 17, 1949, was subjected to another operation. Under the skin of the lateral condyle of the femur superficial to the iliotibial band was a well-encapsulated, 2.5 cm., circumscribed, reddish brown, rubbery nodule. The lateral cortical bone was friable as was the condyle, and the tumor cavity contained large amounts of hemorrhagic granulation tissue. The diagnosis was giant-cell tumor recurrent in the femur and giant-cell tumor of the soft parts due to implantation of the previous operation. The patient subsequently was discharged and did well at home, although the joint was ankylosed as the result of swinging a piece of the tibia into the femur.

The present admission occurred March 26, 1952, after the patient noticed nodules developing in the line of excision. Physical examination revealed nodules, approximately seven in number, along the line of excision, some of which measured as much as 5 cm. in diameter clinically.

Gross pathology: The specimen consists of an elliptical piece of skin measuring 15 by 3 cm., on the surface of which is a well-healed scar. There are multiple tumor nodules dispersed along the line of the scar immediately beneath the skin and ranging up to 7.5 cm. in greatest diameter. Some nodules were buried deep in muscle at the time of operation. A wide local excision had been planned originally, but the tumor was accidentally entered, so that the present incision site undoubtedly is seeded with tumor cells.

Submitted diagnoses.—Giant-cell tumor, benign, 20; giant-cell tumor, malignant, 12; osteoclastoma, 3; osteogenic sarcoma, 2; dermatofibrosarcoma, 1.

Dr. Ackerman: In the diagnosis of bone lesions, as I have said many times, I believe roentgen rays are shadows and pathology is substance. There is no radiologist, no matter how accurate, how knowledgable, or with how much background in pathology, that can make certain diagnoses on many lesions of bone. In other words, there are many pathologic lesions which can cast similar shadows, and the radiologist who is dogmatic in his diagnosis does not know any pathology. I think at times it is easy to make mistakes in calling a lesion of bone benign when it is malignant, and vice versa. The diagnosis must rest on obtaining adequate material from the lesion and having it properly prepared. The radiologist will be more accurate than the pathologist if adequate material is not submitted and if the pathologist does not make good sections of the material which he receives. I think in this lesion the radiologist probably would make the diagnosis of giant-cell tumor and perhaps suggest that it could be malignant because there is some suggestion of perforation of the cortex.

The section shows a fairly well-defined nodule growing in the dermis. It is made up of large numbers of giant cells of the type usually observed in a giant-cell tumor. The stroma is vascular and rather cellular. Individual cells are uniform and show only rare mitotic figures. It is interesting that on the periphery of the lesion bone is being formed.

At the time of operation there was a break in the cortical bone. The lesion was treated by thorough curettage on March 13, 1948. A lesion beneath the skin in the region of the lateral condyle was removed on December 17, 1949. Twenty-one months after the original operation there was apparent persistent

tumor within the femur. Again the lesion recurred in March, 1952, which was about twenty-seven months after the second operation and four years after the first operation. This patient apparently then had microscopically a benign giant-cell tumor which had maintained its benign pattern, which had persisted for a four year period, and which apparently had been inadequately excised. There appears to be little doubt that tumor still remains. I have seen a lesion of this microscopic pattern which has metastasized to the lung. The history of this patient is as follows:

At the age of 43 the patient had a tumor involving the distal end of the radius which apparently had characteristic roentgen changes of a giant-cell tumor. For some reason unknown to me, the arm was amputated half way to the elbow; it has not been possible to obtain the sections on this amputation. Four years later the lesion was identified within the lung. This was resected and microscopically looked like a benign giant-cell tumor. The date of this resection was April 16, 1945. On February 22, 1947, was resected another single lesion of the lung which showed no difference. The patient was last seen October 10, 1952, and was free from evidence of disease.

I also have seen a case in which a giant-cell tumor of the vertebra which looked benign metastasized to the lung after trauma. More commonly than the previous evolution, the stroma undergoes malignant change and becomes fibrosarcoma. I feel in the present case that tumor still remains in the leg and, if something radical is not done, that this lesion will metastasize to the lung and kill the patient. I therefore would recommend amputation at this time.

Col. A. M. Richmond, Fort Sam Houston: Is grading of these tumors based on stromal changes as suggested by Drs. Jaffe and Lichtenstein[19] of value?

Dr. Ackerman: I would say, "Yes." I would say also, as I indicated, that multiple sections should be made. If the tumor is obviously malignant at the time of the first operation, I would seriously consider amputation. But if the tumor was only doubtfully malignant, then I would be content with the curettement procedure.

Col. C. J. Lind, Fort Sam Houston: Where would you amputate?

Dr. Ackerman: The tumor is about 10 inches above the knee joint. You probably would have to disarticulate. I would like to have you give the follow-up on this case, Dr. Flynn.

Dr. P. T. Flynn, Austin: This patient, I believe, was seen in March, 1952, with these local skin recurrences. She was seen by a number of surgeons, most of whom agreed at that time that they were going to be unable to take out all of the tumor nodules by wide local excision. However, there were a few braver souls who went ahead and attempted it. As soon as they got into the leg they were cutting into tumor nodules. Then they had to take the remainder of the soft tissue and get as many nodules out as they could. Having scraped the bone again, they slipped a tibial graft up into the femur. The patient at first refused postoperative irradiation and was discharged from the hospital. About five days later she was in an automobile accident and fractured her ankylosed joint. Since that time she has been in a cast primarily because of instability of the knee joint. She has received now a total of 3,800 r. Clinically it is not possible to tell if there has been any more recurrence primarily because of hip spica, but radiographically none has been noticed. They do not anticipate any change in such a short period of time. It has been only about four months since irradiation therapy.

Let me go back—in 1948 when the patient came in a chest roentgenogram was made to see if she had any metastases that possibly might be an osteogenic sarcoma. Fortunately, the left humerus was included in the chest film and no cystic lesion was found in the left humerus. In 1950 she came in with a recurrence in the soft tissues and in the lower end of the femur. A bone survey was done and this cystic lesion was picked up in the left humerus. She had another complete bone survey in March, 1952, and the radiologist thought that the cyst in the left humerus was exactly the same size as before. We thought possibly that she might have osteitis fibrosa cystica in view of the fact that the lower end of the tibia began to show cystic lesions, her blood calcium measured 12 mg. per 100 cc., phosphorus was about 3.7 mg. per 100 cc., and the alkaline phosphatase activity was under 2 units per 100 cc. That is the case up to date.

Dr. Ackerman: I would say that this could not be hyperparathyroidism on the basis of the normal alkaline phosphatase, because if a patient has bone lesions with hyperparathyroidism, the alkaline phosphatase invariably is elevated because the cystic bone lesions that are present are merely a reflection of the advanced bone lesions. All other bones also show some abnormality. The lesion that is in the humerus I would say had nothing to do with the lesion under discussion. If there is mental distress about it, an easy way to find out what it is, is to subject it to biopsy. I would also say, agreeing with Dr. Flynn, that the procedure done by the surgeon was a piecemeal removal of the tumor. I would be in strong and fervent disagreement with this procedure, for the surgeon is operating through tumor, stirring up the tumor bed and perhaps pushing tumor into the blood vessels. I would have felt at the time this recurrence

appeared that you should prove it by careful incisional biopsy. Then I think at that time you could have gone ahead with amputation. At present you do not know where you are, but the chances are fairly good that you are in a pretty bad state of affairs. Because the patient already has a fracture and probably has persistent tumor, it is doubtful whether the irradiation has sterilized the tumor, and certainly in the presence of fracture plus irradiation, that is not a very good leg any more. At present it has probably lost a great deal of its intrinsic beauty, so I think perhaps the patient at this moment of time might be willing to trade it for an artificial leg because I also suspect that she is going to have continuing disability regardless of the presence or absence of neoplasm. So, I would still be in favor of amputation, and if it is not done, then I would predict that this patient will suffer from the effects of the tumor and that she has a very good chance of developing pulmonary metastases.

CASE 11

Diagnosis.—Chorioadenoma destruens.

Contributor.—Dr. L. J. Manhoff, Jr., Robert B. Green Hospital, San Antonio.

History.—This 23 year old woman passed a hydatidiform mole after having missed three menstrual periods. A dilatation and curettage was done and she had no further difficulty. She was next seen in the clinic two months later at which time her uterus was moderately enlarged to approximately the size of a three-month gestation, and there were small bilateral cystic masses in both adnexa. For the preceding ten days she had had irregular bleeding and stated that she had passed small pieces of tissue. She was still secreting breast milk although she was not nursing a baby. A hysterectomy and left salpingo-oophorectomy were done four days later. The uterus was moderately enlarged and at the fundus there was a small friable nodule of pinkish and reddish tissue which measured about 5 mm. in diameter. On serial sagittal section this reddish tissue seemed to extend into the myometrium for a depth of about 1.5 cm. In the accompanying ovary there were 3 corpus luteum cysts.

Submitted diagnoses.—Decidua (degenerated, retained products of conception, and so forth), 14; choriocarcinoma, 12; hydatidiform mole, 4; syncytial endometritis, 4; decidual endometritis, 3; chorioadenoma destruens, 3; chorioma, benign, 1.

Dr. Ackerman: I believe there were 12 persons who thought it was a malignant lesion. Is the person here who gave us this case? Do you have the follow-up now?

Dr. Manhoff: We have a follow-up at eighteen months and she is perfectly well. There is no evidence of recurrence. Her chest plate was negative.

Dr. Ackerman: I think that if this were a choriocarcinoma the chances are almost 100 per cent that the patient would be dead within a six months' period. I believe there is enough evidence now to show that this is a benign lesion.

Sections of the uterus show active trophoblastic cells with giant nuclei and associated with well defined chorionic villi. This patient passed a hydatidiform mole. Two months later the uterus was enlarged and for the preceding ten days she had had irregular bleeding. I do not see any record of chorionic gonadotropin. However, the presence of chorionic gonadotropin is not an indication of choriocarcinoma but merely an indication of trophoblastic activity. Usually the titer following the passage of a hydatidiform mole is normal by ten weeks. It, therefore, would not have been unusual to have had chorionic gonadotropin present at this time. Furthermore, the elevation may continue for even longer time periods. However, if the titer of chorionic gonadotropin increases, this suggests that trophoblastic tissue is increasing.

Of course, it must be realized that choriocarcinoma in itself is an extremely rare lesion. If it follows hydatidiform mole, death occurs in a short time. There is little doubt that this lesion is frequently over diagnosed. There is also the possibility that if a patient has choriocarcinoma, by the time diagnosis is made death is inevitable. There are also cases of regression of local nodules and even pulmonary metastases.[29] As has been emphasized, the presence of chorionic villi is usually, but not invariably, evidence that the lesion is benign. There is a type which has been designated as chorioadenoma destruens, a form of invasive hydatidiform mole, in which the process can even reach the serosa, perforate into the broad ligament, but still remain localized. There is fairly deep penetration in this case.

Dr. W. R. Mathews, Shreveport: If you had a nodule of chorioadenoma in the vaginal wall and the latter had been removed with healing, would you advise hysterectomy if the uterus was not enlarged and if there was no evidence of hemorrhage?

Dr. Ackerman: There have been a number of cases reported in which that sequence of events has taken place. I think I would be in favor of doing nothing.

Dr. M. L. Trumbull, Memphis, Tenn.: Would you make such a diagnosis in the absence of chorionic villi?

Dr. Ackerman: I think the chorionic villi are the most important part of this diagnosis.

Dr. Trumbull: Rule out syncytial endometritis.

Dr. Ackerman: In this group of lesions the only one of importance is choriocarcinoma. Of course, chorioadenoma destruens might be placed in a separate group because it has really a pretty definite gross appearance. Those lesions such as were shown

here and have been reported by others can even extend outside the uterus and still nothing does happen. There was a case reported like that.

Dr. Wilson G. Brown, Houston: Do you consider invasion of the villi by trophoblasts as a criterion for malignant chorio-epithelioma?

Dr. Ackerman: All I can say in answer is that Dr. Hertig[14] said that scared him, but I do not believe you could be certain either. Again, the worse the mole might look, the greater the chances that choriocarcinoma is present. I think the most important point in the whole discussion of these cases is that the tendency always is to remove the uterus. I am under the impression that at Barnes Hospital there are many uteri removed that do not need to be removed, and I am not certain that if you did nothing, you would not be just as far ahead. In other words, I rather go along with the old German pathologists who believed that if you have a choriocarcinoma, probably it makes no difference what you do.

Dr. B. F. Stout, San Antonio: What is the incidence of choriocarcinoma at Barnes Hospital?

Dr. Ackerman: The incidence of choriocarcinoma during the past five years in St. Louis is 3 cases as far as I know. This disease is rare except in the Philippine Islands and Indonesia where choriocarcinoma is a common disease. By common I mean it is killing the patients so I think it is perfectly bona fide. Dr. Manuel Penas in Manila is going to write up the cases there, and the pathologist, Dr. Sutoma from Indonesia, who is a fine pathologist, has written to me about the high incidence of choriocarcinoma there. From the standpoint of true choriocarcinomas, those that are going to kill the patient, I suspect that even in the very large cities (St. Louis is a pretty large city), the number of cases will be very few. I would like to know the number in San Antonio that you know of, Dr. Stout, that killed the patient.

Dr. Stout: I know of none.

Dr. A. O. Severance, San Antonio: We had at Brooke Army Hospital during the war one case in which we found villi in the curettage. Then about a year later or maybe less, physicians at the Armed Forces Institute of Pathology found the lung metastases at autopsy.

Dr. Ackerman: Exceptions occur.

CASE 12

Diagnosis.—Von Recklinghausen's disease with malignant schwannoma.

Contributor.—Dr. C. F. Pelphrey, Austin.

History.—The patient was a 39 year old white woman of dark complexion. Since infancy she had had generalized tumor nodules which became prominent and more numerous at 12 or 13 years of age. During the past five years she had had several lesions removed from her hands, face, chest, and back which were diagnosed as neurofibromas, and there was never any local recurrence. No other member of the family had such lesions although some members had olive complexion and had had migraine headaches. Other than migraine headaches and an appendectomy, the patient had had no serious illness in the past. She first noticed tenderness in the right side, then developed pain and weakness in the leg. At surgery a retroperitoneal mass was found and partially removed. The specimen measured 10 by 8 by 10 cm.

Submitted diagnoses.—Neurogenic sarcoma, 9; neurogenic fibrosarcoma, 7; neurofibrosarcoma, 6; fibrosarcoma, 8; malignant schwannoma, 3; leiomyosarcoma, 3; malignant neurilemoma, 1; neurofibroma, 1; angiomatosis, 1.

Dr. Ackerman: A good many pathologists put this tumor into the malignant group, and I think we have enough evidence of its malignant nature to take it out of the benign group. I think this differential diagnosis is difficult, and the only reason I have called it a neurogenous tumor is because of the reticulin pattern, the presence of von Recklinghausen's disease, and the area which to me suggested a neurofibroma.

The sections show an obviously malignant tumor which is infiltrating the surrounding tissue and which is highly cellular. This lesion is made up of spindle-shaped cells which in some areas are well differentiated with rather abundant cytoplasm. In other areas the lesion is quite cellular and appears highly malignant. There are some zones which suggest that this lesion arose from a pre-existing neurofibroma. The reticulin stain shows rather prominent reticulin extending in rather long wiry lines between tumor cells but not wrapping around individual ones as you might expect in a fibrosarcoma.

This patient had von Recklinghausen's disease. Malignant degeneration of a neurofibroma can occur in this entity. Such malignant change only rarely occurs in the superficial nodules but does occur in the deeply placed lesions. We were particularly struck in our review of patients with neurogenous tumors of the thorax to find that in the malignant schwannomas 3 of the 5 had florid von Recklinghausen's disease. These 3 cases made up only a small percentage of our total group of neurogenous tumors.[2] Retroperitoneal neurogenous tumors are rare. The most common malignant primary tumor of the retroperitoneal area is a liposarcoma and the second most common is a leiomyosarcoma. Malignant schwannomas arising from pre-existing neurofibromas first undergo subtle histologic aberrations. We are particularly suspicious of such lesions when the nuclei begin to become more numerous. The nuclei may show few mitotic figures. If such changes occur, it is imperative that adequate local excision be done. The malignant schwannoma tends to recur stubbornly before distantly metastasizing. In the retroperitoneal

area cure of one of these lesions, if at all extensive, is impossible because of the difficulty in doing an adequate resection. I would, therefore, predict that this lesion would recur locally and cause the death of the patient.

CASE 13

Diagnosis.—Von Recklinghausen's disease, neurofibroma with melanin pigment, possibly malignant schwannoma.

Contributor.—Col. C. J. Lind, MC, Brooke Army Hospital, Fort Sam Houston.

History.—This 25 year old white man, active duty personnel, was admitted to the hospital February 11, 1952, for treatment of tumor of the left side of the face and neck. The patient stated that he first noted a mass on the angle of the left side of the jaw approximately seven years prior to admission. He stated that this was neither painful nor tender, and he denied any associated symptoms with the exception of the presence of a much greater growth of hair on the left cheek compared to the right. The patient admitted that beginning about two and one-half years before he noted slow increase in the size of the mass, which approximately one year before began to enlarge more rapidly. The patient stated that he had a similar smaller mass about 5 by 5 cm. removed from the posterior part of the scalp in 1945, but he was not aware of the diagnosis of this mass. Past history was not remarkable.

Physical examination: Vital signs were normal. Examination of the neck revealed diffuse enlargement of the soft tissue over the left side of the jaw and neck. This mass was firm, fixed, and adherent to the surrounding normal structure, and it had a bluish black discoloration with marked increase in the hair over the mass on the left. There was also noted a large area of irregular, spotty hyperpigmentation over the left side of the neck and shoulder region. There was a bluish discoloration of the buccal mucosa over the mass of the left cheek. There was also present a 4 inch, well-healed surgical scar over the left side of the occipital parietal region. Physical examination was otherwise normal.

Laboratory work: Laboratory results were within normal limits except for a roentgenogram of the skull and mandible which revealed the presence of a large, soft tissue tumor mass on the left lateral aspect of the face. There was gross irregularity of the inferior aspect of the left side of the mandible and zygomatic arch, both showing bony atrophy. The type of defect was described as that found secondary to pressure with nothing to indicate primary bone involvement. A roentgenogram of the skull revealed a large, bony defect in the left side of the inferior parietal region, the edges of which had the appearance of old surgical interference. The mastoid bone on the left also showed the effect of surgery.

Course in hospital: The patient was taken to the operating room on February 13, 1952, with a presumptive diagnosis of hemangioma of the left side of the face and neck. The left external carotid artery was ligated. The patient's postoperative course was uneventful. He was observed to be able to move all extremities and talk and respond intelligently to questioning until approximately twelve hours postoperatively, when it was noticed that the patient developed hiccoughs and was unable, apparently, to open and close his right hand. The patient developed a flaccid paralysis of the right upper and lower extremities with diminution of the reflexes on the right but with the absence of any pathologic reflexes. From this point on, the patient ran a gradual downhill course with changing neurologic signs. Despite symptomatic treatment, the patient remained in shock and died the second postoperative day.

Submitted diagnoses.—Neurofibroma, 10; hemangioma, 8; hemangioendothelioma, 6; Kaposi's sarcoma, 5; neurofibrosarcoma, 4; nevus (blue, pigmented, and so forth), 3; hemangiopericytoma, 2; melanoma, 1; liposarcoma, 1.

Dr. Ackerman: This would be an unusual situation for Kaposi's disease, which usually forms in the skin nodules which are usually composed of vascular elements with a sarcomatous background. A blue nevus, as we usually think of blue nevi, is a lesion which occurs in the skin, is relatively small, and is associated with melanin pigment and some schwannian proliferation. The tumor had melanin pigment in it so I suspect that is the reason for this diagnosis. Neurofibromas may have melanin pigment within them.

This tumor microscopically suggests a neurofibroma. It shows apparent Wagner-Meissner corpuscles and a prominent pigment which is positive with the Fontana stain indicating it is melanin. Some of the areas are quite cellular and are growing between muscle bundles. This increased cellularity with invasion would make one worry about the possibility that this was a malignant schwannoma. Such tumors, of course, may show little change early in their evolution except in their cellularity. Mitotic figures are few and far between. The melanin pigment does not indicate that this is a malignant melanoma. I have seen melanin pigment before in neurofibromas and such melanin pigment has been illustrated in a neurofibroma in Dr. A. P. Stout's fascicle on *Tumors of the Peripheral Nervous System.*[38] It is not too unusual in my experience to see malignant melanoma and neurofibroma associated. This patient also had excessive growth of hair, which goes along with von Recklinghausen's disease.

So I will say that case 12 was a case of von Recklinghausen's disease with malignant schwannoma. Case 13 was of a patient with von Recklinghausen's disease with possibly malignant schwannoma. I would be suspicious of this lesion because it has locally infiltrated and because it shows increased cellularity. The melanin pigment does not mean anything to me from the standpoint of deciding whether it is benign or malignant. It has become impressed on me rather forcibly during the past four or five years that when some of these soft tissue neurofibromas occur in particular locations, they have a decided chance of being malignant and their microscopic evidence of malignant change may be subtle. These lesions occur around the face; I have seen 2 of them already in the region of the eye, particularly the lower part of the eyelid in which over quite a long period of

time there was local invasion and destruction of the orbit, and death from meningitis followed. In another instance in the soft tissues of the axilla I saw a large malignant schwannoma which recurred once and was cured by shoulder girdle amputation. So, I think in the deep-seated neurofibromas we must be careful in the estimation of their malignancy, and the only hint that a tumor is malignant is that (1) it may be locally invasive, (2) it may be deeply situated, or (3) it may show increased nuclear cellularity without evidence of mitotic activity.

Audience member: What are the effects of roentgen ray?

Dr. Ackerman: I do not believe that roentgen-ray therapy will be of any value in any of the soft tissue sarcomas with the exception of liposarcoma. In the malignant neurogenous tumors irradiation will have no effect, any more than it will have as a rule in the malignant melanomas. So, in a case of this sort, the patient's only chance is adequate surgery.

Audience member: In this first case, as they knew it was inadequately excised, the physicians went back and gave the patient irradiation. Then some months later they went back in again and found simply a thin-walled cyst in which there was no evidence of the same tumor which was seen primarily, but only the thin wall of the fibrous connective tissue. The patient is now asymptomatic.

Dr. Ackerman: What is the total length of time from the first operation to date?

Audience member: Approximately a year.

Col. C. J. Farinacci, Denver, Colo.: Are plexiform neurofibromas believed to become malignant?

Dr. Ackerman: Plexiform neurofibromas represent gigantism of nerves which may involve a segment of a nerve trunk and this process may in time gradually extend over a long distance. In one of our cases the surgeon finally had to resort to amputation to cure the lesion.

Dr. J. J. Andujar, Fort Worth: What is the relationship of these to so-called neuronevus?

Dr. Ackerman: Neuronevus is a term that some pathologists use when they talk about nevi with prominent nerve structures such as Wagner-Meissner bodies in them. All nevi are essentially neuronevi. Both neurofibromas and nevi may have melanin pigment and both are neurogenous in origin. Malignant melanomas and neurofibromas may occur together.

CASE 14

Diagnosis.—Rectum, adenocarcinoma (well differentiated).

Contributor.—Dr. Lauren V. Ackerman, Washington University School of Medicine, St. Louis.

History.—This 68 year old white woman entered the hospital with a history of pain in the rectum of three months' duration. Tenesmus, frequent stools and mucus had been present for eight months. There had been no bloody or tarry stools. Weight loss was equivocal. On rectal examination a mass could be felt at the anorectal junction.

Submitted diagnoses.—Adenocarcinoma, rectum, 33; polyp, malignant, 3; polyp, adenoma, 6; carcinoma in situ, 1.

Dr. Ackerman: Sections demonstrate fairly well differentiated glands. These glands show loss of nuclear polarity, interglandular budding, and stratification of cells. There is no evidence of real invasion. These changes to me have gone far enough to be called carcinoma in situ and I would suspect that invasive cancer was present. Abdominoperineal resection was recommended and done. Examination of the specimen showed a circumferential tumor which had extended through all layers of the bowel. However, no lymph nodes were involved.

Dr. J. I. Mossberger, Denver: Will you say something about carcinoid tumors of the rectum?

Dr. Ackerman: I believe that all carcinoid tumors are potentially malignant tumors no matter what their location, and what they do clinically is somewhat dependent upon the time of their recognition and their location. In some areas such as in the appendix a carcinoid tumor may be recognized early because of symptoms of appendicitis, or conversely if the tumor is situated in the cecum, it may have an opportunity to grow to a large size before it is recognized; therefore, when first found, a carcinoid tumor may have grown locally all the way through the bowel and may have metastases regionally or distally. The same thing applies in the rectum. I have found on routine rectal examination several instances of incidental carcinoids in which the lesion has been submucosal and measured a centimeter or so, and in those cases thus far I have gotten into no trouble by advising local excision. However, if a carcinoid was found in a rectum and was invasive of any size or depth, I think the operation of choice would be an abdominal perineal resection. I think carcinoids in any location have the capacity to metastasize, and I would not personally divide carcinoids into benign and malignant categories.

Dr. Richard McDonald, La Marque: Can carcinoid tumors be mucin producing? Do they ever show a signet ring appearance?

Dr. Ackerman: Carcinoid tumors in my experience are not mucin producing nor do they ever show a signet ring appearance. There is a case reported by Dr. Robert Horn in the journal *Cancer* in which in one instance the patient had a carcinoid which Dr. Horn thought was mucin producing. But that was such a rare case that I do not believe I would lean on it as evidence that those tumors are mucin

producing. I think if you see a tumor of the rectum that is producing mucin and that has signet ring cells, it is probably an undifferentiated, highly malignant carcinoma.

Col. C. J. Farinacci, Denver, Colo.: Will you please restate what is meant by invasion of the base of a polyp by carcinoma in the case of sessile polyps and pedunculated polyps?

Dr. Ackerman: We are speaking now of epithelial tumors and just when a pedunculated polyp becomes a sessile polyp I am not able to say. If you have a well defined stalk, then if you have tumor extending down that stalk right near the point of excision, that would be a possible indication to do something radical. But if there is no tumor at the point where the surgeon cuts across the stalk and there is a clear area free from tumor, with tumor perhaps in the tip of the polyp, I think that probably you will get into no trouble by doing nothing further. And as I have stated on several occasions, I have never been able to get hold of an example of a patient with a cancer in the tip of the polyp in which the stalk was free and in which there was metastasis. I would like to know whether anyone here has ever had a polyp with cancer in the tip, with stalk free from cancer, and metastases within the regional nodes. I think it could occur, but I think it must be extremely rare. None. Well, I am still looking.

Dr. W. R. Mathews, Shreveport: Have you seen gland formation in carcinoid of the rectum?

Dr. Ackerman: I think that carcinoid tumors of the large bowel often have a pattern of festoons and ribbons as others have described them, but I have not seen true acini. I see what I interpret as false acini.

Dr. Mathews: Have you seen metastasis from a carcinoid of any location in the gastrointestinal tract that was limited to the submucosal zone?

Dr. Ackerman: I do not recall any such case.

CASE 15

Diagnosis.—Adrenal, malignant tumor of the sympathetic nervous system.

Contributor.—Dr. D. A. Todd, The Nix Hospital Laboratories, San Antonio.

History.—The patient was an adult man with symptoms of nervousness present for twelve years. Glycosuria was discovered two years before. Blood sugar was 319 mg. per 100 cc. This responded to diabetic regimen. Blood pressure varied between 110/80 and 140/90. Pain in the right upper quadrant and shock necessitated surgery, at which time a retroperitoneal tumor above the right kidney was seen and removed. Blood pressure and blood sugar postoperatively were normal.

Submitted diagnoses.—Pheochromocytoma, 17; carcinoma, adrenal cortex, 15; adenoma, adrenal cortex, 6; ganglioneuroma, 2; metastatic carcinoma (testes), 1.

Dr. Ackerman: We have adrenal cortex 21, medulla 17, and metastatic carcinoma from the testes. Anything is possible in this world today.

Sections show a tumor with considerable variation in its microscopic pattern. It is highly vascular, and often cells are arranged in ball-like masses separated by small blood vessels. This pattern suggests a pheochromocytoma, or a carotid-body tumor. Individual cells of pheochromocytoma often have large, bizarre nuclei. In the examination of numerous sections collections of ganglion cells and collections of ganglion cells associated with tumor cells are observed. The special stains serve to bring out the vascular pattern, the presence of hemosiderin pigment, and possibly melanin pigment. This lesion represents a tumor of the adrenal, and the differentiation has to be made as to whether it comes from the cortex or the medulla. Examination shows that grossly the tumor was highly hemorrhagic and quite friable. This gross finding is in favor of a tumor arising from the sympathetic system. The cortical adrenal tumors are often rather firm and yellow and may show zones of necrosis. In a cortical adrenal tumor cytoplasmic fat may be present, but the fat stain was negative in this case. Individual cells most closely resemble cortical cells or cells of the fetal adrenal cortex. The microscopic pattern is not always diagnostic in the differential diagnosis between a medullary and a cortical neoplasm.[18] In the pheochromocytoma all the cases that I have observed have been functioning and the patients have shown persistent or intermittent hypertension. This patient's highest blood pressure was 140/90. The glycosuria, with its disappearance after operation, could suggest function.

All things considered, I believe this is a tumor arising from the medulla and that it is malignant. As Wahl[42] pointed out, these tumors vary in their degree of differentiation all the way from a neuroblastoma to a ganglioneuroma. Between these two extremes there are often mixtures. This case suggests this type of pattern because of the collections of adult ganglion cells as well as immature elements. In one of Wahl's cases he described pheochromatous elements in association with well defined elements of the sympathetic nervous system. It is also true that a patient may have more than 1 tumor of the sympathetic nervous system in different locations and in various degrees of differentiation. Dr. Todd, do you have any follow-up on this patient?

Dr. Todd: He is well and going fishing every day during fishing season; his blood sugar has returned to normal; he is looking fine, but I think he is going to get into trouble, as you do.

Dr. Ackerman: What is the time interval between operation and now?

Dr. Todd: It has been about ten or twelve months.

CASE 16

Diagnosis.—Soft tissue, leg; reticulum-cell sarcoma.

Contributor.—Col. C. J. Lind, MC, Brooke Army Hospital, Fort Sam Houston.

History.—This 17 year old girl had a mass present on the left lower leg for twenty-four days with some associated pain. The lesion was firm, questionably fluctuant, tender, and a little warmer than the surrounding skin. The mass was approximately 3 by 2.5 inches in size and somewhat elevated but the borders were poorly defined. Apparently the lesion appeared suddenly. The lesion was locally excised on September 24, 1951. Roentgenograms of the bone were negative. On October 25, the leg was amputated just above the knee.

Submitted diagnoses.—Ewing's sarcoma, 10; lymphosarcoma, 7; sarcoma (lipo-, rhabdo-, round cell, neurogenic), 7; neuroblastoma, 4; synovial sarcoma, 4; melanoma, 3; hemangiopericytoma, 1; dysgerminoma, 1.

Dr. Ackerman: The tumor is highly cellular, made up of cells with rather large nuclei and inconspicuous cytoplasm. Nucleoli are fine. Mitotic figures are normal and abnormal, and abundant. This tumor is infiltrating between muscle bundles and apparently growing in the soft tissue rather than from the periosteum or bone. Special stains are of no help. They show reticulin around the blood vessels with little between individual cells. The Masson trichrome stains differentiate the muscle and the connective tissue. Fat stain is negative. I would feel that this is a fibrosarcoma on the basis of the character of the individual cells, for they do not have a spindle pattern and their reticulin pattern is against this. If it were liposarcoma, it would have much greater variation in the size and shape of cells, and there is no evidence of cytoplasmic fat. Neither does this have the appearance of any of the rhabdomyosarcomas. It is the right location for a synovial sarcoma. However, it does not have the glandular-like nor fibrosarcoma pattern of the synovial sarcoma. I am left with the diagnosis of lymphoma of reticulum cell type. I can see nothing against that diagnosis. The location, the age of the patient, and the microscopic appearance are all compatible. It would be of interest to know of the radiosensitivity of this lesion. Such lesions have previously been reported. I think that if the bones are negative, we would have to rule out Ewing's sarcoma, and I have discussed the differential diagnosis of the different types of sarcoma, and somebody has already asked me how about sympathicoblastoma, which I will discuss later. Hemangiopericytoma—no, this does not have the vascular or reticulum pattern which I think is very important. Dysgerminoma I think is a good diagnosis but again I have given the reasons why I do not think it is that tumor.

Dr. P. T. Flynn, Austin: The follow-up clinical history in this case is important:

Roentgen-ray report of the left femur a few hours prior to surgery on March 26, 1952, showed roentgen-ray evidence of a bone tumor in the distal end of the left femur which radiographically appeared as a giant-cell tumor. The deposits of tumor cells in the soft tissues of the posterior part of the thigh suggested that this was a malignant change. The change in the upper left tibia was probably subsequent to the surgical interference. There was a cystic lesion in the left humerus which appeared new. It is unlikely that any metastatic deposit could have gone to this particular location. The lesion appeared to be cystic and may have been an area of fibrous dysplasia.

Roentgenograms of both forearms showed no abnormalities. The right humerus and the hands were normal. Lateral studies of the skull showed no bony abnormalities. Roentgenograms of the chest showed no definite evidence of any bony abnormalities. There was a questionable area in the anterior end of the seventh rib which might have been due to overlapping vascular markings.

The film of the abdomen showed both normal lumbar spine and normal kidney shadows without evidence of calcification. The pelvis appeared normal without any bony abnormalities. Right tibia, femur, and fibula showed no bony changes. Roentgen-ray study of the left humerus showed a circumscribed cystic lesion in the midshaft of the humerus with definite endosteal erosion on the anterior medial aspect of the shaft. The cyst was fairly sharply demarcated but did not have any sclerotic borders. There was no evidence of any periosteal change about the abnormality. In reviewing the old films on this patient, I was fortunate enough to have the film of the left humerus on a chest study and this lesion was not present at that time.

Roentgen-ray study of the left femur and the left leg showed the previously described operative site to be largely filled in with new bone. The trabecular pattern of the distal end of the femur was somewhat coarser and there may have been some destructive process in the distal femoral end. There had been a fusion between the distal femur and the tibia. Numerous cystlike structures were seen in the shaft of the upper two-thirds of the tibia and these most likely represented changes subsequent to the operative interference. The knee apparently was well fused. There could be seen several soft tissue densities in the posterior aspect of the leg and thigh. These contained irregular strandlike areas of calcification which looked similar to the original tumor noted on the film taken as far back as 1948.

On May 6, 1952, this patient received external irradiation to her left femur and upper tibia through four external ports. She received a tumor dose of approximately 3,840 r in the midportion of the shaft of the femur in fifteen days. The skin dose was in the vicinity of 2,050 r and some erythema in the areas of overlap was expected. The patient tolerated her therapy well.

On May 11, the patient was brought to the emergency room following an automobile accident and roentgen rays revealed a fracture through the ankylosed left knee. The patient was placed in a single long leg hip spica cast. Roentgenograms of the left knee showed a fracture through the previously fused knee joint with the fracture likewise visible laterally and anteriorly. There was no appreciable displacement. The previously described changes in the bone were again noted without any progression or regression in the density since the previous study. The patient was dis-

charged from the hospital June 4. Because the leg failed to heal properly and because of the nonunion and instability of the joint, the patient remained in a hip spica.

On October 22, the blood phosphorus was 2.6 mg. per 100 cc., calcium 12.3 mg. per 100 cc., and alkaline phosphatase 1.7 Bodansky units. On October 23, a roentgenogram of the left humerus revealed no appreciable increase in the size of the cystic lesion; however, there appeared to be more thinning of the cortex on the medial aspect. Roentgenograms of the lower end of the left femur and the upper end of the left tibia revealed no essential change in the cystic lesion in the upper end of the tibia; however, since there was a complication of irradiation therapy to the tumor site plus the additional healing wound of the fracture through the ankylosed joint, it was difficult to interpret the radiographic changes.

Dr. Ackerman: This patient recently died and I looked at the gross specimens. There was tumor in both adrenals and in the lung. Careful examination of the lung showed that the bronchi were free and that the tumor was highly cellular and soft and that it was within the regional lymph node and within the lung but not within the bronchi.

The tumor also was heavily infiltrating the ovary, so the question is whether this patient could have had a primary malignant tumor of the ovary. I do not believe this could be a dysgerminoma of the ovary. It does not have the pattern, but could it be a primary reticulum-cell sarcoma of the ovary? I have seen such lesions on one or two occasions. I know that unfortunately when this patient first came in with a tumor of the soft tissues around the ankle, no pelvic examination was done. And when the patient came in and had advanced disease, a pelvic examination was done and the tumor in the region of the ovary was found. So that information does not help us. I think it would be asking quite a little to have a primary reticulum-cell sarcoma of the ovary have as its first clinical manifestation a soft tissue lesion in the region of the ankle. So, I will stand by my first diagnosis that this is a primary reticulum-cell sarcoma of the soft tissues of the leg with widespread dissemination. It would have been interesting to see what the response of this lesion would have been to roentgen-ray therapy. I would assume that some response would have occurred, but naturally this would not have been of enough value to have helped the patient in the face of such widespread dissemination. I know these sections were sent to Dr. A. P. Stout and it is comforting to me that he made the same diagnosis on this as I did. Are there any questions?

Dr. C. F. Pelphrey, Austin: Have you seen sympathicoblastoma in children regress spontaneously? If so, would you not still give a poor prognosis?

Dr. Ackerman: This is a question that has been brought up on many occasions and it is based on a famous case reported by Gross and Wohlbach. A patient had a tumor in the abdomen which was subjected to biopsy twice and supposedly underwent maturation from relatively undifferentiated to ganglioneuroma. Possibly that occurred, but in the original article there are no photomicrographs; there are only some line drawings. Now, in the review of my patients with tumors of the sympathetic nervous system, the only evidence I have of such an occurrence is that in one case a surgeon removed half of a tumor which was intermediate in differentiation and then later on the rest of it completely disappeared. Also, I have one case in which the patient had a neuroblastoma with liver and bone metastases with radiographic evidence of those lesions with microscopic evidence of liver metastasis in which the patient received roentgen-ray therapy to the liver, and a primary tumor and the bone lesions regressed spontaneously. As you may know, the amount of irradiation necessary to sterilize a neuroblastoma may be relatively little. So, I think it would be possible for a sympathicoblastoma in childhood to regress spontaneously. Has anyone here seen spontaneous regression?

Audience member: I know of an 18 month old girl who received only a biopsy when she was born. The father was a physician and decided against therapy and the thing just disappeared. Then the father went back to Boston, and roentgen-ray therapy was given anyhow.

Dr. Ackerman: That spoiled the experiment. I think it would be possible, as I have said in citing those other cases.

I know of another case in which a patient had a Wilms' tumor and had it removed, and then the patient received large amounts of irradiation which also hit the other kidney and hypertension occurred because of the irradiation of the other kidney. But I would say that if the patient had a neuroblastoma, it would be a real indication for irradiation therapy in view of the fact that Farber now has 6 patients, as you know, with proved liver metastases that are well after irradiation therapy. In that regard I would like to mention parenthetically that I had always thought that if a tumor of the sympathetic nervous system within the mediastinum is well differentiated, it should be removed, but if it is poorly differentiated and cannot be removed, a biopsy should be done and the patient subjected to very thorough irradiation therapy. It will be possible to cure the undifferentiated tumors of the sympathetic system in the same way that it is possible to cure one of the lesions below the diaphragm. I now have this patient with mediastinal tumors that have not gone long enough, but apparently the patient has a good chance of being cured. So that if a diagnosis of neuroblastoma is

made, the prognosis is not necessarily a poor one.

Dr. P. A. B. Cunningham, Galveston: Why do you exclude a highly anaplastic "round-cell" carcinoma of the bronchus as being the primary tumor?

Dr. Ackerman: That is a very good question. I would say that I cannot exclude anything, but all I can do is gather up the things I think are important. I think as pathologists we must realize that pathology is a very inaccurate science based on very tenuous things, and often diagnoses are made according to how forceful a pathologist may be who makes that diagnosis. So, if I seem a little dogmatic, I really hope you will excuse me because I really am not certain of many of these cases. In this particular case I know of no way of excluding, say, a small-cell carcinoma of the bronchus except the sequence of the clinical events, the picture of the tumor in the soft tissue or the thigh, and the fact that none of the tumor as it is growing in any of the sections which I have seen has shown clusters of cells separated by a stromal background. Now I have had a very difficult if not impossible time separating a small-cell carcinoma of the bronchus from a lymphosarcoma when, say, a 40 year old patient that somebody sends me has a large mediastinal mass and a supraclavicular lymph node. The reticulin stain will be of no value and perhaps the microscopic slide will be of no value. And in such cases where I am in doubt, I always advise that the patient receive irradiation therapy. However, I would say in practically all instances that when that patient comes to autopsy, you can decide with certainty whether he had a carcinoma or not by the pattern of its growth in one tissue or another and particularly by picking up tumor cells growing separated by a fibrous stroma in the same way you would do it with a carcinoma of the breast growing within an axillary lymph node. Now, 17 year old white girls do not often get carcinoma of the lungs either. I make the diagnosis on probabilities rather than on certainties.

If there are no further questions, I have enjoyed this brief interlude with you. I think these have been excellent cases with excellent questions.

Dr. A. O. Severance, San Antonio: Thank you. I am sure you can judge by the reaction of the audience how much we have appreciated your efforts and the quality of the work that has been put forth. I am also sure that we can say with certainty that this seminar has lived up to the reputation of those in the past. We would like to invite everybody here to come again in 1953 in the fall and we will have another seminar. Again let me say on the behalf of the local group of pathologists, Dr. Ackerman, we appreciate very much your coming and we would like you to come again. (Applause.)

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CASE REPORTS

NONPARASITIC CYST OF THE LIVER

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NONPARASITIC cysts of the liver are seldom diagnosed preoperatively. The lesion is found when the preoperative diagnosis is some such common condition as acute appendicitis[14] or ovarian cyst.[3] Every surgeon, therefore, must be prepared to treat the lesion whenever the abdomen is entered.

Of the approximately 500 cases reported since the condition was first noted by Bristowe[2] a century ago, only about one-half were recognized before the death of the patient, and exceptionally few of these were recognized prior to operation. Eliason and Smith,[5] in figures compiled from the Philadelphia General Hospital in 1944, found only 2 cases diagnosed during life. Caravati[4] in 1950 found only 1 case of a large solitary cyst of the liver diagnosed preoperatively in 200 cases reported.

A search of the literature further reveals that too little case material has been studied to yield much help in the treatment of nonparasitic cysts. However, it is clear that excision, when possible, is the treatment of choice. Unfortunately in most instances marsupialization appears necessary. One is left the choice of external marsupialization or internal cystenterostomy. The latter method, achieved by suturing the opened cyst to the stomach or to the proximal jejunum, has been tried in 1 case,[10] apparently with success.

The difficulties encountered when cystenterostomy is used in the treatment of a true pancreatic cyst are loculations and incomplete obliteration of the cyst cavity with recurrence of the abdominal mass. The majority of pancreatic cysts are pseudocysts, and these seem best treated by cystenterostomy, if excision cannot be carried out. True pancreatic cysts are rare. Nonparasitic liver cysts are comparable to true cysts of the pancreas. The thorough healing and closure of such cysts which can be insured by marsupialization makes this method of treatment preferable, I believe, particularly when the course of healing can be materially shortened by some such method as instilling Zenker's solution.

External marsupialization has as its main objection the long time necessary for permanent closure and healing. The available data, although vague as to the time necessary, leaves no doubt that it is considerable. The operative mortality in the reported cases varies between 10 and 30 per cent. Montgomery[11] was stimulated to try to shorten the morbidity imposed by external marsupialization. His method, used in the case to be reported, was so encouraging as to merit further trial.

Consideration of the various possible causes discussed by Bland-Sutton,[1] Moschowitz,[12] Kaufmann,[9] and Ewing[6] leads to the conclusion that liver cysts are congenital. Of the various classifications, that of Sonntag[15] is probably the simplest and most generally used. It differentiates (1) blood cysts and degenerated cysts, (2) dermoid cysts, (3) lymphatic cysts, (4) endothelial cysts, (5) cysts due to obstruction of bile ducts, and (6) proliferative cysts. Liver cysts appear to be about four times commoner in women than in men, and there seems to be a predilection for the white race. The average age incidence is about 40 years, although cases have been

reported of patients from 6 months to 80 years of age. The cysts may occur anywhere in the liver but are commonest in the right lobe. They may be either single or multiple and either unilocular or multilocular. The cyst walls are usually smooth and consist of epithelial cells, either flat, cuboidal, or columnar.

Nonparasitic cysts of the liver rarely produce symptoms until they become so large that they exert pressure. Even then symptoms may be vague and obscure because the cysts tend to enlarge gradually. In children the only sign in most cases is the presence of an abdominal mass.[11] Other manifestations include pain in the upper part of the abdomen, nausea, vomiting, a bloated sense of distention, occasionally diarrhea, and rarely jaundice. Tenderness may or may not be present. Carcinoma developing in congenital cysts is rare. The cyst fluid is usually thin and colorless or straw colored, although viscid fluid containing a large amount of true mucin has been found. The largest amount of fluid content reported was 17,000 cc. Analysis of the fluid has been carried out by Burch and Jones.[3]

The case to be reported may be regarded as typical.

CASE REPORT

Mrs. E. W., a 55 year old white woman who was a department store clerk, applied to the gynecology service because of vaginal discharge and irritation. Routine physical examination revealed the presence of a mass, 10 cc. in diameter, in the right upper quadrant of the abdomen just below the costal margin. Specific questioning then revealed that the patient had been aware of the mass for about two months. There was no pain, but the patient had had an aching discomfort in the back for several months. She thought the mass had been increasing in size. The patient was referred to the tumor service on January 20, 1953, with a presumptive diagnosis of a liver cyst.[16]

Physical examination was not remarkable except for the abdomen. The chief complaint of vaginal discharge was found to be due to Trichomonas vaginalis vaginitis. There was a well healed suprapubic midline abdominal incision from a uterine suspension done twenty-eight years previously. An umbilical hernia 4 cc. in diameter was present. In the right hypochondrium was the mass previously described. It was found to be firm but not hard, and moved with deep respiration.

Laboratory data included a 5,400,000 red blood cell count; a hemoglobin of 15.0 Gm.; and 7,850 white blood cells, with 58 per cent polymorphonuclear cells, 38 per cent lymphocytes, 3 per cent eosinophils, and 1 per cent basophils. The urine was negative, and the Kline test was negative. Survey roentgenograms revealed nothing diagnostic. The Echinococcus skin test was negative.

On January 29, operation was carried out through a Kocher incision under nitrous oxide, oxygen, and ether anesthesia. The tumor was found to be a cyst bulging from the right lobe of the liver and measuring 18 by 14 by 12 cm. The largest cyst mentioned in previous reports measured 19 by 18 by 16 cm.[3] The surface and the lining of the cyst were smooth and glistening, and the contained fluid was clear. A portion of the cyst presenting anteroinferiorly had a very thin wall for an area of 8 by 5 cm. The remainder of the cyst was deeply embedded in the substance of the right lobe of the liver. The gallbladder and biliary ducts, although displaced to the left, were free and clear.

The cyst was opened and the cyst fluid collected for laboratory examination. The thin 8 by 5 cm. area of cyst was excised, and marsupilization of the remainder to the central portion of the operative incision was carried out. The remainder of the incision was closed in layers, after the depths of the cyst were packed loosely with about 5 yards of folded fine mesh gauze. The umbilical hernia was repaired, and the patient was in good condition following the operation.

Sections of the cyst wall removed at operation showed it to be composed of what was apparently condensed compressed fibrous tissue and hepatic cords and cells with a mild chronic inflammatory response that was not specific. There was no evidence of hydatid cyst formation and the Echinococcus complement fixation test on the fluid was negative.

The patient's postoperative course was uneventful. The packing in the cyst was gradually removed during the first four postoperative days, and the patient was discharged from the hospital on her eighth postoperative day, to be followed in the clinic. Three weeks postoperatively a sufficient quantity of Zenker's solution to fill the cavity was injected, as suggested by Montgomery,[11] and this procedure was repeated twice weekly thereafter. The size of the cavity gradually decreased, and within twelve weeks after the operation the sinus closed. This represents a much more rapid closure than has been achieved in previously reported cases and lends support to Montgomery's idea of using Zenker's solution as a sclerosing agent in the obliteration of these cysts. The patient was followed for twelve months and remained without evidence of disease or tumor.

SUMMARY

The problem of how to treat a cyst of the liver is discussed.

It is believed that marsupialization remains the treatment of choice when excision cannot be carried out. The time required for permanent healing and closure is materially shortened by filling the cavity with Zenker's solution.

A case so treated is reported.

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NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, San Antonio, May 3-5, 1954. Dr. George Turner, El Paso, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, San Francisco, June 21-25, 1954. Dr. Edward J. McCormick, Toledo, Ohio, Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice. Dr. U. R. Bryner, Salt Lake City, Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Cincinnati, Dec. 14-16, 1954. Dr. Robert A. Kimbrough, Jr., Philadelphia, Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Montreal, Canada, May 3-5, 1954. Dr. Emile F. Holman, San Francisco, Pres.; Dr. Paul C. Samson, 2938 McClure St., Oakland 9, Calif., Secy.

American Association of Genito-Urinary Surgeons, Shawnee-on Delaware, Pa., May 26-28, 1954. Dr. Vincent J. O'Conor, Chicago, Pres.; Dr. Norris J. Heckel, 122 S. Michigan Ave., Chicago 3, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 9-11, 1954. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Miami Beach, April 5-10, 1954. Dr. M. Murray Peshkin, New York, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, San Francisco, June 17-20, 1954. Dr. Alvis E. Greer, Houston, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Chicago, April 5-9, 1954. Dr. Leroy H. Sloan, Chicago, Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 4, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-18, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress of Physical Medicine and Rehabilitation, Washington, D. C., Sept. 6-11, 1954. Dr. William B. Snow, New York, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, White Sulphur Springs, W. Va., April 13-17, 1954. Dr. Louis A. Brunsting, Rochester, Minn., Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, San Francisco, June 18-19, 1954. Dr. J. M. Ruffin, Durham, N. C., Pres.; Dr. H. Marvin Pollard, 1313 E. Ann St., Ann Arbor, Mich., Secy.

American Gynecological Society, Hot Springs, Va., May 20-22, 1954. Dr. Richard W. TeLinde, Baltimore, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, Chicago, April 1-4, 1954. Dr. Robert L. King, Seattle, Pres.; Dr. William H. Bunn, 44 E. 23d St., New York 10, Secy.

American Hospital Association, Chicago, Sept. 13-16, 1954. Mr. Ritz E. Heerman, Los Angeles, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Boston, May 25-27, 1954. Dr. LeRoy A. Schall, Boston, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Atlantic City, N. J., June 14-16, 1954. Dr. Roland P. Mackay, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, Glacier Park, Mont., June 16-18, 1954. Dr. William L. Benedict, Rochester, Minn., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, Bretton Woods, N. H., June 6-9, 1954. Dr. A. R. Shands, Jr., Wilmington, Del., Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Buck Hill Falls, Pa., May 3-5, 1954. Dr. Rustin McIntosh, New York, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, Los Angeles, June 2-5, 1954. Dr. Wendell Green, Toledo, Ohio, Pres.; Dr. Stuart T. Ross, 131 Fulton Ave., Hempstead, N. Y., Secy.

American Psychiatric Association, St. Louis, May 3-7, 1954. Dr. Kenneth E. Appel, Philadelphia, Pres.; Dr. R. Finley Gayle, 6300 Three Chopt Rd., Richmond 21, Va., Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Cincinnati, Oct. 25-30, 1954. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Washington, D. C., Sept. 6, 1954. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Cleveland, April 28-30, 1954. Dr. Howard C. Naffziger, San Francisco, Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison St., Chicago 3, Secy.

American Urological Association, New York, May 31-June 3, 1954. Dr. J. A. Campbell Colston, Baltimore, Md., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Jackson, Miss., April 1-3, 1954. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1954. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Atlantic City, N. J., May 17-21, 1954. Mr. Mark H. Harrington, Denver, Pres.; Mr. Kemp D. Battle, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nashville, Pres.; Dr. George G. Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum, New Orleans, May 9-11, 1954. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, 1954. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Oklahoma City, Sept. 27-29, 1954. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secy.

Tri-State Medical Assembly, Fall, 1954. Dr. Joe D. Nichols, Atlanta, Pres.; Dr. Broox C. Garrett, 940 Margaret Pl., Shreveport, La., Secy.

United States-Mexico Border Public Health Association, Albuquerque, N. M., April 6-9, 1954. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice, Galveston, Sept. 9-11, 1954. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris, 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 11-12, 1954. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association, San Antonio, May 2-3, 1954. Dr. George L. Gallaher, Harlingen, Pres.; Dr. J. S. Minnett, 2512 Welborn, Dallas, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, San Antonio, May 2, 1954. Dr. Henry H. Hoskins, San Antonio, Pres.; Dr. Walter C. Brown, 1733 S. Brownlee Blvd., Corpus Christi, Secy.

Texas Club of Internists. Dr. Joseph F. McVeigh, Fort Worth, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, San Antonio, May 2, 1954. Dr. Maurice Barnes, Waco, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, San Antonio, May 2, 1954. Dr. Raymond L. Gregory, Galveston, Pres.; Dr. Edmond K. Doak, 501 Hermann Professional Bldg., Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas, Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Heart Association, San Antonio, May 3, 1954. Dr. Joseph McVeigh, Fort Worth, Pres.; Miss Roberta Miller, 412 Fidelity Union Life Bldg., 1511 Bryan St., Dallas, Executive Secy.

Texas Hospital Association, Houston, May 18-20, 1954. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, San Antonio, May 2, 1954. Dr. James Blair, San Antonio, Pres.; Dr. John L. Otto, John Sealy Hospital, Galveston, Secy.

Texas Orthopedic Association, San Antonio, May 3, 1954. Dr. Edward T. Smith, Houston, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, Oct. 22-23, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society, Dr. Jack Kerr, Dallas, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 13-16, 1955. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Houston. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, San Antonio, May 3, 1954. Dr. William E. Crump, Wichita Falls, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred H. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Mineral Wells, 1955. Dr. Charles N. Burrows, San Antonio, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 3, Executive Secy.

Texas Society of Anesthesiologists, San Antonio, May 2, 1954. Dr. James B. Robinett, Jr., Houston, Pres.; Dr. C. R. Allen, John Sealy Hospital, Galveston, Secy.

Texas Society of Gastroenterologists and Proctologists, San Antonio, May 3, 1954. Dr. Cecil O. Patterson, Dallas, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, San Antonio, May 3, 1954. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society, Waco, April 5-6, 1954. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Dallas, April 9-10, 1954. Mrs. Joella Terrill Butler, Wichita Falls, Vice-Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Corpus Christi, 1954. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg., Corpus Christi, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society, Sweetwater, April 15, 1954. Dr. T. D. Young, Sweetwater, Pres.; Dr. Francis Hood, Sweetwater, Secy.

Third District Society, Amarillo, April 13, 1954. Dr. Robert A. Neblett, Canyon, Pres.; Dr. James T. Hall, 1626 Fifteenth St., Lubbock, Secy.

Fourth District Society, San Angelo, Oct. 14, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July, 1954. Dr. Y. C. Smith, Sr., Corpus Christi, Pres.; Dr. Robert J. Sigler, 1126 Third Street, Corpus Christi, Secy.

Seventh District Society, 1954. Dr. Benjamin Clary Bates, Austin, Pres.; Dr. William McLean, 4618 Burnet Road, Austin, Secy.

Eighth District Society, Victoria, September, 1954. Dr. Howard Z. Fretz, Wharton, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society. Dr. Thomas H. Giddings, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society, Nacogdoches, April 17, 1954. Dr. Edmund D. Jones, Beaumont, Pres.; Dr. O. W. Harris, Jr., Liberty, Secy.

Eleventh District Society, Crockett, April 15, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society. Dr. Neil Buie, Marlin, Pres.. Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society, Fort Worth, March 24, 1954. Dr. William E. Crump, Wichita Falls, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society, Denton, June 1, 1954. Dr. J. W. Atchison, Gainesville, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Longview, April 20, 1954. Dr. Bain Leake, Gladewater, Pres.; Dr. George Tate, Longview, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas. Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco, April 7, 1954. Dr. Walter B. King, 2320 Columbus Ave., Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Feb. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Sept. 22, 1954. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, July 19-21, 1954. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences, Austin, April 23-24, 1954. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, June 21-23, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

International Surgeons Examinations

Qualifying examinations for fellowship in the International College of Surgeons will be held May 3-4. Written examinations will be given at Cook County Graduate School of Medicine, Chicago, on May 3; clinical examinations, at Cook County Hospital on May 4. Further details may be obtained from the International College of Surgeons, United States Chapter, 1516 Lake Shore Drive, Chicago 10.

SINGLETON SURGICAL SOCIETY

The first annual scientific program of the Singleton Surgical Society, organized by former residents of the Department of Surgery of the University of Texas Medical Branch to further surgery in the state and to advance the prestige of the department, was held January 23 and 24 in Galveston. Future meetings will be held alternately in Galveston and in some other outstanding university or clinic, the 1955 session being scheduled for Dallas in January.

Charter members of the organization are general surgery residents who trained under Dr. A. O. Singleton during the period from 1927 to 1947 when he was chairman of the department. Active and honorary members have been elected from graduates or members of the department.

Officers of the newly established group are Dr. J. Peyton Barnes, Houston, president; Dr. Norman Duren, Beaumont, vice-president; Dr. Walter B. King, Jr., Waco, secretary-treasurer; and Dr. Truman G. Blocker, Jr., Galveston, and Dr. John C. Kennedy, Houston, members of the council. In addition to these officers, charter members include Drs. W. H. Ainsworth, Galveston; Sam R. Barnes, Trinity; Gustavus A. Bynum, Hattiesburg; Isadore V. Epstein, Pasadena; Harold E. Griffin, Corpus Christi; J. W. Hillsman, Carlsbad, N. Mex.; Adolph Kauffman, III, Fort Worth; O. T. Kirksey, Jr., Galveston; Maynard D. Knight, San Angelo; Joseph P. McNeill, Dallas; J. C. Neel, Dallas; John Peek, Jacinto City; W. H. Pickett, Dallas; F. F. Rogers, Corpus Christi; Ed B. Rowe, Galveston; Robert H. Rowland, Sheppard Air Force Base; C. E. Thomas, Big Spring; George W. Tipton, Austin; Alfred M. Tocker, Wichita, Kan.; Jack L. Walker, Cameron; Sam Wallis, Lihue, Kauai, T. H.; Charles E. Webb, El Paso; Harriss Williams, Austin; and Fred J. Wolma, Galveston.

The scientific program by Galveston physicians included the following presentations:

Present Concepts of Surgical Treatment of Peptic Ulcer—Dr. R. M. Moore.
Surgery of Adrenal Gland—Dr. E. J. Poth.
Varicose Veins; Postphlebitic Syndrome—Drs. J. M. Thiel and Truman G. Blocker, Jr.
Healing of Fractures—Dr. W. H. Ainsworth.
Postoperative Atelectasis—Dr. A. W. Harrison.
Report of Current Research; Activities Relating to Severely Burned—Dr. Blocker.
Future Plans of the Department of Surgery Regarding Resident Training Program; Diagnostic Clinic Policies of New Hospital—Drs. Moore and Poth.
Portal Hypertension—Dr. Poth.

Wives of many of the surgeons were present and participated in a cocktail party, luncheon, and supper.

Texas Society of Pathologists

The Texas Society of Pathologists met January 31 at Galveston and adopted a new constitution and by-laws in compliance with the society's policy to revise completely that document every ten years. Dr. John J. Andujar, Fort Worth, became president; Dr. C. B. Sanders, Houston, president-elect; Dr. A. J. Gill, Dallas, vice-president; and Dr. Lloyd R. Hershberger, San Angelo, secretary-treasurer.

The forty-one members in attendance were presented with the following scientific program: "Paper Chromatography" by J. G. Bieri, Ph.D., associate professor of biochemistry at the University of Texas Medical Branch, Galveston; "Antibiotic Sensitivities" and "Bacterial Problems of Air Conditioning" by Frank B. Engley, Ph.D., associate professor of bacteriology; and following two motion picture films, a conducted tour of the Tissue Culture Laboratory by its director, C. M. Pomerat, Ph.D., professor of cytology.

PERSONALS

Dr. W. H. Bennett recently resigned his position as Marshall Health Officer after twenty years of service. Dr. Bennett gave his age and other practice as reasons for his resignation. *Dr. Roger Harmon* was named to take his place.

Dr. George Aagaard, dean of the Southwestern Medical School, Dallas, has been elected chairman of the American Medical Association's Committee on Medical Motion Pictures.

Governor Allan Shivers appointed two doctors to serve on the state's Advisory Hospital Council for terms ending July 17, 1959. They are *Dr. Raymond E. Sitta,* Chillicothe, hospital administrator member, and *Dr. John M. White, Jr.,* Port Arthur, physician member.

Dr. Stephen B. Tucker has been elected president of the Nacogdoches County Fair and Livestock Exposition.

A new member of the board of directors of the Citizens National Bank, Greenville, is *Dr. Frank J. Little.*

Dr. M. A. King was recently elected "Man-of-the-Year" by the Frankston Lions Club.

Dr. L. Louis Harrop, Harlingen, is the new president of the Gulf Coast Magic Club.

Dr. M. C. Overton, Jr., Pampa, was reelected president of the Top o' Texas Hereford Breeders Association recently.

A special award citation was given *Dr. W. W. Flowers,* Livingston, by the Polk County Chamber of Commerce for his work in the medical field and with veterans, the American Legion, and Boy Scouts.

Mrs. W. H. Barnett, wife of *Dr. W. H. Barnett,* Abilene, died at a local hospital in March after suffering a stroke.

Dr. and Mrs. Wiley Roosth, Tyler, and *Dr. Frances Pierce Lankford and Eugene Lankford,* Grand Prairie, are parents of girls, according to the *Alumni Bulletin,* The University of Texas Medical Branch, Galveston.

New parents of boys, according to the *Alumni Bulletin,* are *Dr. and Mrs. Cecil R. Glass,* Galveston, and *Dr. and Mrs. H. G. Tree,* Texas City.

Wichita Falls Boy Wins Essay Contest

Wichita Falls, El Paso, and El Campo high school students won first, second, and third places in the state essay contest on "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care." Sponsored nationally by the Association of American Physicians and Surgeons, the contest was held in Texas under the direction of the Woman's Auxiliary to the Texas Medical Association with the Association supplying cash prizes.

Milton Copeland, Wichita Falls; David Curry, El Paso; and Kate Wood, El Campo, won prizes of $250, $150, and $100, respectively, in the state contest, and their essays have been forwarded to compete in the national contest. Dr. Royall M. Calder, Owen J. Reamer, Ph. D., and Robert D. O'Callaghan, all of San Antonio, judged the entries in the state competition, for which Mrs. A. O. Severance, San Antonio, was chairman. Dr. Mal Rumph, Fort Worth, is chairman of the national contest committee for the Association of American Physicians and Surgeons, and Drs. Charles D. Reece and Hampton C. Robinson, Houston, are members of the committee.

In addition to the first three awards, the Texas Medical Association provided prizes for essays up to tenth place in the state contest and for each of the fifteen districts, altogether a total of $1,000. These additional prizes were won as follows:

State—fourth, $50, Gerald Richman, Henderson; fifth, $25, Tobye Fram, Baytown; sixth, $10, Carolyn Monaghan,

Waco; seventh, $10, Bernadette Borchers, Laredo; eighth, $10, Sheridan Mott, El Paso; ninth, $10, Helen Meurer, Fredericksburg; tenth, $10, Jackey Lumpkin, Houston.

Districts ($25 each)—1, David Curry, El Paso; 2, Nancy Conway, Big Spring; 3, Norma Friedman, Amarillo; 4, Gladys Ruth Coldewey, Winchell; 5, Helen Meurer, Fredericksburg; 6, Bernadette Borchers, Laredo; 7, Caroline Covington, Burnet; 8, Kate Wood, El Campo; 9, Tobye Fram, Baytown; 10, Billy M. Willis, Nacogdoches; 11, Gerald Richmond, Henderson; 12, Carolyn Monaghan, Waco; 13, Milton Copeland, Wichita Falls; 14, Ernest F. Couch, Dallas; 15, Clara Schell, Longview.

OBSTETRICIANS AND GYNECOLOGISTS MEET

The Texas Society of Obstetricians and Gynecologists held its twenty-fifth annual meeting February 19 and 20 in Waco, with Dr. Carl T. Javert, associate professor of obstetrics and gynecology at Cornell University Medical College, New York, as the society's guest.

New officers named were Dr. G. F. Goff, Dallas, president; Dr. John Delaney, Galveston, president-elect; Dr. Oran V. Prejean, Dallas, vice-president; and Dr. Carey Hiett, Fort Worth, secretary-treasurer.

The scientific program included discussions on pudendal block in obstetrics, pelvic lymphatics and gynecological disease, emotional component in trichomonas vaginalis, induction of labor, present trends in vaginal hysterectomy technique, use of extraperitoneal pelvic lymphadenectomy in female malignancy, transverse lower abdominal incision for pelvic tumors, modern trends in therapeutic abortion, pathology of spontaneous abortion, use of Demerol and scopolamine in labor and delivery, and poliomyelitis as a complication of pregnancy.

Speakers were Drs. J. R. Harris, Jr., Lubbock; S. Foster Moore, Jr., San Antonio; John W. Simpson, Col. (MC) AUS, Fort Sam Houston; Stanley Rogers, Houston; John Thomas Armstrong, Houston; Jack Moore, Houston; Felix Rutledge, Houston; John J. Delaney, Galveston; R. Vernon Colpitts, Houston; G. G. Passmore, San Antonio; E. W. Santa Cruz, San Antonio; Robert K. Gassler, Waco; and Dr. Javert. The resident award paper was given by Dr. Charles R. S. Mackenzie, resident in obstetrics and gynecology at John Sealy Hospital, Galveston.

Discussions were begun by Drs. O. Robert Hand, Lubbock; Walter Morse, Houston; Allen L. McMurrey, Houston; Howard O. Smith, Marlin; S. Foster Moore, San Antonio; Charles William Braselton, Jr., Fort Worth; Milton A. Davison, Marlin; and J. W. Jones, Texarkana.

Approximately 150 members and guests attended.

Cancer Symposium

The eighth annual Symposium on Fundamental Cancer Research was given by the University of Texas M. D. Anderson Hospital and Tumor Institute April 5-6 in Houston. In addition to the usual joint meeting with the South Central Region of the College of American Pathologists, the program included a joint session with the Tissue Culture Association on "Tissue Culture in Cancer Research."

Dr. Peyton Rous, emeritus member of the pathology and bacteriology department of the Rockefeller Institute for Medical Research in New York, received the Bertner Foundation award. Dr. Rous delivered the Bertner Lecture the night of April 5.

Out-of-state patticipants included Dr. George O. Gey, Dr. Frederik B. Bang, and Margaret K. Gey, Baltimore; Mary F. Orr and Dr. Barton McSwain, Nashville; Dr. Joseph Leighton, Bethesda, Md.; Margaret R. Murray, Ph. D., and Dr. Arthur P. Stout, New York; Dr. Austin Brues and Agnes N. Stroud, Lemont, Ill.; Dr. William C. Moloney, Boston; Dr. Leonard Hamilton, New York; Mary L. Petermann, Ph. D., New York; Dr. Edith L. Potter, Chicago; Dr. Frederick N. Silverman, Cincinnati; and Dr. Wylie D. Forbus, Durham, N. C.

Others on the program were Dr. Peter M. Marcuse, Houston; Dr. T. C. Hsu, Galveston; and F. Gonzales, Ph. D.; Jorge Awapara, Ph. D.; Bruno Jirgensons, Ph. D.; and Dr. Grant Taylor, from the M. D. Anderson Hospital. Dr. Taylor is also dean of the University of Texas Postgraduate School of Medicine.

The April 5 program was on "Tissue Culture in Cancer Research," and on April 6 there was a cancer pathology and radiology conference on "Tumors of Infancy and Childhood."

Audio-Digest Foundation

The Audio-Digest Foundation, established to further postgraduate medical education and a nonprofit corporation sponsored and owned by the California Medical Association, offers a new type of service to physicians. Tape recordings of abstracts of current medical literature, which can be played on any tape machine, are available from Audio-Digest for individual physicians, staff groups, or county medical societies. With proceeds going to the American Medical Education Foundation, Audio-Digest issues weekly a one-hour tape for general practitioners, on which is recorded from twenty to thirty abstracts of outstanding current medical information. A second service includes semimonthly digests in the fields of surgery, internal medicine, and obstetrics and gynecology. The new foundation also has available tape-recorded lectures and panel discussions on one-hour reels as a third service.

All articles are screened by a board of medical editors of which Dr. Edward C. Rosenow, Jr., Pasadena, Calif., is editor-in-chief. Headquarters for the Audio-Digest Foundation are at 800 North Glendale, Glendale, Calif.

Texas Club of Internists

The Texas Club of Internists met February 26-27 in Galveston, with seventy-seven members present. Dr. Joseph F. McVeigh, president, presided over the morning meeting February 26, with Dr. L. C. Carter presiding that afternoon. Dr. V. E. Schulze, president-elect, presided over the meeting February 27.

Dr. Lawrence G. May spoke on "Clinical Use of Radioactive Iodine"; Dr. Edward D. Futch, III, "Clinical Manifestations of Torulosis"; Dr. M. R. Hejtmancik and Dr. H. W. Palley, "Electrocardiogram in Congenital Heart Disease"; and Dr. Raymond Gregory, "Diagnosis and Treatment of Hyperadrenocortico States."

Afternoon speakers were Dr. James C. Wright, Jr., who spoke on "Cardiac Arrest and Resuscitation"; Dr. J. E. Johnson, "Blood Volume Studies Before and After Diuretics"; Dr. M. Ruth Baxter, "Effects of Newer Diuretics"; and Dr. Fred Mullins, "Cutaneous Manifestations of Xanthomatous Biliary Cirrhosis."

Dr. G. W. A. Currie welcomed the group to the John Sealy Hospital, where the February 27 meeting was held. "Pulmonary Emphysema-Physiology and Treatment" was the subject of Dr. John W. Middleton, Dr. A. M. Longfield, and Dr. David Miesch. Dr. Bernard R. Cooley spoke on "Angiocardiography and Aortography in Diagnosis of Coarctation of Aorta, Patent Ductus Arteriosus and Tetralogy of Fallot."

TEXAS UROLOGICAL SOCIETY

Eighty-two Texas urologists and forty-five wives were in Fort Worth February 21-22 for the meeting of the Texas Urological Society. The following scientific program was presented for the physicians:

Management of Lower Ureteral Calculi—Dr. Harold A. O'Brien, Dallas.

Cystectomy and Plastic Procedures in Exstrophy—Dr. Harry M. Spence, Dallas.

Testicular Biopsy: Its Indications and Interpretation—Dr. Warren O. Nelson, Iowa City, Iowa.

Experiences With Injection of Radioactive Gold for Carcinoma of Prostate Gland—Dr. Noble S. Malus and Dr. J. Reese Blundell, Houston.

Radioactive Cobalt in Treatment of Bladder Tumors—Dr. Vincent Vermooten, Dallas.

A pyelogram conference concluded the scientific program.

During the business meeting, the society elected Dr. S. J. R. Murchison, Fort Worth, president, and Dr. A. J. Ashmore, Corpus Christi, secretary. It was decided that the next meeting would be held in Corpus Christi, the date to be set later.

A cocktail party and dinner were held February 21. Luncheons were held February 22 for the society and for the ladies.

New Mexico Medical Society

Texas doctors have been invited to attend the seventy-second meeting of the New Mexico Medical Society May 13-15 in Santa Fe. The registration fee is $15.

Eight guest specialists will speak at the scientific meetings, which will begin at noon, May 13, and end at noon, June 15. Thirty technical exhibits, round-table luncheons, and the annual presidential dinner dance will be included in the three-day meeting. Additional information is available from Ralph R. Marshall, Executive Secretary, 223-224 First National Bank Building, Albuquerque, N. Mex.

TEXAS HOSPITAL ASSOCIATION

The twenty-fifth annual convention of the Texas Hospital Association will be held in Houston, May 18-20.

Out-of-state speakers include Dr. Frank R. Bradley, Saint Louis, president-elect of the American Hospital Association, and Dr. Edwin L. Crosby, Chicago, president of the American Hospital Association in 1952-1953. Dr. F. J. L. Blasingame, Wharton, President-Elect of the Texas Medical Association, will speak to the group on "National Trends in Medical and Hospital Care." Other Texas speakers include Dr. Everett C. Fox, Dallas, who will speak on "Who Should Pay for the Medical Care of Indigents?"; William L. McGill, Austin, civil defense coordinator for the Texas State Division of Defense and Disaster Relief; E. M. Collier, Abilene, who will report as chairman of the association's Committee on Shortage of Professional Personnel; and Philip R. Overton, Austin, who will speak on national legislation affecting hospitals.

The exhibit show and meetings will be held in the Shamrock Hotel.

TEXAS PROCTOLOGIC SOCIETY

An operative clinic was conducted at Memorial Hospital, Houston, at the February 27 meeting of the Texas Proctologic Society. A three-hour round table discussion of unusual cases was held by the members. Officers elected were Dr. Jack Kerr, Dallas, president and Dr. John McGivney, Galveston, secretary-treasurer.

NATIONAL HEALTH LEGISLATION

A large amount of national health legislation is well advanced, and if Congress holds to an average pace, several bills affecting the medical profession are likely to become law in the next month or so, the Washington staff of the American Medical Association reports. Here is the situation in brief:

Medical Deductions.—Legislation to increase the amount deducted from taxable income for medical expenses is a part of the omnibus tax revision bill which cleared the House by a wide margin but ran into some delay in the Senate. This bill, with the medical deduction liberalization intact, should reach the White House in plenty of time for enactment.

Hill-Burton Expansion.—A move to make important changes in the hospital construction bill developed in the Senate Labor and Welfare Committee after the House had passed its version with some amendments. The American Hospital Association proposed that the rather complicated House legislation be scrapped and instead that the Hill-Burton act be amended (a) to include rehabilitation centers and nursing homes and (b) to place a high priority on hospitals for the chronically ill. The AHA idea immediately attracted support. The new approach meant inevitable, but probably not fatal, delays.

Reinsurance.—The proposal to reinsure health policies, once hailed as the keystone of the Eisenhower administration's health program, continued to encounter opposition. At one stage, of all the national associations to testify on reinsurance only the American Hospital Association was giving it unqualified support. The American Medical Association, United States Chamber of Commerce, and national spokesmen for the insurance industry took about the same position: (1) Reinsurance alone cannot make uninsurable risks insurable. (2) The threat of federal control of medicine is inherent in any program that would bring the federal government in such close contact with medical practice.

Health Grants.—An administration plan would do away with the present categorical grants for identified projects, such as venereal disease control, and substitute funds earmarked for three general purposes, (a) to maintain present programs, (b) to initiate new programs or to expand existing ones, and (c) to finance public or private experimental or pilot programs of national or regional significance. In both committees the question was whether to group the first and second type grants together, with the state health authorities deciding how to divide up the federal money among old and new projects. Funds for the third type of grant—experimental—would be completely controlled by the surgeon general. One suggestion is to require approval of the state health officer for any experimental (type three) grant in his state. Another is to eliminate the third type of grants altogether, letting the National Institutes of Health handle public health as well as other medical research grants.

Social Security.—The American Medical Association, American Dental Association, and a number of other national groups are fighting vigorously to prevent compulsory extension of old age and survivors insurance to physicians, dentists, and most other self-employed. Instead, they want the privilege of deferring income tax payments on that part of earnings placed in restricted annuities—the Jenkins-Keogh plan. AMA also feels that there is no need for the bill's provision that pension rights be frozen during periods when the worker has been medically determined to be disabled. A better suggestion, the Association maintains, is to base pension rates on the ten best working years, thus vir-

tually eliminating the need for the controversial medical examinations. Prospects are good that social security will be extended, either with or without these changes.

Vocational Rehabilitation.—Generally, Senate witnesses favor the administration's proposal to expand the federal-state programs for vocational rehabilitation providing United States grants are not cut. However, with no House bill introduced as of this writing, there is some doubt that, even if the Senate clears the measure, the House can find time to deal with it.

Doctor Draft Amendment.—A bill growing out of the Peress case swept through the Senate without objection. It may be law by the time this is published. It would amend the doctor draft act to permit the services to keep on duty as an enlisted man, assigned to professional tasks, anyone called under the doctor draft act whose loyalty is questioned. The Defense Department has promised to investigate such cases immediately, so that the man can be cleared promptly and offered a commission or discharged. The discharge would state that action was taken on loyalty grounds.

LIBRARY SECTION

ATOMIC MEDICINE

The increasing number of articles in the medical literature dealing with atomic medicine indicates its great value in therapeutics as well as diagnosis. Continuing experiments and clinical experience in this field have helped scientists to understand many of the life processes and mechanisms which were only dimly recognized before.

"The Atom and Medicine," a film recently purchased by the Texas Medical Association Memorial Library, will be of assistance to the physician presenting a program to the lay public on the medical uses of atomic energy.

The following articles and films will be of interest:

Articles and Books

Badenoch, D. M., and Callender, Sheila T.: Iron Metabolism in Steatorrhea—Use of Radioactive Iron in Studies of Absorption and Utilization, Blood *9:*123-133 (Feb.) 1954.

Behrens, C. F.: Atomic Medicine, ed. 2, Baltimore, Williams and Wilkins, 1953.

Bettman, J. W., and Fellows, Victor: Radioactive Phosphorus as Diagnostic Aid in Ophthalmology, Arch. Ophth. *51:*171-179 (Feb.) 1954.

Conklin, Stanley D., and Knisely, Samuel W.: Radioactive Iodine in Thyroid Disease, Guthrie Clin. Bull. *23:* 144-148 (Oct.) 1953.

Dobyns, Brown M., and Brownell, Gordon: Directional Scintillation Counter for Laboratory Study of Thyroid Tumors, Lab. Invest. *3:*39-47 (Jan.) 1954.

Harris, Norman O.: Role of Radioactive Isotope in Bone Metabolism, Mil. Surgeon *114:*108-111 (Feb.) 1954.

Meschan, Isadore, and others: Dosage Tables for Cobalt 60 for Use with Interstitial, Plaque, and Intracavitary Applications, Am. J. Roentgenol. *71:*320-332 (Feb.) 1954.

National Industrial Conference Board: Atomic Energy in Industry, Special Conference, Oct. 16-17, 1952.

Owen, Charles A., Jr.: Laboratory Aids to Medical Practice—Radioactive Isotopes in Diagnosis and Treatment, Minnesota Med. *37:*138-139, 1954.

Taber, Kenneth W.: Scintiscanning Entire Body for Radioiodine, Mississippi Valley M. J. *75:*188-191 (Nov.) 1953.

Films

The Atom and Medicine, 16 mm., sound, 12 minutes.

BOOKS RECEIVED IN MARCH

Angevine, D. M., and Ash, J. E.: *Atlas of Orthopedic Pathology,* Washington, D. C., American Registry of Pathology, 1943.

Button, John C.: *Hope and Help in Parkinson's Disease,* New York, Vantage Press, 1954.

Cabot, Blake: *Motion of Heart, Story of Cardiovascular Research,* New York, Harper and Brothers, 1954.

Fishbein, Morris: *Children for Childless,* Garden City, Doubleday, 1954.

Levitt, T.: *Thyroid; Physiological, Pathological, Clinical and Surgical Study,* Edinburgh, E. & S. Livingstone, 1954.

Means, James Howard: *Doctors, People and Government,* Boston, Little, Brown and Co., 1953.

Moloney, James Clark: *Understanding the Japanese Mind,* New York, Philosophical Library, 1954.

National Society for Crippled Children and Adults: *Proceedings,* 1952.

National Society for Crippled Children and Adults: *Rehabilitation Centers in United States,* 1953.

National Society for Crippled Children and Adults: *Speed Problems of School Children,* 1953.

New York State Joint Legislative Committee on Problems of the Aging: *Enriching Years,* 1953.

Percival, Thomas: *Medical Ethics,* Manchester, S. Russell, 1803.

Physicians Desk Reference to Pharmaceutical Specialties and Biologicals, 1954.

Sweet, Richard H.: *Thoracic Surgery,* ed. 2, Philadelphia, W. B. Saunders, 1954.

Williamson, Bruce: *Handbook on Diseases of Children,* ed. 7, Edinburgh, E. & S. Livingstone, 1953.

Wilmer Ophthalmological Institute of the Johns Hopkins University and Hospital: *Collected Reprints,* vol. 11, 1953.

MOTION PICTURES FOR LOAN

Oral Cancer: The Problem of Early Diagnosis

16 mm., sound, color, 32 minutes.

Clinical illustrations of early lesions of the tongue, floor of the mouth, gingiva, cheek, palate, and lip are presented, and the technique of biopsy and a method of thorough oral examination are shown. Emphasis is on the fact that only by routine, thorough examination of the oral cavity and the nodes of the neck is it possible to discover cancer of the oral cavity in an early stage.

This film is excellent for general practitioners and dentists. It will be of interest also to interns, residents, and medical students.

Conquering Darkness

16 mm., sound, 20 minutes.

Produced in cooperation with the New Jersey State Commission for the Blind, this film shows how blind persons can find their rightful place in the workaday world. It includes education, industrial placement, assistance, home industry, and prevention. The film is excellent for high school students, adult lay audiences, and nursing trainees.

The Role of Gastroscopy in the Diagnosis and Treatment of Gastric Pathology

16 mm., sound, color, 33 minutes.

Gastroscopy and its place in the diagnosis of gastric disease are presented in an informative manner. Following a brief historical introduction, the film shows the development of the modern flexible gastroscope. The indications and contraindications for gastroscopy are clearly defined and evaluated. By appropriate models, roentgenograms, and other illustrative materials, the film clearly depicts the lesions which may be differentiated by gastroscopy. The close cooperation between the gastroscopist and roentgenologist is stressed. Advantages and disadvantages of each procedure are clearly shown.

Athletic Type Injuries, Prevention and Immediate Care

16 mm., silent, color, 45 minutes.

This film is designed to give a more complete understanding of the problems of athletic types of injuries. Starting with the ankle, it shows preventive measures. It also shows methods for the immediate care of athletic injuries to the knee, tendons and muscles, groin and hip bone, rib and shoulder, elbow, wrist, and fingers.

This film will be of interest to general practitioners, medical students, and interns.

CONTRIBUTIONS TO LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library of the following recent gifts:

Bexar County Medical Society Library, San Antonio, 63 reprints.

Dr. Wylie F. Creel, Austin, 103 journals.

Dr. Everett C. Fox, Dallas, 32 reprints.

Dr. Dan B. Hamill, Corsicana, 19 books.

Dr. George R. Herrmann, Galveston, assorted reprints.

Dr. Amedeo Magliolo, Dickinson, 38 journals.

Mr. J. Louis Neff, Texas Division, American Cancer Society, Austin, 1 journal and assorted reprints.

Dr. Henry Renfert, Austin, 29 journals.

Dr. N. L. Schiller, Austin, 16 journals, 3 reprints.

Mrs. G. F. Thornhill, Austin, 159 books.

Dr. Samuel P. Todaro, Austin, 29 books.

BOOK NOTICES

[1]Peptic Ulcer; Pain Patterns, Diagnosis and Medical Treatment

LUCIAN A. SMITH, M. D., M. S. in Med., F.A.C.P., *Assistant Professor of Medicine, Mayo Foundation, and Head of Section Division of Medicine, Mayo Clinic, Rochester, Minn., and* ANDREW B. RIVERS, M. D., M. S. in Med., F.A.C.P., *Late Associate Professor of Medicine, Mayo Foundation, and Consultant, Division of Medicine, Mayo Clinic. Foreword by George B. Eusterman. 576 pages. $12.50. New York, Appleton-Century-Crofts, Inc., 1953.*

This exceptionally complete book on peptic ulcer stresses an approach to peptic ulcer different from the usual. Pain produced by stomach and duodenal lesions in reference to skin sites is particularly detailed and exact. The section on roentgenologic diagnosis is excellent.

The section on treatment of peptic ulcer and its complications is excellent in all aspects.

This book is interesting, readable, and well illustrated and is recommended as a very complete work on peptic ulcer.

[1]*E. S. Rogers, M. D., Nacogdoches.*

Atomic Medicine

Edited by CHARLES F. BEHRENS, M. D., *Rear Admiral (MC) United States Navy; Staff Medical Officer, Eastern Sea Frontier. Formerly Director, Atomic Defense Division, Bureau of Medicine and Surgery, Navy Department; Commanding Officer, Naval Medical Research Institute, National Naval Medical Center, Bethesda, Md. Second edition. 632 pages. $11. Baltimore, Williams and Wilkins Company, 1953.*

The second edition is the work of twenty well known physicians and scientists who are authorities in their fields. The related subjects such as atomic disasters and method of survival are discussed.

The material presented in this new edition is fundamental; its application to medicine is well presented. For physicians seeking only the basic knowledge of the subject the book is exceptionally good.

The Conception of Disease

WALTHER RIESE, M. D. *120 pages. $3.75. New York, Philosophical Library, 1953.*

The various concepts of diseases have been analyzed and in many instances the concept has been traced back to its historical origin.

It is the purpose of this book to unfold and analyze a complete picture of disease, its history, its versions, and its nature. In the chapter on disease and art is found this interesting remark, "A mental disease may be the source of new experiences, representing the contents of disease. These new experiences may be a stimulus to the artist. . . . So far no case has come to my knowledge in which disease itself produced an artist. It is true that psychotic individuals frequently start drawing and painting for the first time during their disease." There is an excellent discussion on the social conception of disease. This is a very interesting and a well written book.

[2]Modern Treatment; A Guide for General Practice

By fifty-three authors, edited by AUSTIN SMITH, M. D., *Editor of The Journal of the American Medical Association, and* PAUL L. WERMER, M. D., *Secretary, Committee on Research, American Medical Association. First edition. 1146 pages. $20. New York, Paul B. Hoeber, 1953.*

In more than 1,000 pages Drs. Smith and Wermer and others, all specialists in their fields, have amassed all the known therapies for the ills of mankind. Their prescribed therapy is lucid, brief, and authoritative. Several different courses of treatment are given in which the therapy is not specific. The first chapter, "The Patient-Physician Relationship," should be read by everyone, as it covers a phase of medical education often heard but not read in text form.

I have found the book very helpful and hope that the authors will revise it within the next two years.

[3]Nervous Transmission

ICHIJI TASAKI, M. D., *Central Institute for the Deaf, St. Louis. 164 pages. $7.50. Springfield, Ill., Charles C Thomas, 1953.*

This monograph presents the author's concept of nervous transmission supported by well illustrated personal experimental data. The author is an experienced investigator in this field and this work should be of considerable value to other researchers. Included is the description of a technique for isolation of a single nerve fiber for study of electrical transmission. Photomicrographs display this technique nicely.

[2]*E. B. Groner, M. D., Corpus Christi.*
[3]*Thomas M. Runge, M. D., Austin.*

[4]**Ballistocardiography**

WILLIAM DOCK, M. D., F.A.C.P., *Professor of Medicine, State University Medical Center at New York City, College of Medicine; Visiting Physician, Kings County Hospital, Brooklyn;* HARRY MANDELBAUM, M. D., F.A.C.P., *Associate in Medicine, Jewish Hospital of Brooklyn; Physician in Charge, Hypertension and Nephritis Clinic at Jewish Hospital of Brooklyn; and* ROBERT A. MANDELBAUM, M. D., *Assistant in Medicine, Jewish Hospital of Brooklyn; Assistant in Cardiology, Beth-El Hospital, Brooklyn. 203 pages. $9.50. St. Louis, C. V. Mosby Company, 1953.*

This is doubtless the best book that has been prepared on ballistocardiography. The book is compact, the printing is excellent, the illustrations are well presented, and the text is as clear as it is reasonable to expect of a subject that is relatively new to the practitioner. Let it be clear that this is no book for general practitioners, nor is it at present a very useful book for specialists in heart disease. The usefulness of the book would be confined to those who are interested in ballistocardiography as a sort of research tool. It has not definitely been determined that this is an instrument of value in clinical medicine. The reviewer spent a day recently with Dr. Isaac Starr, the father of ballistocardiography, who still feels there is a future usefulness for the subject. He did not encourage the reviewer to buy a type of ballistocardiograph used by Dr. Dock and his coauthors because it is impossible to standardize the type of instruments used. Of course, the cumbersome type that Dr. Starr uses can be standardized very well. Despite the fact that the author's instruments cannot be standardized, they measure wave lengths and derive conclusions from them. Certainly, on a research basis, this would be a debatable procedure.

Dr. Dock, the senior author, has been a pioneer in so many adventures in medicine and has been right so many times—though, as with all pioneers, he is sometimes wrong—it would not surprise the reviewer to find that the above statements in regard to the clinical use of this instrument will be archaic some day.

[5]**Modern Clinical Psychiatry**

ARTHUR P. NOYES, M. D., *Superintendent, Norristown State Hospital, Norristown, Pa.; Associate Professor of Psychiatry, Graduate School of Medicine, University of Pennsylvania. Fourth edition. 609 pages. $7. Philadelphia, W. B. Saunders Company, 1953.*

The fourth edition of this standard textbook has been revised considerably. The various entities are classified according to the most recent classification of the American Psychiatric Association, and the text is much more in accordance with present concepts concerning personality disturbances.

The work is definitely one of the better textbooks, designed primarily for the student and the general practitioner. Like previous editions, it covers all of the major entities in a comprehensive fashion, yet in simple enough language so that the nonpsychiatrist physician can understand the terminology. It does retain sufficient dynamic material to be of real interest in spite of this simplification.

All forms of psychiatric treatment are adequately discussed. The reader would do well to keep this as a reference book. The reviewer finds it helpful in organizing material for teaching medical students.

[4]*Samuel A. Shelburne, M. D., F.A.C.P., Dallas.*
[5]*Howard M. Burkett, M. D., Dallas.*

[6]**Mechanisms of Urologic Disease**

DAVID M. DAVIS, M. D., *Professor of Urology Emeritus, Jefferson Medical College, Philadelphia. 156 pages. $4.50. Philadelphia, W. B. Saunders Company, 1953.*

This small book is a new approach to urologic pathology, namely, from a physiologic rather than an anatomic viewpoint. It is organized on the basis of eight different types of pathologic changes: obstruction, infection, stone formation, neoplasm, congenital malformation, trauma, foreign body, and neurogenic, dealing with each as it applies to the entire urogenital tract.

The author, well qualified by a lifetime of teaching and practice of urology, presents a work that beginners and general practitioners can use to systematize the body of urologic knowledge and from which the urologic specialist can benefit in gaining a new viewpoint of urologic pathology. It has a minimum of charts and tables, and the bibliography is rather extensive; hence, it is easy to read and serves well as a lead to further study if one is interested in any particular phase.

[7]**Drug Addiction Among Adolescents**

Sponsored by the Committee on Public Health Relations of the New York Academy of Medicine with the assistance of the Josiah Macy, Jr. Foundation. 320 pages. $4. New York, Blakiston Company, 1953.

This book is a compilation of two conferences held at the New York Academy of Medicine on November 30, 1951, and March 13 and 14, 1952. They were sponsored by the Committee on Public Health Relations and all agencies interested in the problem were asked to attend and to contribute information. The thinking of authorities in medical, psychiatric, sociologic, educational, and law enforcement fields is presented.

The roots of ill health no longer are sought only in the physical environment, but are found in psychologic and social fields. The World Health Organization has defined health as including "physical, psychological, and social well-being." With this in mind, representatives of the physical, biologic, and social sciences are needed in this field of adolescent problems as particularly identified in the use of drugs. There is an urgent need for more effective cooperation between the varieties of professions and agencies in both prevention and treatment of drug users. A result of the conference was the fact that addiction must be seen, not as a problem of moral degeneracy, nor merely as a failure of law enforcement, but rather as one symptom of the serious deprivations suffered by many children in crowded cities.

Medicine has a special role of leadership in this situation because medicine is both a biologic science and a social science, while the newer understanding of psychosomatic relations provides a bridge across the gap which heretofore has so sharply divided the biologic from the social sciences. One fact especially stands out: the continuation of drug use depends to a great extent on the euphoria the individual receives. A new drug, N-allyl-nor-mor-phine, which counteracts the effects of morphine, is being developed. It also can be used in the identification of addicts.

The report of this conference is of interest to any social agency and any lay person interested in the adolescent. Physicians as members of a social order as well as being directly responsible for the well-being of their communities would do well to read it. The psychiatrist and the general

[6]*Emile Maltry, Jr., M. D., Wichita Falls.*
[7]*Mrs. A. B. Pumphrey, Fort Worth, Chairman, Committee on Mental Health, Woman's Auxiliary to the Texas Medical Association.*

practitioner will find much of recent findings in the problems and treatment of the adolescent drug user to help them.

Holt Pediatrics

L. EMMETT HOLT, JR., M. D., *Professor of Pediatrics, New York University College of Medicine; Director, Children's Medical Service, Bellevue Hospital; Rustin McIntosh Carpentier Professor of Pediatrics, Columbia University; and Director of the Pediatrics Service in the Babies Hospital, New York. Twelfth edition. 1542 pages. $15. New York, Appleton-Century-Crofts, 1953.*

The last previous edition of this standard textbook was published in 1940. The new edition has been completely rewritten by the author and sixty-nine collaborators, who have succeeded in presenting a complete, up to date textbook for students which also should be a desk reference for all practicing physicians.

New drugs and their applications are fully discussed. Modern concepts of mental diseases in children are presented in a readable form. The new chapter on disturbed fluid and electrolyte balance is of special interest.

Second Annual Report on Stress

HANS SELYE, M. D., Ph. D. *(Prague)*, D. Sc. *(McGill)*, F.R.S. *(Canada), Professor and Director of the Institut de Médecine et de Chirurgie expérimentales, Université de Montréal, and* ALEXANDER HORAVA, M. D. *(Lausanne), Research Associate and Librarian of the Institut de Médecine et de Chirurgie expérimentales, Université de Montréal. 526 pages. $10. Montreal, Canada, Acta, Inc., Medical Publishers, 1952.*

This is the second annual supplement to "Stress," which was published by Dr. Selye in 1950. The book is divided into two parts, general physiology and pathology of stress and special physiology and pathology of stress. The section on principal objections against the stress concept is well presented and many references are given. The bibliography is arranged alphabetically by author. More than 4,000 publications were noted and the literature for 1951 is reviewed. The book is essentially a reference tool for medical librarians and endocrinologists. The book is easy to use, and the material on any special subject can be found in the detailed subject index.

[8]Antibiotics

ROBERTSON PRATT, Ph. D., *Professor of Pharmacognosy and Plant Physiology, University of California College of Pharmacy; Consultant on Antibiotics; and* JEAN DUFRENOY, D. Sci. *(Paris), Research Associate in Antibiotics, University of California College of Pharmacy. Second edition. 398 pages. $7.50. Philadelphia, J. B. Lippincott Company, 1953.*

This book was written to "present in a succinct, integrated plan the facts and principles of fundamental and permanent value relating to antibiotics." The material as presented in the first edition has been revised and new material included in the second edition in the light of some 7,000 research papers which have appeared in the four year interval following the publishing of the first edition.

The presentation has been organized into four parts: fundamental aspects, industrial aspects, applied aspects, and modification of biologic and social systems. The fundamentals of antibiosis; the production and control aspects; the individual antibiotics with their general uses in the medical, dental, and veterinary fields; resistant strains of microorganisms; and the mechanism of antibiotic action are covered along with some interesting thoughts on the social and economic aspects of antibiotics.

The type of the book is large and easily read, and there are numerous aids in the form of charts, graphs, and diagrams. The volume is sufficiently comprehensive to be informative to one interested in the health sciences and contains numerous references of suggested reading material for the person who wishes to develop the subject in more detail.

[9]Managing Your Coronary

WILLIAM A. BRAMS. *158 pages. $2.95. First edition. Philadelphia, J. B. Lippincott Company, 1953.*

The purpose of this book is to give patients with coronary thrombosis "a better understanding of the nature of their illness, the aim of treatment and the prospects for useful employment after the attack has subsided." Various aspects of incidence, etiology, pathology, diagnosis, therapy, convalescence, and rehabilitation and reemployment are ably discussed in nontechnical language. The subject matter is medically accurate, and where controversial matters are discussed, the author generally prefers the conservative approach but presents the various shades of opinion without bias.

The one objection is the part of the chapter on diagnosis which relates to history taking, physical examination, and differential diagnosis. This could be deleted since it serves neither of the three purposes for which the book was written, adds unnecessarily to its length, and offers the author too great an opportunity to recount his successes in diagnosis and to use the pronoun "I" much too frequently. The mood of this section is evident on page 48: "In the light of this combination of symptoms, his doctor wisely put him to bed and called me in on the case."

Except for this criticism, this book may be read with profit by patients wishing more detailed information about their disease, but the impersonal printed page can never substitute for the specific instructions and warnings directed to the patient by his own physician.

[10]A Textbook of Orthopedics

With a Section on Neurology in Orthopedics. M. BECKETT HOWORTH, M. D., *Clinical Professor of Orthopedic Surgery, New York University Post-Graduate Medical School. 1,110 pages. $16. Philadelphia, W. B. Saunders Company, 1952.*

Dr. Howorth has chosen a Herculean task in presenting a new textbook in a field where so many have failed. The effort is laudable and deserving of praise. However, the reviewer feels that this volume, in its inaugural edition, leaves much to be desired before it finds a niche among the classics.

The author has divided the text into four sections to avoid confusion and repetition. The initial section of "Introduction and Basic Principles" concerns mainly a history of orthopedic surgery and a fundamental description of the anatomy and physiology of the musculoskeletal system. The latter is much too general in scope for value and will undoubtedly be one of the generally unread portions of the text.

The second section concerns regional orthopedics and serves only as a classification to include one of the brighter aspects of the book, that being the fine discussion of the hand written by Dr. J. William Littler, a contributor. It is of significance that twenty-two pages of this section are devoted to posture and obesity with only three pages dealing with the shoulder, shoulder girdle, and elbow.

[8]*Stephen B. Longino, Jr., M. D., Sulphur Springs.*

[9]*Sidney Schnur, M. D., Houston.*

[10]*David R. Oliver, M. D., San Antonio.*

The third section, entitled "Orthopedic Disorders," actually contains the meat of the volume, so far as orthopedic surgery is concerned. The sections on congenital anomalies and metabolic disorders contributed by Dr. Donovan J. McCune are excellent. The author's discussion of congenital dislocation of the hip and slipped femoral epiphysis indicates his thorough knowledge and study of these subjects. The discussion of fractures, infections of bone, and bone tumors is incomplete for advanced students or practitioners.

The final section contributed by Dr. Fritz Cramer and entitled "Neurology in Relation to Orthopedic Surgery" is the highlight of the volume. These 180 pages contain a clear, concise treatise on neurologic conditions of interest to all orthopedic surgeons. If for no other reason, this last section is justification for this textbook.

[11]Fractures and Joint Injuries

SIR REGINALD WATSON-JONES, M. Ch. Orth., F.R.C.S., F.A.C.S. *(Hon.), Orthopedic Surgeon to His Majesty the King; Director of Orthopedic and Accident Service, London Hospital; Senior Surgeon to the Robert Jones and Agnes Hunt Orthopaedic Hospital. Fourth edition. Volume 1, 443 pages. $22 per set. Baltimore, Williams and Wilkins Company, 1952.*

This is the first volume of the fourth edition of Watson-Jones. The preceding sentence sounds much like a biblical reference, and as such it might well be considered. This text, in its past three editions, has become a "Bible of Fractures and Dislocations" in the orthopedic world.

Although the general appearance of this volume is similar to its predecessor, the contents and illustrations are considerably altered, chiefly by addition. New chapters dealing with shock and the adaptation syndrome have been added. The lessons learned in World War II are evident in revised chapters on compound fractures, open reduction (including intramedullary nailing), vascular injuries, and nerve injuries. The unique chapter on clinical and radiologic diagnosis continues, as in previous editions, to be a stimulating method of teaching and information. Many new illustrations, frequently in color, add to the beauty of this new volume.

Because of the concise, often dogmatic, method in which the subject matter is presented, Watson-Jones will always be a favorite with students and orthopedists the world over. This new edition certainly justifies its eminent position in medical literary classics.

[12]Practical Blood Grouping Methods

ROBERT L. WALL, M. D., *Department of Research Medicine, Ohio State University Hospital, Columbus; Formerly, Blood Research Section, Department of Biologic Products, Army Medical Department Research and Graduate School, Washington, D. C. A Monograph in the Bannerstone Division of American Lectures in Hematology. 175 pages. $5. Springfield, Ill., Charles C Thomas, 1953.*

This book represents another monograph in the American lecture series which has embodied many different subjects. As such, it attempts a wide coverage in a short space, making it considerably less informative than the standard works on blood antigens and antibodies and the techniques involved in their manipulations, and possibly making it more comprehensive than the usual reviews in standard journals dealing with this subject. The bibliography is satisfactory. Certain techniques are satisfactorily outlined, but in general interpretation is limited. In view of the availability of more comprehensive works, this book seems best suited as an introduction to the subject for those entering this field. It cannot be recommended as a standard reference.

[13]Therapeutics in Internal Medicine

By Eighty-Four Authorities. Edited by FRANKLIN A. KYSER, M. D., F.A.C.P., *Assistant Professor of Medicine, Northwestern University Medical School, Chicago; Attending Physician, Evanston Hospital, Evanston, Ill. Second edition. 830 pages. $15. New York, Paul B. Hoeber, Medical Book Department of Harper and Brothers, 1953.*

This volume has been prepared by eighty-four authorities whose teaching experience and investigations in the field of internal medicine have been outstanding. The commonly accepted methods of therapy are given in addition to some of the preferences of the authors. Even though this book has been published fundamentally as a reference to treatment of internal diseases, it does have a liberal amount of clinical and basic science considerations to make treatments described more understandable.

The arrangement of the book is excellent and the type easy to read, making quick reference easy. There is in addition a final chapter on symptomatic treatment which is excellent and complete. Even though the treatment of many symptoms is discussed previously in the book, all are collected in one chapter for easy reference. This chapter alone offers many valuable adjuncts for the relief of troublesome and frequently encountered complaints. At the end of the final chapter is an appendix of useful diets and tables. In general the statements on dosage are given clearly, accurately, and in detail. Such an excellent volume as this on therapeutics in internal medicine should find great appeal and usefulness not only to the internist but also to those doing general work who need quick and complete reference to treatment of disorders of internal medicine.

[14]Unipolar Lead Electrocardiography and Vectorcardiography

EMANUEL GOLDBERGER, M. D., F.A.C.P., *Cardiologist and Attending Physician, Lincoln Hospital, New York; Lecturer in Medicine, Columbia University. Third edition. 601 pages. $10. Philadelphia, Lea & Febiger, 1953.*

This textbook of electrocardiography is written in a clear and concise style. It will serve the beginner as well as the more experienced student of electrocardiography in everyday interpretation of electrocardiographs. The first section gives the principles of electrocardiography. A discussion of the normal electrocardiogram comprises the second section. Abnormal electrocardiography patterns are presented in section three. Section four deals with normal and abnormal cardiac rhythms. The final section on vectorcardiography is the best the reviewer has read on this rather complicated subject.

This book is recommended without reservation as a basic text for the clinician who studies electrocardiograms made on his patients and wishes to keep abreast of developments in the field.

[15]Office Management of Ocular Diseases

WILLIAM F. HUGHES, JR., M. D., *Professor and Head, Department of Ophthalmology, University of Illinois College of Medicine; Ophthalmologist-in-Chief, Illinois Eye and Ear Infirmary, Chicago. 452 pages. $9. Chicago, Year Book Publishers, 1953.*

Although this book could much more appropriately be called a "handbook" because it contains much more than

[11]*David R. Oliver, M. D., San Antonio.*
[12]*E. E. Muirhead, M. D., Dallas.*
[13]*Alfred L. Lane, M. D., Corpus Christi.*
[14]*Horace L. Wolf, M. D., Amarillo.*
[15]*James D. McCall, M. D., Mineral Wells.*

pertains to "office management," it is nevertheless a competent work, interesting and useful to both the general practitioner and the specialist. The author has stated in his preface that the chapters on beta irradiation and chemical burns show his special interest; it seems to the reviewer that he might have added two more chapters, those on diseases of the conjunctiva and on the cornea, which are in themselves worth the price of the book. These are done carefully and, although comprehensive in their content, are so constructed that the busy practitioner can use them as a quick reference to almost any phase of the subject matter. It is true that there is some material in the book that could be deleted, such as physiologic optics, but the author has endeavored to include as much diagnostic and treatment material as possible to make this book worth while.

The illustrations and the tables are first rate although it is to be regretted that the former are all black and white. The ophthalmic formulary is the last chapter in the book and seems to be as up to date and complete as one could expect in a textbook of this kind.

As a whole this book is well done and would be an asset to any ophthalmologist's book collection as well as that of the general practitioner.

[16]Diseases of Children

Edited by ALAN MONCRIEFF, C.B.E., M. D., F.R.C.P., *Nuffield Professor of Child Health, University of London, and* PHILIP EVANS, M. D., M. Sc., F.R.C.P., *Physician to the Children's Department and Director of the Department of Child Health, Guy's Hospital. Fifth edition. Volume 1, 1014 pages; Volume 2, 1973 pages. Both volumes $21. London, Edward Arnold and Company, 1953. Distributed by Williams and Wilkins, Baltimore.*

"Diseases of Children" consists of two volumes with contributions from fifty authors. The book, published first in 1913, is an outstanding contribution from Great Britain to pediatrics. Of particular interest is the chapter on vital statistics and administrative aspects, which delves into the early history of infant mortality in England. New sections in this edition include causes of congenital malformations, growth and development, drug therapy, endocrine disorders, and congenital heart disease. The chapter on infant feeding presents views in keeping with newer methods and concepts prevalent in the United States. In general, this edition is similar to standard American textbooks on pediatrics. There are numerous illustrations, tables, photographs, and roentgen-ray prints which add immeasurably to the volume. Of interest is the style in which it is written. This treatise on pediatrics should be a valuable addition to any medical library.

[17]The Obstetrical Forceps

L. V. DILL, M. D., F.A.C.S., *Assistant Professor, Obstetrics and Gynecology, Georgetown University School of Medicine, and Consultant, Obstetrics and Gynecology, Army Medical School and Walter Reed General Hospital, Washington, D. C. 156 pages. $5.25. Springfield, Ill., Charles C Thomas, 1953.*

This book is the first attempt to reach publication devoting itself entirely to this subject. It is a readable book with a large number of illustrations. It covers briefly the history of forceps, indications for their use, technique, and complications. It covers briefly the various types of forceps and gives the author's version of how they should be used.

The mechanics of delivery and forceps application are perhaps oversimplified, and one is left with the impression that the use of forceps is of less importance in general practice than it actually is.

It is hardly the type of book that could be used as a textbook and adds little to what has been written in standard textbooks.

[18]The Radiology of Bones and Joints

JAMES F. BRAILSFORD, M. D., Ph. D., F.R.C.P., F.I.C.S. (Hon.), *Emeritus Director of Radiological Studies in Living Anatomy, University of Birmingham; Consulting Radiologist to the Queen Elizabeth Hospital, Royal Orthopaedic Hospital, Accident Hospital and Warwickshire Orthopaedic Hospital. Fifth edition. 875 pages. $19. Baltimore, Williams and Wilkins Company, 1953.*

"The Radiology of Bones and Joints" is a comprehensive and completely illustrated text on all diseases of the bones and joints. The author has correlated the literature with his long experience in radiology, pathology, and clinical medicine in publishing this textbook.

Each disease in the bones and in the joints is illustrated, and the pathology, along with the diagnosis, is discussed. The book is valuable as a reference text, especially in the fields of radiology, orthopedics, and general practice.

The author is a senior British radiologist whose authority was recognized by an invitation to speak in America. He spent two months speaking in most of the medical centers in 1949.

[19]Diuretic Therapy

ALFRED VOGL, M. D., *Assistant Professor of Clinical Medicine, New York University College of Medicine; Formerly, Associate Visiting Physician, Policlinic Hospital, Vienna, and Clinical Assistant, Guy's Hospital Medical School, London. 248 pages. $5. Baltimore, Williams and Wilkins, 1953.*

This is the initial edition of a small book which should prove useful for the internist, the practitioner of general medicine, and the intern. Dr. Vogl has done a commendable job of distilling clinically helpful information from 725 bibliographic references and from his personal experience with the rational and scientific exhibition of diuretic medications.

Naturally, there are some facets in the treatise concerning which shadings of contrary opinion may be expressed. Some practitioners would be reluctant to administer intramuscularly a certain drug to a patient who had previously manifested a definite hypersensitive systemic reaction to that drug given intravenously. Concerning Decholin it is stated, "There is no evidence of toxicity . . . in man." A recent report of a serious untoward reaction to the injection of a small amount of Decholin probably warrants qualification of this statement. The author's views on safe dosage schedules for the administration of organic mercurial diuretics may be challenged by some as too heroic. The emergence of diuretic carbonic anhydrase inhibitors apparently has postdated the writing of this book.

This reviewer especially appreciated Dr. Vogl's concise and readable literary style, the orderly way in which he organized and presented the essence of a tremendous subject, and the major substance of his views relating to the clinical use and abuse of diuretic agents. The chapter on antidiuretic agents is considered particularly meritorious.

It is felt that there is a deserved space for "Diuretic Therapy" in the library of the physician who has occasion to employ diuretic therapy.

[16]*Donald H. McDonald, M. D., Abilene.*
[17]*M. D. McCauley, M. D., Austin.*
[18]*L. M. Vaughan, M. D., Houston.*
[19]*James Y. Bradfield, M. D., Dallas.*

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION

PHYSICIANS STUDY

A preliminary report by the American Medical Association's Council on Medical Education and Hospitals finds that the average practicing physician devotes the equivalent of 83.3 eight-hour days a year to keeping up with what is happening in the field of medicine. This survey is based on data compiled on personal visits to more than 220 institutions engaged in postgraduate medical education and questionnaires filled out by 5,000 physicians from a random sample of 17,000 practicing physicians throughout the country.

The survey shows that more than 41,000 practicing physicians took some form of postgraduate medical course last year. Physicians responding to the questionnaire indicated that about one-third of the time spent in continuing their education is devoted to medical reading and another one-third to professional contacts. The remaining one-third is devoted to hospital staff meetings, attendance and participation in medical society and specialty group meetings at the local, state, and national level, and postgraduate courses.

The chief reason listed for not taking postgraduate courses is the lack of someone to take care of patients while the physician is away. More than 90 per cent of the responding physicians felt that the maximum time they could be away from their practice was less than fifteen days.

The final report on the survey is expected to be ready about the middle of the year.

TEXAS MEDICAL ASSOCIATION

ENTERTAINMENT FOR ALL

In addition to having outstanding guest speakers and a full schedule of scientific meetings at the annual session, a wealth of opportunity for a good time exists for Association and Auxiliary members and guests from the time they arrive at the convention city until the time they depart. The Committee on General Arrangements hopes that each person will take time to attend the parties and entertainment provided.

Perhaps the highlight of the social life at the convention this year will be the President's Party with Buffet, Tuesday, May 4, beginning at 7:30 p. m. This will be held at La Villita, a restored Spanish town with all the atmosphere of "A Night in Old San Antonio," which the entertainment is scheduled to depict. After the buffet Eddie Martinez and his company of 18 performers will entertain, and there will be dancing from 10:30 until 12:00 midnight.

The General Meeting Luncheon Wednesday, May 5, will be open to members of the Association, Woman's Auxiliary, guests, and visitors, as will be the President's Party. This event will be in the Grand Ballroom, Gunter Hotel, at 12:30 p. m.

In addition to the larger group entertainment, banquets for alumni groups have been planned for May 3 at 6 p. m. Banquets have been arranged for the University of Texas Medical Branch, Baylor University College of Medicine, Southwestern Medical School, Tulane University, Louisiana State University, the University of Tennessee, and Vanderbilt University. Dr. William D. Montgomery is general chairman, and Dr. William M. Center is co-chairman.

Fraternities have planned parties for May 4 from 6:30 until 8:00 p. m. Alpha Kappa Kappa, Nu Sigma Nu, Phi Beta Pi, Phi Chi, Phi Delta Epsilon, Phi Rho Sigma, and Theta Kappa Psi fraternities have arranged for parties at the convention. Dr. William J. Johnson, Jr., is general chairman.

Of interest to many Association members will be the Texas Medical Association Golf Tournament at the San Antonio Country Club, May 3, 1:00 p. m. Prizes will be awarded to winners of the golf tournament. The chairman is Dr. John B. Case.

Tickets should be bought or reservations made to participate in these various events promptly. Details for all events appear in the program in the March JOURNAL, pages 172-191.

Williston Becomes Assistant Executive

C. Lincoln Williston assumed the duties of assistant executive secretary of the Texas Medical Association on April 2.

During the past seven years, Williston has been manager of public relations for the University of Illinois Medical Center in Chicago. In addition, he was chairman of the Medical Schools Section, American College Public Relations Association; lecturer in public relations, Northwestern University; and chairman, Section on Public Relations, Tri-State Hospital Assembly.

Williston was awarded the bachelor of science degree by the University of Illinois in 1942 and served as a captain with the United States Air Force on Guam during World War II. He is married and has two daughters, aged 5 and 3 years.

NEW APPOINTEES ANNOUNCED

Dr. Tate Miller, Dallas, a member of the Committee on Medical History of the Texas Medical Association, was named April 5 to the chairmanship, which had been vacant since the death July 31, 1953, of Dr. H. R. Dudgeon, Sr. of Waco. At the same time Dr. Felix P. Miller, El Paso, was appointed to fill the vacancy on the committee.

Also named to serve the Association was Dr. J. C. Terrell, Stephenville, appointed by the President as a special delegate to the Private Hospitals and Clinics Association of Texas.

Dr. J. M. Travis, Jacksonville, resigned April 12 as chairman and a member of the Library Endowment Committee. Dr. Travis is secretary of the Association.

COUNTY SOCIETIES

Bell County Society

February 3, 1954

(Reported by F. M. Hammond, Secretary)

Diagnosis and Treatment of Face Pain—W. A. Johnson, D.D.S., Temple.

Bell County Medical Society met at Temple on February 3 for a business meeting. After Dr. Johnson presented the above paper, J. C. Walker discussed it.

A brief report of the third annual meeting of county medical society presidents and secretaries was given by F. M. Hammond, Jr.

Bowie County Society

January 14, 1954

Ambrose Storck, New Orleans, professor of clinical surgery at Tulane University, gave a scientific lecture at the

January 14 meeting of the Bowie and Miller Counties Medical Societies at Texarkana.

Brazoria County Society

February 25, 1954

(Reported by Carlos E. Fuste, Jr., Secretary)

Chemotherapy of Leukemia—Robert Hettig, Houston.

The Brazoria County Medical Society met at a dinner meeting February 25 at the Community House in Freeport and heard the above speaker. The president, William D. Nicholson, presided over the business meeting.

Cameron-Willacy Counties Society

February 15, 1954

(Reported by Harry A. Miller, Executive Secretary)

Diagnosis in Problem of Gallbladder Disease—Robert Nixon, San Antonio.

The Cameron-Willacy Counties Medical Society met with its auxiliary February 15 for a dinner at San Benito. Seventy-one were present. The above scientific report was given, and a question and answer period followed.

James C. George withdrew as chairman of the board of censors so that he might have more time for his duties as president of the society. John Brown, San Benito, was nominated to serve in his place.

Cass-Marion Counties Society

January 13, 1954

Diseases of Colon and Their Surgical Treatment—William M. Dawson, Texarkana.

Radiological Findings in Colon Disease—Cyrus P. Kline, Texarkana.

After a dinner with the woman's auxiliary, the following officers were elected for Cass-Marion Counties Medical Society at the January 13 meeting in Atlanta: James Brooks, Jr., Atlanta, president; A. J. Woods, Jefferson, vice-president; Roy S. Bucy, Linden, secretary; and William Terry, Jefferson, delegate.

The above scientific program was heard by the society.

Cherokee County Society

January 26, 1954

Mr. N. C. Forrester, Austin, executive secretary of the Texas Medical Association, spoke to the Cherokee County Medical Society at its January 26 meeting in Rusk. Mr. Forrester spoke on forthcoming legislation concerning the medical profession.

New officers of the society are Harbert Davenport, Jr., Jacksonville, president; F. H. Brigham, Rusk, vice-president; and T. H. Cobble, Rusk, secretary.

Clay-Montague-Wise Counties Society

January, 1954

New officers of Clay-Montague-Wise Counties Medical Society are David Bryant, Bridgeport, president; L. L. Pickett, Henrietta, vice-president; Harold Shilling, Bridgeport, secretary-treasurer; J. T. Darwin, Decatur, delegate; J. H. Valcki, Decatur, board of censors; and John Major, Nocona, alternate delegate.

Cooke County Society

January 18, 1954

Allergy—James Holman, Dallas.

New officers of the Cooke County Medical Society were installed at the January 14 meeting at Gainesville. They are Ben Fisch, president; Ira Thomas, vice-president; George Evashwick, secretary; Charles Mills, delegate; and Dr. Thomas, Vincent Cirone, and Silas Yarbrough, censors.

Dr. Holman's speech emphasized new treatment of asthma.

Dallas County Society

January 14, 1954

Frank A. Selecman was installed as president of the Dallas County Medical Society at a dinner January 14 attended by 400 members and their guests. Mr. Clarence Manion, former dean of the law school at Notre Dame University and more recently chairman of the Commission on Intergovernmental Relations, was the principal speaker. Other officers installed were Harry M. Spence, vice-president; R. A. Trumbull, president-elect; Glenn D. Carlson, secretary; and Porter K. Mason, treasurer. W. W. Fowler was named secretary emeritus and presented an appreciative plaque for thirty-four years of service to the society as its secretary.

Falls County Society

January 26, 1954

Falls County Medical Society met in Marlin January 26, and heard Franklin G. Ebaugh, a Denver psychiatrist, speak on what constitutes normality.

Gregg County Society

January 24, 1954

Gregg County Medical Society met January 24 in a joint session with the East Texas chapter of the American Academy of General Practice. Speakers for the meeting were W. P. Devereux, gynecologist; T. Haynes Harvill, internist; and J. E. Miller, Jr., radiologist. The speakers were from the Southwestern Medical School of the University of Texas, Dallas.

Hale-Floyd-Briscoe-Swisher Counties Society

February 9, 1954

(Reported by John C. Long, Jr., Secretary)

Problem of Differential Diagnosis with Patients with Chest Pain—Horace L. Wolf, Amarillo.
Discussion—M. C. Schlecte, Plainview.

At the February 9 meeting of the Hale-Floyd-Briscoe-Swisher Counties Medical Society in Plainview, the above scientific program was presented. N. E. Greer, Lockney, was elected to honorary membership. It was announced that Wa T. Mok, Amarillo, would speak at the March meeting.

March 9, 1954

(Reported by John C. Long, Jr., Secretary)

Treatment of Burns—Dr. Wa T. Mok, Amarillo.

John C. Long led a discussion of the above subject after Dr. Mok spoke. The regularly scheduled April meeting was cancelled so that members might attend the Third District Medical Society meeting.

Harris County Society

February 10, 1954

(Reported by Mrs. W. M. Palm, Public Relations Secretary)

Functional Dyspepsia—Belton G. Griffin, Houston.

The Harris County Medical Society met February 10 at the Baylor University College of Medicine Auditorium, Houston. Following the presentation of the above discussion, the business meeting was held.

The society voted to levy an assessment of $18 for the remainder of 1954 to pay the society's pro rata share of maintenance of the new Houston Academy of Medicine Library Building. An additional $2 assessment was made to employ additional personnel for the executive office.

It was announced that it would be necessary to amend the society's by-laws to fill the office of president-elect, which is vacant due to the sudden death of L. E. Williford. The amendment was read, and the election will be held at an early date.

The medical jurisprudence and public relations board and the veterans affairs committee announced a special meeting which they will sponsor on February 24, with a distinguished panel of speakers discussing current problems facing the medical profession. Ernest B. Howard, Chicago, assistant secretary of the American Medical Association, will speak on the "President's Health Program and the AMA Position." F. J. L. Blasingame, Wharton, President-Elect of the Texas Medical Association, will discuss "Implementing the Program on a Local and State Basis," and Everett C. Fox, Dallas, will speak on the "Veteran Problem."

Hidalgo-Starr Counties Society

January 15, 1954

Aspects of Blood Coagulation—H. E. Whigham, McAllen.

Paul H. Frenzel, Donna, was installed as president of the Hidalgo-Starr Counties Medical Society at a January 15 meeting at Pharr. Separate business meetings were held after a joint dinner by the society and its woman's auxiliary.

Limestone County Society

January 5, 1954

New officers were elected at the Limestone County Medical Society meeting January 5 at Mexia. T. R. Wilson, Groesbeck, was reelected president; G. C. Smith, Jr., Mexia, was named vice-president; and Stanley Cox, Groesbeck, was reelected secretary.

Lubbock-Crosby Counties Society

February 2, 1954

(Reported by Richard K. O'Loughlin, Secretary)

Vaginal Hysterectomy Without Prolapse—Joseph Kelso, Oklahoma City.
Discussion—Charles Nash, Sam Dunn, and Warren B. Poole, Lubbock.

The Lubbock-Crosby Counties Medical Society met February 2 in Lubbock for a business and scientific session.

A telegram from the chairman of the Council on Medical Jurisprudence of the Texas Medical Association was read urging members to send requests for support of the Bricker Amendment to Texas Senators.

An invitation from R. A. Reid, Levelland, secretary of the Lamb-Bailey-Hockley-Cochran Counties Medical Society, was read inviting society and auxiliary members to hear Clifford Snyder, Galveston, speak on February 5 in Levelland.

Warren B. Poole introduced the guest speaker, who delivered the above discussion and presented a film of the surgical procedure. Dr. Kelso also showed slides demonstrating foreign bodies found in his practice.

March 3, 1954

(Reported by Richard K. O'Loughlin, Secretary)

Treatment of Acute Hand Injuries—William Waldrop, Oklahoma City.

The Lubbock-Crosby Counties Medical Society met March 3 in Lubbock to hear Dr. Waldrop's speech, which was accompanied by slides demonstrating hand and finger injuries and surgical repair.

Frank C. Goodwin, president, reported on the third annual Conference for County Society Presidents and Secretaries.

Nueces County Society

February 9, 1954

(Reported by Gerald S. Ahern, Secretary)

At the February 9 meeting of the Nueces County Medical Society in Corpus Christi, John Howard, assistant professor of surgery at the Baylor University College of Medicine, Houston, discussed his experiences on the Korean battle front.

Polk-San Jacinto Counties Society

January 8, 1954

Ivison Grimes, Camden, was elected president of Polk-San Jacinto Counties Medical Society at its January meeting in Livingston. Also elected were Joe T. Dabney, Jr., Livingston, vice-president, and Paul C. A. Singleton, Corrigan, secretary-treasurer.

Runnels County Society

January 7, 1954

Runnels County Medical Society met January 7 in Ballinger and elected John E. Green, Jr., president; Lloyd Downing, vice-president; Glenn Jones, secretary-treasurer; O. H. Chandler, board of censors; and Charles F. Bailey, delegate. All of the officers are from Ballinger.

Tarrant County Society

February 2, 1954

(Reported by S. W. Wilson, Secretary)

Symposium on Diagnosis and Treatment of Hemoptysis—James O. McBride, Douglas E. Bibby, and John Wiggins, Fort Worth.

Seventy-three members of the Tarrant County Medical Society heard the above scientific discussion when the Tarrant County Medical Society met February 2 in Fort Worth.

Elected to membership were Darrell W. Boren, R. L. Campbell, Werner H. Frietsch, Lee Ray Lawson, James H. Mann, Virginia G. Russell, Henry G. Stephenson, Jr., and Raymond R. Thomas.

Ernest E. Anthony, Jr., gave a detailed report for the legislative committee.

February 16, 1954

(Reported by S. W. Wilson, Secretary)

Tarrant County Medical Society met February 16 in Fort Worth to hear the telephone broadcast originating in Austin, "Recent Advances in Internal Medicine."

Henry G. Gardiner, Jr., was elected to membership in the society.

March 2, 1954

(Reported by S. W. Wilson, Secretary)

Bundie Branch Block—Demetrio Sodi, Mexico, D. F.
Hemodynamics of Compressed Heart by Constrictive Pericarditis—Rudolfo Limon, Mexico, D. F.

At the March 2 meeting of Tarrant County Medical Society in Fort Worth the above scientific program was given by Dr. Sodi and Dr. Limon. Both are professors of medicine at the University of Mexico.

Tom Green-Eight County Society

January 11, 1954

(Reported by Joe L. Cornelison, Secretary)

A called business meeting of the Tom Green-Eight County Medical Society was held January 11. It was decided that the society would not participate in the February or March telephone broadcasts sponsored by the Texas Medical Association. Bills before Congress which would affect health were considered at the San Angelo meeting.

February 1, 1954

(Reported by Joe L. Cornelison, Secretary)

Mental Health—Stephen Weisz, Dallas.

Meeting in joint session with the woman's auxiliary, the Tom Green-Eight County Medical Society heard the above

discussion February 1 in San Angelo, following its business meeting.

Thirty-two members attended the business session, presided over by R. M. Arledge. A motion was passed to allow Mr. John Webb Graham to address the society again regarding his telephone answering service for local physicians.

The society decided that the question of inviting laymen and nonmembers to attend its regular meetings should be decided by the public relations committee.

The society also passed a motion permitting the Planned Parenthood Clinic to have biopsies of and to cauterize cervices when necessary.

March 1, 1954

(Reported by Joe L. Cornelison, Secretary)

At the March 1 meeting of the Tom Green-Eight County Medical Society in San Angelo, the society approved the experimental use of a new poliomyelitis vaccine in San Angelo. Jerome Smith was elected to honorary membership in the society. The scientific program was a discussion on low back pain.

Travis County Society

December 15, 1953

New officers of the Travis County Medical Society were elected at the December 15 meeting at the Texas Medical Association headquarters building in Austin. J. M. Coleman was elected president; Harold L. Williams, vice-president; C. H. McCuistion, secretary; and Sam N. Key, Jr., John F. Thomas, and Charles B. Dildy, delegates.

February 16, 1954

(Reported by C. H. McCuistion, Secretary)

Travis County Medical Society participated in the February 16 telephone postgraduate broadcast on "Recent Advances in Internal Medicine" as the program for the group's meeting at the Texas Medical Association headquarters building in Austin. Members of the faculty of the University of Texas Medical Branch, Galveston, comprised the panel. A film from the American Cancer Society, "Living Insurance," was shown also.

March 9, 1954

(Reported by C. H. McCuistion, Secretary)

Symposium: Diet in Disease—Henry M. Winans, Dallas, Moderator.
Diet in Cardiovascular Disease—Donald Seldin, Dallas.
Diet in Metabolic Disease—Edwin L. Rippy, Dallas.
Diet in Gastrointestinal Disease—Tate Miller, Dallas.

Travis County Medical Society heard the above program, given by Dallas physicians, and broadcast by telephone throughout the state, at the Texas Medical Association building in Austin on March 9.

Wichita County Society

January 12, 1954

Wichita County Medical Society met at the Wichita Falls Country Club January 12 and heard John Goode, professor of surgery at the Southwestern Medical School of the University of Texas, Dallas, speak on surgery in the aged.

James Lee, president, presided over the business meeting at which the society adopted resolutions favoring the Bricker amendment.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

March 9, 1954

(Reported by S. E. Thompson, Secretary)

A panel discussion on anesthesia in general practice, under the direction of C. R. Allen and Leo Duflot, faculty members at the University of Texas Medical Branch, Galveston, was presented at the March 9 meeting of Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society in Richmond.

Wilbarger County Society

January 12, 1954

F. B. Steele was elected president of the Wilbarger County Medical Society January 12 at Vernon. J. J. Slaugenhop is vice-president, and C. Curtis Allen was reelected secretary-treasurer. The official delegate to the 1954 state convention will be A. L. Borchardt.

DISTRICT SOCIETIES

First District Society

February 12, 1954

(Reported by H. D. Garrett, Secretary)

Control of Pain in Childbirth—Celso C. Stapp, El Paso.
Early Diagnosis and Treatment of Congenital Dislocation of Hip—C. A. Robinson, Kermit.
Newer Hypertensive Agents—Ben Cooley, El Paso.
Some Common Eye Conditions That Should Be Recognized in General Practice—Newton F. Walker, El Paso.
Congenital Renal Anomalies as Cause of Pain and Disease—Robert F. Thompson, El Paso.
Early Diagnosis of Tumors of Lung—Maynard S. Hart, El Paso.
Surgical Treatment of Thyroid Disease—Leigh E. Wilcox, El Paso.

The program outlined above was presented at Pecos on February 12 at the annual meeting of the First District Medical Society after a luncheon with the district woman's auxiliary.

New officers were elected as follows: Charles E. Oswalt, Jr., Fort Stockton, president; H. M. Gibson, El Paso, vice-president; and H. D. Garrett, El Paso, secretary-treasurer.

Before the dinner, at which George Turner, El Paso, President of the Texas Medical Association, was speaker, cocktails were served by the Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Medical Society.

Forty-seven members attended.

Mrs. E. W. Coyle, San Antonio, President of the Woman's Auxiliary to the Texas Medical Association, spoke at the auxiliary meeting. About forty wives attended.

Ninth District Society

March 25, 1954

(Reported by Lyman C. Blair, Secretary)

Observations on Tubal Pregnancies—S. D. Coleman, Navasota.
Peptic Ulcer Problem—William T. Arnold, Houston.
Backache: When Can a Urologist Help?—Michael K. O'Heeron, Houston.
Present Status of Steroid Therapy in Rheumatoid Arthritis—Jesse W. Hofer, Houston.
Intra-Articular Use of Hydrocortisone Acetate in Rheumatic Diseases—M. D. Levy, Jr., Houston.
Diagnosis of Herniated Lumbar Disk—Robert J. Goodall, Houston.
Modern Therapy of Severely Injured Patient—John D. Staub, Houston.
Comparative Efficacy of Various Oral Diuretics—Ralph V. Ford, Houston.
Convulsions: Their Significance in General Practice—Henry S. Meyer, Houston.

The program outlined above was presented to members of the Ninth District Medical Society when they met March 25 in Brenham. Guest speaker was Dr. Troy Shafer, Harlingen, chairman of the Committee on Public Relations of the Texas Medical Association.

Thomas H. Giddings, Brenham, was elected president: Joseph T. Dabney, Jr., Livingston, vice-president; Lyman C. Blair, Houston, secretary-treasurer. J. T. Billups, Houston, was nominated Councilor of the district.

AUXILIARY SECTION

COUNTY AUXILIARIES

The *Nueces County Auxiliary* recently conducted an educational program designed to teach the different types of free medical services available to county residents. Tours were conducted through Driscoll Foundation for Children, the Crippled Children's Hospital, and Memorial Hospital during the first week of March by members of the auxiliary. At the February 19 meeting in Corpus Christi, Mrs. E. King Gill was installed as president of the Nueces County Auxiliary. Mrs. Paul Gray is president-elect.

Speakers for the *Travis County Auxiliary* at its January 19 meeting in Austin were Miss Ruby Neubauer, administrator of the Johns Clinic and Hospital in Taylor, who talked on vocational nursing, and Miss Elizabeth King, nursing arts director at Brackenridge Hospital, who discussed professional nursing.

Tarrant County Auxiliary had a guest day luncheon and style show March 12 and a "Tonics and Sedatives" variety show March 27 for the benefit of its nurse scholarship fund. Talent was from auxiliary and medical society members. More than $600 was raised.

The *Bexar County Auxiliary* heard Dr. W. W. Bondurant, Jr., speak on "Community Nursing Service" at its March 12 meeting. The mental health committee furnished a team of workers for the financial drive of the Guidance Institute and Bexar County Society of Mental Health.

Another auxiliary having a program on nursing was *Cass-Marion Counties Auxiliary*. Meeting at the home of Dr. and Mrs. H. L. D. Jenkins, Hughes Springs, on March 10, members heard Mrs. Eva Rabitarle, American Red Cross nurse, speak on home nursing.

Horace Cardwell, administrator of Memorial Hospital, spoke on nurse recruitment to the *Angelina County Auxiliary* at the home of Mrs. T. A. Taylor, Lufkin, January 26. Plans were made for the nurse recruitment drive at the January 15 meeting of *Armstrong-Donley-Childress-Collingsworth-Hall Counties Auxiliary* at the home of Dr. and Mrs. Jack Fox, Childress.

Mrs. K. W. McFatridge was elected president of the *Wichita County Auxiliary* at a dinner meeting January 12 in Wichita Falls. Dr. Bailey R. Collins spoke on "The World Beautiful," illustrating his speech with pictures made during his travels.

Mrs. J. W. Ward spoke on "Medical Legislation" at the January 2 meeting of *Hunt-Rockwall-Rains-Delta Counties Auxiliary* in the home of Dr. and Mrs. S. D. Whitten, Greenville.

Galveston County Auxiliary met January 19 for a business meeting and luncheon. Mrs. John Otto was chairman.

Plans for a tea with proceeds going to the Heart Fund Drive were made at the meeting of *Brown-Comanche-Mills-San Saba Counties Auxiliary* January 12 at the home of Dr. and Mrs. Ernest F. Cadenhead, Brownwood. A film, "How to Catch a Cold," was shown.

Mrs. Ellis McInnis, representing the American Cancer Society, spoke about the necessity for a yearly physical check-up to members of *Taylor-Jones Counties Auxiliary* at the home of Dr. and Mrs. Earl R. Cockrell, Abilene. Officers elected were Mrs. Virgil A. Pate, Jr., president, and Mrs. J. M. Hooks, Jr., president-elect.

Camp-Morris-Titus Counties Auxiliary met January 27 in the home of Dr. and Mrs. R. L. Johnson, Pittsburg, for a business meeting and film, "Good Mental Health." Mrs. William A. Taylor was elected president of the auxiliary at the meeting.

Smith County Auxiliary met February 3 in the home of Dr. and Mrs. S. W. Bradford, Tyler, and heard Mrs. Thomas J. Jarmon discuss state schools for the deaf, blind, and feeble-minded.

Mrs. Haskell D. Hatfield was elected president of the *El Paso County Auxiliary* and Mrs. W. W. Schuessler, president-elect at the March 8 meeting honoring past presidents. The program included a speech by Dr. John Sharp, Texas Western University, on the go-back-to-church movement and a book review, "Dr. Pygmalion," by Mrs. James Gorman. El Paso County Auxiliary is sponsoring a course in nursing and first aid on television.

A luncheon in Denison honoring Mrs. E. W. Coyle, San Antonio, State Auxiliary President, was given by *Grayson County Auxiliary* January 8. Other honored guests were Mrs. Frank Haggard, San Antonio, Past President of State, Southern, and National Auxiliaries; Mrs. O. W. Robinson, Paris, Past State President; Mrs. John Glecker, Denison, First Vice-President of the State Auxiliary; and Mrs. Emmett Essin, Sherman, president-elect of the Fourteenth District. At the Grayson County Auxiliary's February meeting, held in the home of Mrs. Jack McGhee, Sherman, a film on "The Effects of the Atomic Bomb" was shown.

DISTRICT AUXILIARIES

First District Auxiliary

New officers of the Woman's Auxiliary to the First District Medical Society were elected at the February 12 meeting in Pecos. Mrs. A. J. Eck, El Paso, was elected president; Mrs. Hugh Martin, Pecos, vice-president; and Mrs. Charles E. Oswalt, Jr., Fort Stockton, secretary-treasurer. Special guests were Mrs. E. W. Coyle, San Antonio, State President, and Mrs. George Turner, El Paso, National President-Elect.

Twelfth District Auxiliary

The Woman's Auxiliary to the Twelfth District Medical Society met in Waco January 12, with Mrs. Milton Spark, president, presiding over the business session. The slate of officers submitted by the nominating committee was unanimously elected as follows: Mrs. G. V. Brindley, Jr., Temple, president; Mrs. E. B. Fine, Waco, vice-president; Mrs. S. J. Barron, Corsicana, secretary-treasurer; and Mrs. C. R. Miller, Ward, reporter.

A memorial offering was contributed in memory of Dr. O. C. Bowmer and Dr. J. E. McClung, Corsicana; Dr. V. M. Longmire, Temple; and Dr. Howard Dudgeon, Sr., Waco.

The auxiliary joined the society for a luncheon, at which Dr. F. J. L. Blasingame, Wharton, President-Elect of the Texas Medical Association, was guest speaker. His address was "Can Private Practice Survive?"

Those serving on the nominating committee were Mrs. S. H. Burnett, Corsicana; Mrs. F. F. Kirby, Waco; and Mrs. J. H. Johnson, Temple.—Mrs. C. L. Gary, Jr., Corsicana.

Mrs. E. W. Coyle, San Antonio, State Auxiliary President, who spoke on "The Doctor's Wife in Public Service," was a guest at the *Dallas County Auxiliary* meeting February 2. Also honored were Mrs. James Atchison, president of the Woman's Auxiliary to the Fourteenth District Medical Society, and county presidents of District 14.

DEATHS

J. M. JACKSON

Dr. Jacob Marcus Jackson, Port Arthur, Texas, died December 17, 1953, of diabetes, uremia, and hypertensive heart disease. He had suffered a stroke about a year ago, and recently had returned to Port Arthur from a hospital in Louisiana.

Dr. Jackson was born December 6, 1892, at Ratcliff near Crockett and attended Ratcliff public schools before being graduated in 1917 from the University of Tennessee College of Medicine, Memphis. He practiced at Ratcliff for one year, Lufkin for three years, and Port Arthur for more than thirty years. Dr. Jackson maintained an office in Port Arthur, but had not practiced recently because of ill health.

A member of the American Medical Association and Texas Medical Association through Jefferson County Medical Society, Dr. Jackson previously had belonged to Angelina County society, and had been a member of the Phi Chi medical fraternity. He belonged to the Elks Club and the Baptist Church.

Survivors include two daughters, Mrs. Virginia Reese, Houston, and Mrs. Lillian Cooper, Lufkin; a son, John Marcus Jackson, Austin; two sisters, Mrs. Jewel Mackey, Wharton, and Mrs. Claire Logston, Houston; and three grandsons.

C. M. HENDRICKS

Dr. Charles McChristie Hendricks, El Paso, Texas, died December 9, 1953, of cancer.

Dr. Hendricks was born December 5, 1878, in Gratis, Ohio, the son of Dallas C. and Elenora (McChristie) Hendricks. He attended Gratis schools and Miami University, Oxford, Ohio. He was graduated from Medical College of the University of Ohio, Cincinnati, Ohio, in 1905. He interned at National Jewish Hospital in Denver.

An honorary member of the Texas Medical Association since 1952 and a member almost continuously since 1908, Dr. Hendricks was past president of the El Paso County Medical Society and served as chairman of the Committee on Tuberculosis of the Texas Medical Association. He also belonged to the American Medical Association. Dr. Hendricks was past president of the American College of Chest Physicians, and he was awarded its medal for furthering progress in the field of diseases of the chest in 1948. He was a member of the American Trudeau Society, an honorary life member of the Pan American Medical Association, a member of the United States Committee of World Medical Association, director of Research and Education Council of College of Chest Physicians, and executive director of the Common Cold Foundation. He was first editor of *Diseases of the Chest.* He was former medical director of Baldwin and El Paso Sanatoriums and Hendricks-Laws Sanatorium, which he founded. Dr. Hendricks had practiced medicine in El Paso for forty-six years.

Dr. Hendricks was a member of Phi Delta Theta fraternity and the Sons of the American Revolution. He was a charter member of El Paso Rotary Club, an honorary member of Kiwanis, a member of the Masonic Order, past chairman of the American Red Cross in El Paso, and past president of the Gate Way Club. Dr. Hendricks was a member of the Presbyterian Church. He was one of the founders of the Sun Carnival Association.

A colonel in the United States Army Reserve Medical Corps, Dr. Hendricks served during World War I as a lieutenant colonel with the Ninetieth Regiment in San Antonio, Europe, and the Army of Occupation in Germany.

Dr. Hendricks was married to Miss Edith Louise Duguid in Toledo, Ohio, in June, 1905. She survives, as do four daughters, Mrs. James M. Campbell, Jr., Burbank, Calif.; Mrs. George N. Broderson, Jr., El Paso; Mrs. Don B. Thurman, Havana, Cuba; and Mrs. Charles H. Caldwell, Dallas; and three sisters, Mrs. Fred Clawson, Glendale, Calif.; Mrs. H. S. Ebbinghouse, Richmond, Ind.; and Mrs. D. P. Swain, Columbus, Ohio.

M. A. RAMSDELL

Dr. Marshall Albert Ramsdell, San Antonio, died February 22, 1954, in a local hospital of acute leukemia.

Dr. Ramsdell was born in Salado April 4, 1887, the son of Charles Henry and Augusta (Halley) Ramsdell. He was educated in the Salado and Austin public schools; the University of Texas, Austin; and the University of Texas School

DR. MARSHALL A. RAMSDELL

of Medicine, Galveston, from which he was graduated in 1916. Dr. Ramsdell served an internship at John Sealy Hospital, Galveston, and practiced medicine in Santa Anna and Eagle Pass before settling in San Antonio in 1926. He did general practice until moving to San Antonio, when he began specializing in pediatrics. He did postgraduate work at Barnes Children's Hospital, St. Louis.

A member of the American Medical Association and the Texas Medical Association through Bexar County Medical Society, Dr. Ramsdell was also a member of the local and Texas Pediatric Societies. He formerly had been president of the Coleman County Medical Society and secretary of the Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Society.

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

A member of Phi Chi medical fraternity, Dr. Ramsdell helped to found the San Antonio Blood Bank. He served as secretary and director of the local Kiwanis Club, was a Mason, served as director of the Oak Hills Country Club, and was a member of the Central Christian Church. In 1911 he was captain of the University of Texas football team and was chosen All-Southwest Conference tackle the same year. He was well known as a local amateur golfer. Dr. Ramsdell was a captain in the Army Medical Corps in World War I.

He married the former Miss Evelyn Lenz February 7, 1917, in Galveston. Surviving Dr. Ramsdell are his wife; a daughter, Mrs. G. J. Laughead, San Antonio; a son, W. H. Ramsdell, Houston; a sister, Mrs. R. L. Adamson, Glendale, Calif.; and a brother, R. L. Ramsdell, Havertown, Pa.

L. T. WALLER

Dr. LeRoy T. Waller, Commerce, Texas, died December 16, 1953, at his home of coronary occlusion.

The son of Monroe and Allie (Hanson) Waller, Dr. Waller was born October 15, 1875, in Grayson County. He attended Nashville Medical College, Nashville, Tenn., and was graduated from Louisville Medical College, Louisville, Ky., in 1906. Beginning his practice in Sarepta, La., Dr. Waller moved to Paoli, Okla., in 1911. He practiced in Pickton from 1914 until he moved to Commerce in 1935. At the time of his death he was city health officer of Commerce.

Dr. Waller, a member of the Texas Medical Association through Hunt-Rockwall-Raines-Delta Counties Medical Society, was a Mason and a member of the Methodist Church. He was surgeon for Missouri-Kansas-Texas Railroad and for Cotton Belt Railroads for many years.

DR. LEROY T. WALLER

Dr. Waller was married to Miss Mittie Ann Crow near Homer, La., May 7, 1899. She survives, as do a daughter, Mrs. Howard Miller, Brownsville; four sons, Martin M. Waller, Dallas; Dr. Alvin L. Waller, Brownwood; Ray L. Waller, Corsicana; and J. D. Waller, Malakoff; two sisters, Mrs. W. W. Dean, Minden, La., and Mrs. Ed New, Alexandria, La.; two brothers, Jessie D. Waller, Sarepta, and Reed R. Waller, Tulia; and five grandchildren. The youngest son, Louis Waller, was killed in the New London school explosion in March, 1937.

J. A. SEAY

Dr. Joseph Amsa Seay, Wichita Falls, Texas, died January 28, 1954, at his home of a heart attack. He had been in retirement and a semi-invalid since suffering a stroke in 1946.

Born in Fountain Run, Ky., on March 13, 1879, the son of Joseph A. and Sally (Childress) Seay, he moved with his parents to Bonham when he was quite young. He attended school in Bonham and Fort Worth and was graduated in 1904 from the Kentucky School of Medicine, Louisville, which later merged with the University of Louisville School of Medicine. Dr. Seay did postgraduate work in New York City in proctology, the field in which he specialized during the latter years of his career. He began practicing in the Indian Territory and practiced in Clarksville from 1909 to 1921, when he moved to Wichita Falls.

DR. JOE A. SEAY

An honorary member of the Texas Medical Association since 1949, he had been a member of Wichita County Medical Society almost continuously since 1926. He was a member of the Baptist Church. Dr. Seay was an ardent sportsman and loved the out-of-doors.

He married the former Miss Gladys Wave Paup on September 4, 1929. She survives, as do a daughter, Mrs. Jack Roberts, Jr., Crowell, and a sister, Mrs. Virgie Cowart, Whitewright.

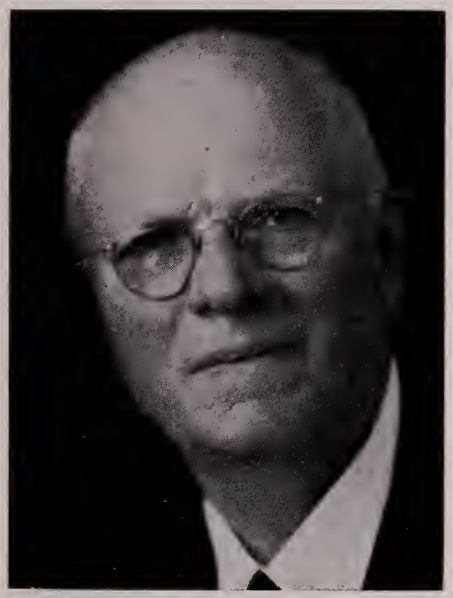
C. H. RULFS

Dr. Carl Henry Rulfs, San Augustine, Texas, died January 11, 1954, at a local hospital from the results of a stroke suffered the preceding November.

Born September 26, 1878, in Wurtemberg, Germany, the son of D. and Johanna (Boschen) Rulfs, he moved to this country with his parents in 1880, settling in Nacogdoches County. He attended the Nacogdoches public schools and Barnes Medical College, Saint Louis, and was graduated from the Tulane University School of Medicine, New Orleans, in 1905. Dr. Rulfs began practicing in Nacog-

doches in 1906 and moved to Lufkin in 1908 to be company physician for Evan's Lumber Mill. Following this, he was company physician for Long-Bell Lumber Company for fifteen years. He moved to San Augustine and practiced there from 1923 until his death, at one time serving as both city and county health officer. Dr. Rulfs retired in 1942, but because of a shortage of doctors during World War II, he began practicing again shortly after his retirement.

An honorary member of the Texas Medical Association since 1952, Dr. Rulfs had been a member of Nacogdoches County Medical Society continuously since 1938. He was a member of the American Medical Association, the Association of American Physicians and Surgeons, and the Southern Medical Association. He was a Mason, being a Knight Templar, and a senior warden of Christ Episcopal Church in San Augustine. Dr. Rulfs served during the Spanish American War as a private with the Second Texas Infantry Division.



DR. C. H. RULFS

He was married to the former Miss Anna Taylor of Nacogdoches, granddaughter of one of the signers of the Texas Declaration of Independence, on January 30, 1907. She survives; as do three sons, Carl Henry Rulfs, Jr., Lamar, Mo.; Lawrence D. Rulfs, San Augustine; and Dietrich Rulfs, Nacogdoches; a daughter, Mrs. Anna Kathryn Holbrook, San Augustine; a brother, John Rulfs, Arlington; and three grandchildren. One son, Milam Irion Rulfs, was killed in 1943 while serving with the United States Marine Corps.

J. R. NICHOLS

Dr. James Routte Nichols, Austin, Texas, died March 2, 1954, of coronary occlusion in a local hospital.

Born in Bastrop, July 26, 1870, the son of James Robert and Josephine Frances (Garth) Nichols, Dr. Nichols attended Sarah Jane Orgain School in Bastrop and public school in Giddings. He was graduated from Texas Agricultural and Mechanical College in 1889 and from Smith's Commercial College, Lexington, Ky., in 1890. He attended the University of Virginia Department of Medicine, Charlottesville, and was graduated from Tulane University of Louisiana School of Medicine, New Orleans, in 1893. Beginning his practice at Greenville in 1894, Dr. Nichols was Hunt County physician and health officer and local surgeon for the Texas Midland Railroad. He worked for the Terrell State Hospital from 1899 to 1907. He then took postgraduate training in eye, ear, nose, and throat at New York Polyclinic Medical School. Soon after returning to Greenville, he was appointed superintendent of the San Antonio State Hospital in 1909. He moved to Austin in 1911 and practiced there until 1947, when he discontinued the practice of medicine. He served as visiting oculist and aurist to several state hospitals after coming to Austin.

Dr. Nichols was a member of the Texas Medical Association and American Medical Association through Travis County Medical Society, which he had served as president,

DR. JAMES R. NICHOLS

and formerly had been a member of Kaufman, Hunt, and Bexar Counties Societies. In 1953 he was elected to inactive membership in the state organization. He was a member of the Presbyterian Church, Masonic Order, Woodmen of the World, Elks, board of directors of the American National Bank, and board of directors of the Security Trust Company, and a former member of the Rotary Club and the Austin Country Club. Dr. Nichols was deeply interested in politics and considered himself a "brass collar" Democrat.

Dr. Nichols married Miss Annie David Fry December 19, 1894. She died in 1910, and he married Miss Anna Douglass Young May 14, 1923. Dr. Nichols is survived by his wife; four daughters, Mrs. Marvin C. Nichols, Fort Worth, and Mrs. Will E. Watt, Mrs. Ben F. Jones, and Mrs. Jess Ashford, all of Austin; two sons, James Wood Nichols, Coral Gables, Fla., and Douglass Young Nichols, Austin; and a brother, Joseph Francis Nichols, Greenville.

G. W. EDGERTON

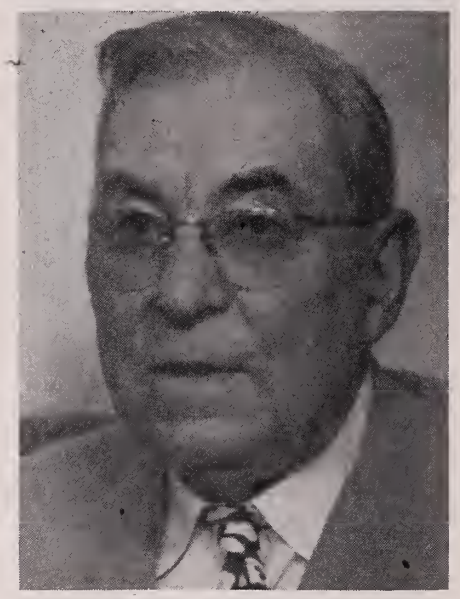
Dr. George W. Edgerton, Corpus Christi, Texas, died January 16, 1954, in a local hospital of congestive heart failure and uremia. He had not been well for several years and had been confined to bed since April.

A native of Plattsmouth, Neb., Dr. Edgerton was born in 1887. He came to Texas as a boy with his parents and finished high school at Sherman, where he also attended

Austin College. He was graduated from the University of Texas, Austin, and the University of Texas School of Medicine, Galveston, receiving his medical degree in 1910. He did postgraduate work at Johns Hopkins University, Baltimore; Mayo Clinic, Rochester, Minn.; Cook County Hospital, Chicago; and in California.

For thirteen years at the start of his medical career he practiced in Rio Grande City. He had patients in Northern Mexico as far away as Monterrey and served as United States health officer along the border during World War I. He practiced in San Benito before moving to Harlingen in 1933. He had lived in Corpus Christi since 1941. Dr. Edgerton was chairman of the Corpus Christi City-County Health Board in 1946 and was instrumental in preventing a threatened poliomyelitis epidemic in that year. He was the first local doctor named to the draft board in Corpus Christi and was a state director of Selective Service.

He was a member of the American Medical Association and Texas Medical Association through Nueces County Medical Society, previously belonging to Grayson, Hidalgo, and Cameron Counties Societies. In 1930 he was president



DR. G. W. EDGERTON

of Cameron County Medical Society. He was a Methodist, Mason, Shriner, and member of the Harlingen Kiwanis Club, serving at one time as its president. He had oil interests near Abilene and in California.

Survivors include his wife, Betty; five children by a former marriage, Mrs. Estrella Raybourn, Harlingen; G. H. Edgerton, Austin; Charles H. Edgerton, New Braunfels; Joe Edgerton, San Antonio; and Robbie H. Edgerton, Corpus Christi; a step-daughter, Mrs. R. O. McCarty, Jr., Grand Isle, La.; and seven grandchildren.

T. N. GOODSON

Dr. Thomas Neavitt Goodson, health officer of Bexar County for twenty years, died January 11, 1954, in Waco, Texas, of coronary thrombosis. Dr. Goodson had been ill since his retirement from the post in San Antonio in 1947.

The son of Greene Herbert and Nora (Neavitt) Goodson, Dr. Goodson was born March 27, 1883, in Hamilton. He was graduated from Texas Christian University, then in Waco, and the University of Texas School of Medicine, Galveston, receiving his degree from the latter institution in 1908. After serving an internship at Santa Rosa Hospital, San Antonio, Dr. Goodson entered private practice in that city. In 1917 he became assistant county health officer, and in the twenties, health officer. He is credited as having set up a permanent, wholesale immunization program in the county schools during his term of office.

A member of Bexar County Medical Society, the Texas Medical Association, and the American Medical Association throughout his career, Dr. Goodson also was a member of the city and county boards of health and of the Christian Church. He saw overseas service in France during World War I and was active in county politics for years.

Dr. Goodson's wife, the former Mrs. Katherine Turner, whom he married in 1911, was killed in an automobile accident March 23, 1953. Several nieces and nephews survive.

J. D. MOTHERAL

Dr. Jefferson Davis Motheral, Katy, Texas, died February 4, 1954, in a Houston hospital.

The son of John and Tennie (Martin) Motheral, Dr. Motheral was born September 29, 1878, near San Marcos, where he attended public school and the old Coronal Institute. He went to Vanderbilt University, Nashville, and received his medical education at the old Hospital College of Medicine, Louisville, Ky., being graduated in 1904. From 1904 until 1911 he practiced in Cotulla; from 1911 until 1913 in Bloomington; and from 1913 to 1917 in Angleton. For the next two years he was in the Army Medical Corps, serving in the European theater and being promoted to the

DR. J. D. MOTHERAL

rank of major. Returning to private practice, Dr. Motheral was in Houston from 1919 to 1939 and in Katy since then. He had retired from active practice in 1951.

A member of Harris County Medical Society and the Texas Medical Association, Dr. Motheral was named to honorary membership in the latter organization in 1951. He was a lifetime member of the Methodist Church, a charter member of the Katy Rotary Club, and a Mason.

Miss Julia E. Howard and Dr. Motheral were married June 12, 1906, in Devine. She survives, as do two sons, J. D. Motheral, Katy, and George E. Motheral, Fort Worth; a daughter, Mrs. Edwin P. Neilan, Wilmington, Del.; a sister, Miss Tennie Motheral, Katy; and four grandchildren.

President's Page

AN INVITATION

I should like to begin my initial monthly message by extending an invitation for greater participation in the affairs of our Association by its members. Every physician has numerous demands on his time; but it is reasonable to expect him to give some of his energy and effort to organized medicine.

Membership in our Association for the past fiscal year was the largest in its history and totalled 6,725; but there continues lack of interest on the part of many member physicians. Attendance at county, district, and state meetings is generally poor. In many quarters, there is apparent lack of understanding of the policies and programs of our Association.

Specialty and general practice groups have formed and meet some professional needs. Hospital staff meetings are numerous and often semicompulsory. Large postgraduate assemblies have developed in three of our large cities and produce attractive programs.

Yet, most thoughtful physicians recognize that our Texas Medical Association is the primary and fundamental part of organized medicine in Texas and the only group through which all physicians can meet and express themselves and help to determine the policies and programs in medical affairs in Texas.

Over 100 years of experience has seasoned our Association. Its central office and staff, its councils, and its committees are set up to be of service in health matters in our state.

While it is primarily a scientific body and must continue ever to be such, our Association, of necessity, must concern itself also in prob-

lems of the socio-economic environment in which medicine is practiced if many of its traditional benefits are to be preserved.

A position of leadership must be maintained by our Association; but it can do so only by increasing its vitality and by increasing its effectiveness through service to our profession and to our citizens.

An Advisory Committee

To this end, I have requested that an Advisory Committee to the President be formed. This committee is composed of the President-Elect, the Vice-President, the Speaker of the House of Delegates, the President of the Woman's Auxiliary, the Chairman of the Board of Trustees, the Chairman of the Board of Councilors, the Chairman of the Council on Scientific Work, Chairman of the Council on Medical Jurisprudence, Chairman of the Council on Medical Economics, Chairman of the Council on Medical Defense, Chairman of the Council on Medical Education and Hospitals, and Chairman of the Committee on Public Relations. The members of this committee have agreed to give of their time and attention to forward the affairs of the Texas Medical Association.

It is my considered opinion that this committee will serve to coordinate the various functions of our Association. Through this committee every part of the Association will know the current problems and the needs of the other portions of the Association. Meetings of this committee will be held as circumstances require. Opportunity for prompt and necessary discussion of problems and policies will make for decision and action, thus implementing the program of our Association. This committee will stand ready to give attention to your constructive suggestions.

Your help is invited.

J. J. L. Bloomfield, M.D.

PR diagnotes

REPORT OF COMMITTEE ON PUBLIC RELATIONS: The eighty-seventh annual session of the Texas Medical Association, San Antonio, May 3 through 5, presented one of its most interesting sessions to date.

On the PR side of meeting were two able speakers. William Alan Richardson, Medical Economics' editor from Rutherford, N. J., underscored the necessity for and benefits of sound PR programs, on both individual and organizational levels. He pointed out that the seed of public distrust is often unintentionally planted in the busy physician's office. He covered results of this distrust when he assured listeners that the first stop-gap for encroachment of socialization, both business and professional, is favor in the public mind.

Assemblage at the general meeting luncheon heard Roger Fleming, secretary of the American Farm Bureau Federation, Washington, D. C. He warned medics that the favorite technique of those who favor maximum political intervention in the economic field is to try to put those who support the American system of private enterprise on the defensive.

An advisory committee to the President formed and met on last day of meeting. Committee is composed of President-Elect, Vice-President Speaker of House of Delegates, President of Woman's Auxiliary, and chairmen of key boards, councils, and committees. Members' background variety in special interests and geographical areas will afford better coordination in various functions of the Association. Endeavor: to strengthen county and state societies.

Detailed attendance survey of county medical societies, conducted at request of President F. J. L. Blasingame and analyzed by C. Lincoln Williston, new assistant executive secretary, brings to light speculative results, pinpoints weak areas, and provides a starting point from which to develop more interest, better attendance. Results showed higher attendance ratio in societies listing less than ten on their membership rolls.

MAJOR HEALTH LEGISLATION MOVING IN CONGRESS: On a number of health bills, attention will shift shortly from committees to House and Senate floors; the Hill-Burton bill and Public Health Service grants bill already have passed the House.

From questionnaires checking actions by delegates to the AMA House of Delegates, the Iowa State Medical Society has released figures showing that 89 per cent of Iowa doctors approved AMA's stand against treatment of nonservice connected disability cases in Veterans Administration hospitals; 95 per cent favor the Keogh-Jenkins bills, allowing physicians to set aside retirement funds exempt from current taxation; 83.5 per cent agree that more liberal deductions for medical expenses should be made under federal income tax laws.

FROM OVER THE STATE: Tarrant County Medical Society assisted its auxiliary in the production of a variety show, "Tonics and Sedatives," recently. Active cooperation between these allied groups resulted in $600 supplement to the auxiliary's nurse scholarship fund and interesting entertainment for all.

Travis County Medical Society joined forces with local unit of American Cancer Society in day-long presentation of brief educational films on cancer. Doctors were in attendance to answer questions of lay audience. Local firms were asked to allow employees thirty minutes during day to view film facts.

AMA makes this observation on rating of the "Ask Your Doctor" show being televised each Sunday by the Lubbock-Crosby Counties Medical Society over KCBD-TV: says the panel-type program competes with the network's Omnibus production and is currently running a higher audience rating than this stiff competition. Dr. William H. Gordon, Lubbock-Crosby Society's TV committee chairman, sums up the program's PR value by saying: "I think it has done more in the past few weeks to help improve public relations in our community than any other possible project."

Harris County Medical Society joins forces with Houston's Museum of Natural History group in producing two programs for their "Nature in Action" series. In addition, the society is launching its own sequence, "Focus on Health." Program titles prove to be important promotional pegs. "The Biggest Little Pump," "A Tale of Two Teeth," and "TB Need Not To Be" are both eye and ear catching - provide viewer with hint at subject matter.

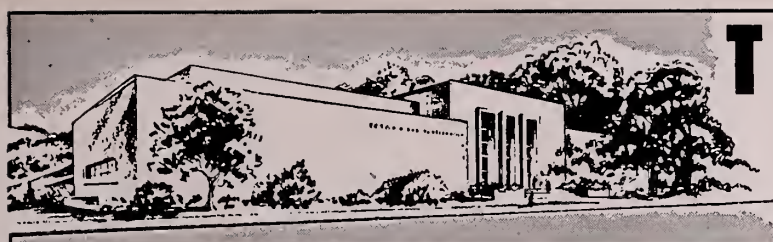
TIP OF THE MONTH

Building good television relations is as important to a medical society as establishing good press relations. TV contacts pave the way not only for securing public service time for regular shows - - but also for arranging "spot" interviews with outstanding medical men who may visit the community from time to time.

F. J. L. BLASINGAME, M. D.

Eighty-Ninth President, Texas Medical Association

WHARTON, TEXAS



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DR. F. J. L. BLASINGAME

Taking office as the eighty-ninth President of the Texas Medical Association, Dr. F. J. L. Blasingame of Wharton on May 5 accepted the gavel of office from his predecessor, Dr. George Turner of El Paso, in the closing moments of the 1954 annual session in San Antonio.

Son of John Mitchell Coleman Blasingame and Lillian Adams White Blasingame, native Texans, Dr. Blasingame was born January 17, 1907, in Hot Springs, Ark., where he lived only two years. He spent the remainder of his childhood in Hempstead, which he considers his "home town." It was there that he received his early education and from there that he went to the University of Texas, Austin, where he was granted a bachelor of arts degree in 1929, and to the University of Texas Medical Branch, Galveston, where he obtained a doctor of medicine degree in 1932.

Dr. Blasingame says that he had a particular attachment to the medical school in Galveston because of circumstances which happened long before his birth. His Grandfather White was killed by lightning while he was herding cattle one day on Galveston Island. His wife, left to provide for herself and her family, moved near the medical school at the other end of the island and opened a boarding house for the faculty and students. Dr. Blasingame's mother, an infant when her father was killed, spent a number of years in the environment of the medical school and came to know many of its staff and students. Later, she and her husband encouraged their son to seek a good education, and these earlier contacts pointed the way to the Medical Branch at Galveston.

Since the time of his graduation from the University of Texas Medical Branch, Dr. Blasingame has maintained active connection with it as a teacher of anatomy. He began with the rank of instructor, became an associate professor, and now holds the title of lecturer. His interest in educational institutions is reflected also in his membership on the Wharton County Junior College board of trustees, which he has chaired since its establishment eight years ago.

Dr. Blasingame served an internship in Henry Ford Hospital, Detroit, and has been engaged in the private practice of medicine at Wharton since August, 1937. He is a senior member of the staff and part owner of the Rugeley and Blasingame Clinic and Hospital, where he does general practice with special interest in surgery.

Dr. Blasingame is nationally known as an earnest and effective participant in professional organizations. He is a member of the Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society, Eighth District Medical Society, Texas Medical Association, American Medical Association, Southern Medical Association, and United States Committee of the World Medical Association. He served as Councilor of the Eighth District from 1941 until his election to the Board of Trustees of the Texas Medical Association in 1947. In 1946 he introduced into the House of Delegates a resolution which eventually led to passage by the Texas Legislature of the minimum standards law which now applies to all Texans practicing a healing art.

In 1949 Dr. Blasingame was elected to the Board of Trustees of the American Medical Association. One of the youngest physicians to hold such an important post with the AMA, he has exerted considerable influence in the promotion of active programs aimed toward providing better health for American people. For almost three years he headed the AMA's Legislative Committee. On a number of occasions he has represented the American Medical Association before committees of the Congress in presenting testimony on proposed legislation affecting health matters. He now is a member of the three-man Executive Committee of the AMA Board, which serves as the Finance Committee and the interim functioning unit for the Trustees. Last year he was one of the AMA representatives at the first World Conference on Medical Education in London and was alternate delegate at the World Medical Association assembly at The Hague.

Dr. Blasingame is a fellow of the American College of Surgeons; president of the board of trustees of the Blue Cross and Blue Shield plans in Texas; and a member of Phi Chi medical fraternity and Alpha Omega Alpha honorary medical fraternity. He is an active member of the Episcopal Church, a member of the Masonic Order including the Scottish Rite and Shrine, and a member of Wharton Country Club.

An able speaker, Dr. Blasingame has found time to publish articles in state and national publications, his topics ranging from technical medical subjects to discussion of current socio-economic problems.

Dr. Blasingame's wife, the former Miss Dorothy Isbel Rugeley of Wichita Falls, whom he married June 8, 1932, in Austin, has shared her husband's interest in the medical profession. A member of the Woman's Auxiliary to the county and state medical organizations, Mrs. Blasingame has held various official positions including that of district council woman. The Blasingames have five children, Mary Lillian, Betty Nan, John Chester, Rebecca Louise, and James Edward. Dr. Blasingame's mother lives in Hempstead. He has one brother, John Gray Blasingame of Los Angeles.

A vigorous man imbued with enthusiasm for his profession and engrained with the ideals which have made America great, "Bing" Blasingame, as his friends affectionately call him, did not wait until the mantle of the presidency fell about his shoulders before considering the job seriously. He spent much of his year as President-Elect conferring with members of the Association and its staff to determine wherein weakness lay and through what means the program of the Texas Medical Association might be strengthened and made more effective during his administration. He has extended a hearty invitation to his colleagues to

work with him in the next twelve months to further the goals of the Association and to spread the base of participation not only in the state organization, but also in the county society. Anyone with the energy, the vision, and the talent that Dr. Blasingame has cannot fail if the cooperation which his program deserves is forthcoming.

AT SAN ANTONIO

San Antonio seemed to be full of doctors and doctors' wives the first week in May when the Texas Medical Association and the Woman's Auxiliary held their annual conventions. The consensus was that the meetings ran smoothly, that the hosts and hostesses were gracious and adept at their tasks, and that a good time was had by almost all. Details of the meetings will appear in the June and July issues of the JOURNAL.

The business sessions of the House of Delegates of the Association were singularly free of controversy. A proposal introduced a year ago to increase the number of Trustees and to elect them from geographical districts was defeated, but approval was given to the elimination of dues for honorary, inactive, and military members. Several Constitutional amendments pertaining to membership were introduced for final action next year. The House approved the stand of the American Medical Association relative to care of veterans and adopted a resolution recommending that further steps toward cooperation and amalgamation with doctors of osteopathy be delayed until the osteopaths express greater interest in such a move. The House also took a stand against further expansion of social security on a compulsory basis. A special committee to make a study of maternal mortality was authorized.

Naming Dr. A. L. Thomas of Ennis as General Practitioner of the Year, the House of Delegates elected a full slate of officers and council members by acclamation. Dr. J. L. Cochran, San Antonio, formerly Councilor of the Fifth District, was chosen President-Elect; Dr. J. C. Terrell, Stephenville, Vice-President; and Dr. Troy A. Shafer, Harlingen, Trustee. Dr. F. J. L. Blasingame, Wharton, took office as President, succeeding Dr. George Turner of El Paso.

The Woman's Auxiliary named Mrs. Joseph H. McCracken, Jr., of Dallas as President-Elect. Mrs. Mark H. Latimer, Houston, is the new President, filling the post held last year by Mrs. Edward W. Coyle of San Antonio. Mrs. George Turner, El Paso, a former president of the State Auxiliary and now President-Elect of the Woman's Auxiliary to the American Medical Association, and Mrs. Sam Thompson, Kerrville, a past president of the State Auxiliary and, with Dr. Thompson, a generous donor to the Library of the Texas Medical Association, were made honorary life presidents. Special tribute was paid at a luncheon meeting to Mrs. E. H. Cary of Dallas, first president of the State Auxiliary; Mrs. Cary was unable to be present, but sent a letter to the membership. The Auxiliary adopted extensive revisions in its Constitution aimed at providing a more effective organizational framework and voted to hold Executive Board meetings each fall in Austin.

Special guests of the Association and Auxiliary included Dr. Simeon T. Cantril, Seattle; Dr. George T. Harrell, Jr., Gainesville, Fla.; Dr. Harold D. Palmer, Denver; Dr. E. Stewart Taylor, Denver; Roger Fleming, Washington, D. C.; William Alan Richardson, Rutherford, N. J.; and Mrs. George D. Feldner, New Orleans. Two other guests were unable to be present, Dr. Robert L. Sanders, Memphis, Tenn., because of his own illness and Mrs. Leo J. Schaefer, Salina, Kan., because of her husband's illness. Other out-of-state speakers were featured on the programs of the more than a dozen specialty societies which met in San Antonio in conjunction with the annual session of the Texas Medical Association.

A departure from traditional entertainments honoring the Association's President, the buffet and party held in the patio at La Villita the evening of May 4 attracted well over 400 persons, all of whom seemed to enjoy the bountiful food and drink and the Mexican-flavored floor show despite unseasonably cool weather which had the women reaching for wraps.

Final registration figures gave a total of 2,114, of which 1,209 registrants were members, 6 guests, 180 visitors and students, 182 exhibitors, and 537 Woman's Auxiliary members and guests.

Plans already are under way for the 1955 annual session, which will be held in Fort Worth, April 25, 26, and 27. The invitation of Galveston County Medical Society for 1956 was accepted; dates have not been set yet.

CURRENT EDITORIAL COMMENT

INDISCRIMINATE USE OF CORTISONE IN OPHTHALMOLOGY

While the internist has become weary of the indefinite results of cortisone in arthritis, the ophthalmologist has found more and more uses for the drug. In the treatment of acute iritis, acute choroiditis, vernal catarrh, phlyctenular keratitis, some types of marginal ulcers of the cornea, reduction of scar formation in late wound healing, and collagen diseases, cortisone is effective. Inevitably, such a beneficial drug often will be used in diseases where it can do no good, and to use cortisone in such a fashion is to invite disaster.

Clinicians and research workers have emphasized repeatedly that cortisone is not an antibiotic. Although bacterial infection responds dramatically to cortisone, which blocks the inflammatory reaction, it should be remembered that cortisone does not attack the cause of the disease, and symptomatic control should not lull the physician into a false sense of security.[12] Early workers had the feeling that cortisone was an addition to the body defense, that it brought forth added defensive mechanisms that helped to fight disease. This concept has changed, and it is now believed that what cortisone actually does is to block the inflammatory and exudative phases of allergic reaction, as well as nonallergic reaction.[11] Because of this blocking of the inflammatory reaction, the patient is not annoyed by the toxins of his infection and will scarcely know he is sick.[2]

Probably the most insidious part of the improper use of cortisone in ophthalmology is the soothing effect it has upon the eye and the fact that objectively the eye appears to be healing well. One can administer cortisone to a patient with panophthalmitis, and while the eyeball progresses to a bag of virulent pus, it will scarcely look inflamed. Or one can commence to use cortisone immediately after an operation, and with the eye appearing white and uninfected, bacterial invasion may progress to a point at which the eye is hopelessly lost.

In cases of corneal grafts, cortisone has proved of great value in the secondary stages of healing to prevent blood vessel and scar formation,[7] and in other cases of corneal scarring, cortisone will lessen the scar, but it must be used in the secondary stages of healing and not while fibrin is forming. Healing is delayed unduly if cortisone is administered too soon.[10] One should not be confused by the fact that a wound often will heal when cortisone is given, say, three times daily. Such infrequent use is not always sufficient to prevent healing. Cortisone, to be really effective, should be used every hour or two.

Perhaps in no other condition has the misuse of cortisone been more disastrous than in the treatment of virus diseases of the eye. Vari-

This department of the JOURNAL *presents editorial comments on current items pertaining to the science, art, and practice of medicine, contributed by members of the Texas Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the Texas Medical Association to submit such discussions for this department. The discussions should not be more than 500 words in length.*

ous researchers[5, 8] have observed no or poor results from cortisone in virus conditions. Thygeson, Hogan, and Kimura cited 4 cases, including 1 of their own, in which herpes zoster resulted in corneal perforations following the use of cortisone.[9] Adult mice ordinarily immune to coxsackie virus infection may be lethally infected if first given cortisone,[6] and cortisone applied to the cornea when a dendritic ulcer begins will spread the lesion to the entire cornea.[3, 4] Allen reported disastrous results in 3 cases of dendritic ulcer treated with cortisone.[1] I have observed in 2 cases of dendritic ulcer treated with cortisone the development of ring keratitis and cloudiness of the cornea with eventual vision in 1 patient of only 20/60 and in the other of only light perception, the poor results probably caused by the use of cortisone.

Because of its wide field of usefulness and its tendency to relieve pain and soreness, cortisone has come to be used in an indiscriminate fashion in ophthalmology. It is not an antibiotic but may give a false sense of security. It will prevent excessive vascularization and scar formation, but will delay wound healing if used too soon. It is deleterious to virus disease. Care must be taken in the choice of cases and in the method of administration of cortisone to prevent serious visual loss from its misuse.

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GAMMA GLOBULIN

The Department of Health, Education, and Welfare has announced plans for the distribution of gamma globulin for use against poliomyelitis during the coming season. Poliomyelitis gamma globulin is being kept and issued separately from the gamma globulin furnished for the prophylaxis of measles and infectious hepatitis.

Forty-five per cent of the supply of gamma globulin available for the prophylaxis of poliomyelitis will be set aside in accordance with each state's proportionate share of the national aggregate number of reported poliomyelitis cases during the five year period from 1949 to 1953; 45 per cent of the supply will be set aside in accordance with each state's proportionate share of the total population under the age of 15 years in counties which had annual crude poliomyelitis attack rates at least four times the national poliomyelitis crude attack rate during any of the years 1949 to 1953; and 10 per cent will be held as a contingency reserve for issuance to state and territorial health officers on special request.

The first allotment of gamma globulin for use against poliomyelitis became available to all state health departments on April 7, and the second allotment will be ready for distribution on or about June 1. State health departments have been instructed to submit requests for gamma globulin for use against poliomyelitis to the Division of Civilian Health Requirements, Public Health Service, Department of Health, Education, and Welfare, Washington 25, D. C.

CORRECTION

At the time the Current Editorial Comment, "A Challenge to Leadership in Mental Health," appeared in the April, 1954, issue of the JOURNAL (pages 208-209) the author, Dr. Don P. Morris, was professor of psychiatry and mental health at the University of Illinois, Urbana. Dr. Morris formerly was professor of neuropsychiatry at Southwestern Medical School of the University of Texas, Dallas, and will be in private practice in Dallas within the next few weeks.

Committee to Study Subsidy of Education

William V. Houston, Ph. D., president of Rice Institute, Houston, is one of thirteen members of an advisory committee appointed by the National Science Foundation, Washington, D. C., to consider the effects of government support to colleges and universities on their research and teaching functions, *The Journal of the American Medical Association* reports. According to the foundation, 225 educational institutions received some federal support for development and research in the year 1951-1952. In the year ending June 30, 1952, educational institutions received almost $300,000,000 from federal agencies for development and research.

ORIGINAL ARTICLES

IS DEAFNESS GOING UNRECOGNIZED?

WAYMAN B. NORMAN, M. D., Longview, Texas

THIS provocative title is not meant to condemn but to call attention to the fact that all of us are guilty of the sin of neglect and thereby share responsibility for many partially deaf children each year. How can this be possible? We simply fail to recognize serous otitis media. This is one of the most frequently and unfortunately missed diagnoses in otolaryngology today.

Synonyms are numerous because of etiologic confusion—acute catarrhal otitis media, tubotympanitis, eustachian salpingitis, otitis media with effusion, tubotympanal catarrh, tympanic hydrops, secretory otitis media, serous otitis media, and fluid ear. The two terms otitis media with effusion and serous otitis media are more apropos than secretory otitis because in many cases surely there is a transudation of fluid rather than an actual secretion. Perhaps when the real cause of the many different types of this disease is found, we will have several etiologic names.

Historically speaking, Adam Politzer deserves the credit for first accurately describing this condition in 1869;[6] however, if the truth were known, it might well be that Sir Astly Cooper actually was employing one of our modern methods of treatment in 1802, when he described paracentesis as a successful method of relieving deafness due to eustachian tube obstruction. It is interesting to note that paracentesis of the drum head was being employed to relieve deafness before myringotomy was used for infectious ears.[9]

Anatomically, the eustachian tube, tympanic cavity, attic, antrum, and mastoid cells are entodermal derivatives of the first pharyngeal pouch.[11] The eustachian tube in the adult is 35 mm. long with an outer bony part of 10 mm. and an inner cartilaginous part of 25 mm.[1] The mucous membrane of the middle ear is of the low cuboidal type and no goblet cells are present, whereas the eustachian tube is lined by columnar ciliated epithelium which reveals many goblet cells in the cartilaginous part.[2]

In physiologic function, the eustachian tube acts as a flutter valve for the middle ear; that is, if pressure changes take place, the air can exit from the cavity much easier than it can enter.

Read before the Dallas Academy of Ophthalmology and Otolaryngology, June, 1953.

The following is an attempt at an etiologic classication:[7, 8]

I. Eustachian tube obstruction.
  A. Lymphoid tissue in the nasopharynx.
  B. Enlargement of peritubal lymph nodes.
  C. Eustachian tube obstruction due to vasomotor imbalance involving the nose and nasopharynx.
    1. Allergy.
    2. Hypothyroidism.
    3. Menopausal vasomotor rhinitis.
    4. Pregnancy.
    5. Psychogenic vasomotor rhinitis.[3]
  D. All infection of upper respiratory tract.
    1. Acute.
    2. Chronic with superimposed sinusitis.
  E. Dental malocclusion.
  F. Carcinoma of nasopharynx.
II. Barotrauma.
III. General hydropic states such as severe renal disease and cardiac failure.
IV. Postantibiotic deafness.

DIAGNOSIS

The symptomatology of serous otitis media is typical. Indeed, the patient usually will make the diagnosis for the alert physician by making the following common statement:

"When I speak, it seems as if my head is in a barrel or in a well; I hear my own voice. There is a roar in one of my ears and a deafness. I feel numb all over one side of my head. My condition came on suddenly; one day I was normal and the next day I was deaf. I can hear normally when I first get out of bed in the morning but very soon thereafter my hearing leaves me."[10]

Needless to say, if the condition is bilateral, the patient is in a state of depression regarding his hearing, and as in any other partial conductive deafness he hears better in a noisy place than in a quiet one. Frequently he reports that the condition came on a few days after a severe infection of the upper respiratory tract.

The physical examination is extremely revealing, especially in the unilateral case. Brief tuning fork examination reveals a partial conductive deafness in the affected ear; the Weber test lateralizes strongly to the affected ear. The Schwabach reaction is prolonged and the Rinne test is negative. The appearance of the drum head is typical, and I prefer to use reflected light to get a better differentiation in the color of the two drums. The normal ear drum has the usual bluish white appearance, whereas the

affected ear reveals a variation from yellow to amber; occasionally a deep bluish tint is present. Hoople has called attention to the chalk whiteness of the handle of the malleus and the sharp prominence of its lateral process.[4] This difference in appearance is well illustrated by T. E. Walsh, who compared the appearance of the handle of the malleus in a normal ear to a piece of cigarette paper lying over a match on top of a table and in a fluid ear to a cigarette paper lying over a match floating over a surface of water, thus causing a close adherence of the paper to the match.[12] These are the findings in a physical examination if the ear is completely filled with fluid. Of course if there is a meniscus or an obvious bubble, the diagnosis practically leaps out at the observer.

Occasionally in a bilateral case the patient has the symptoms; however, the drums are so thickened either by previous disease or by calcium deposits that the observer is doubtful as to whether or not fluid is present. Hoople[4] advocated auscultation to ascertain the presence of fluid, but I have never found this to be necessary. A small paracentesis is relatively painless, entirely safe, and absolutely conclusive. Indeed if one decides by auscultation that fluid is present, he probably will do a paracentesis anyway; therefore, I believe that I will not be strongly criticized for making the dogmatic statement that it is safe in certain selected difficult cases to do an exploratory paracentesis to ascertain whether or not the fluid is present.

As a general rule the audiometer findings are that of a flat curve between 25 and 30 decibels down. After removal of the fluid the curve rises to within 5 to 10 decibels of the normal, and within two weeks, if no trouble ensues, the hearing is absolutely normal.

Roentgen-ray findings are interesting in that almost all of these cases definitely show mastoid haziness[5] and in the cases following upper respiratory conditions the maxillary sinus reveals clouding on the same side.

TREATMENT

The most gratifying thing about serous otitis is the remarkable immediate relief the patient gets when the fluid is removed from the ear. Therefore, the removal of the fluid by any method is of primary importance. To accomplish this removal, I make a paracentesis of approximately ⅛ inch in length in the postero-inferior part of the drum head near the annulus. The puncture can be made in one quick movement with a small bayonet knife.

Local anesthesia of the drum can be attempted with Bonain's solution or with Pontocaine Hydrochloride; however, the paracentesis is not painful and most physicians do not attempt local anesthesia. If there is definite evidence of an external otitis, it is best to postpone paracentesis until the ear is clean. After the paracentesis is made, it is wise to apply gentle pressure back and forth with a Siegle otoscope to tell definitely whether or not fluid is present. A needle and syringe are used by some physicians, but in my hands this has been more painful.

As a general rule there are two specific types of fluid encountered, one is a thin, rather oily, yellowish fluid and the other is thick, mucoid, and tenacious. Amazing amounts of the thin type fluid sometimes are found and can be removed easily by placing a large pledget of cotton against the paracentesis opening and applying negative pressure to the external auditory canal with the Siegle otoscope. Several large pledgets of cotton may be saturated completely by the fluid. Surely all otolaryngologists have experienced the actual removal at one time of larger amounts of fluid than possibly could be held in the middle ear cavity alone, thus indicating that some mastoid cells have been emptied. If the fluid is found to be of the thick, tenacious type, spot suction is almost always necessary to be certain that complete evacuation of the ear has been achieved.

The dramatic moment is over; the patient is hearing, his roar has stopped, the hollow sound in his head has stopped, and he is agreeably amazed, as is the physician, at the relief obtained. Now is the real testing time when the cause must be found. For this I go back to the original classification and examine the nasopharynx for lymphoid tissue, which is removed either by adenoidectomy or by irradiation. In adults the search is made for vasomotor obstruction of the eustachian tube including allergy, hypothyroidism, menopause syndrome, and pregnancy. The psychogenic diagnosis is made after repeated attacks that are definitely associated with emotional trauma after all other examination is negative. In stubborn cases frequently one maxillary sinus is full of pus and the removal of it is the answer to the problem. The temporomandibular joint syndrome occasionally is found, and of course the physician must be ever alert for the fossa of Rosenmüller cancer. As was learned in World War II, many dive bomber pilots suffered severe barotrauma because of retained lymphoid tissue in the nasopharynx, and this condition responded nicely to irradiation. Of course if the patient is ill enough to have some general hydropic state, it will be obvious.

The otolaryngologist's real opportunity to be of help is when the patient is a child. In preantibiotic days if a child had otitis media, the drum was opened and he was watched carefully. However, today a drum head seldom is opened. When otitis media is diagnosed early, an antibiotic is given and the child is not seen again. In many unfortunate cases the in-

fection is conquered but fluid remains in the middle ear. Occasionally parents notice the child's difficulty in hearing; indeed, I have seen children given penicillin repeatedly to clear up the hearing loss. These cases are usually bilateral.

The main causes of the disease in children are large adenoids, regrowth of adenoids, and allergy, or a combination.

One has to go largely by his own experience in examining these children's ears to ascertain whether or not fluid is present. If there is absolutely no indication that anything should be done surgically in the nasopharynx, the child briefly should be put under an anesthetic and the fluid removed, just as in the adult. This procedure should be repeated as often as necessary, always bearing in mind that the fluid must not be left in the middle ear because in certain cases it will thicken and adhesive deafness will develop. In many cases repetitious or original adenoid surgery can and must be performed. Many types of well made palate retractors and adenoid curets have been fashioned to facilitate better cleaning of the adenoid area. After the definite mechanical block is removed, allergy should be ruled out and treatment rendered as indicated. Here again irradiation is a great ally in cases that do not respond to surgery alone.

CASE REPORTS

Four brief cases are cited to illustrate different types of cases.

CASE 1.—Mrs. G. A. W., a 47 year old white woman, had a history of right sided deafness for three months following influenza. All symptoms and signs pointed toward serous otitis media. Roentgenograms revealed clouding in both mastoid and sinus on the right side. Hearing returned to normal after one paracentesis, but the ear refilled in one week. Another paracentesis and removal of fluid was performed and in addition pus was washed out of the right antrum. No more fluid reformed in the ear.

CASE 2.—Mrs. B. C., a 52 year old white woman, had a history of bilateral deafness five days after hay fever season started in August, 1951. Allergy treatment without paracentesis was to no avail. Paracentesis was performed. Allergy treatment continued and the fluid did not reform. This patient repeated the same cycle in August, 1952. She was desensitized in 1953 in preparation for the hay fever season.

CASE 3.—Mrs. B. C. D., a 48 year old white woman, represents the psychogenic type of serous otitis media. The husband of this patient has a recurrent type of heart disease and has had three major attacks. Approximately one week after each attack the patient has become deaf. Only one paracentesis and adequate medications with Tolserol have been effective in relieving her attacks. There are no positive physical findings otherwise.

CASE 4.—B. W., a white boy with a history of tonsillectomy and adenoidectomy at the age of 3, did well until January of his eighth year, at which time he had a severe earache which responded to penicillin therapy. Two weeks later his parents got a note from his teacher stating that the child did not seem to be hearing well. More penicillin was given but the hearing did not clear up. Another course of penicillin was given two weeks later and again two weeks after that, but the hearing still did not clear up. In the early part of March, bilateral serous otitis media was diagnosed and a regrowth of adenoid tissue was discovered. The adenoid tissue was removed surgically and at the same time the fluid was removed from the child's ears. The fluid returned in three weeks. Irradiation to the nasopharynx was done and fluid again was removed from the patient's ears. The patient was seen again twelve months later, at which time the fluid had not returned and hearing was normal.

CONCLUSIONS

Surely the only way that we as physicians can have a clear conscience through the years is for a great awakening to take place. This is the age of antibiotics, and as bacteria become resistant to present antibiotics, perhaps new ones will be developed. Therefore it behooves us to take warning that we can let a far more formidable enemy creep up under our very noses while we are helping combat the old enemy of infection. We must examine every child routinely two weeks after an infectious ear is treated as well as listen carefully while a patient tries to tell us that he has fluid in his ear.

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MEDICAL SCHOLARSHIP INFORMATION

A booklet containing information regarding all types of medical scholarships and loan funds, listed by state, was scheduled for release in April by the American Medical Association's Council on Rural Health in cooperation with the Department of Public Relations. The booklet, which contains information about all types of medical scholarships and loan funds now available through medical society, governmental, and other special funds, may be obtained from the Council on Rural Health.

THE CRANIOVERTEBRAL SYNDROME

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THE purpose of this paper is to call attention to a syndrome that is frequently seen but seldom given adequate treatment. When patients suffering with this symptom complex consult regular physicians, too many are told that they are psychoneurotic. They then fall into the hands of cultists or medicate themselves with various nostrums. An answer to all the problems involved has not been found, but an attempt has been made to review and define them. The basiocciput and first two vertebrae with the soft parts nearby have been given the name "craniovertebral region."[3] Here skeletal motion is accomplished with five complicated, interrelated joints. The upper portions of the vertebral artery and cervical plexus are closely related to these joints, and numerous muscles important in maintaining posture surround them. If it is shown that derangements of these structures are responsible for a clinical entity, its name should be "the craniovertebral syndrome."

LITERATURE

Most authors reviewing the headache problem list lesions of the cervical spine as a possible cause, but pain above the occiput is rarely attributed to lesions in the neck. On the other hand, neck lesions are described as causing pain in the suboccipital region with radiation into the shoulders and arms. Harstock[1] in 1940 and Kelly[5] in 1942 described lesions in the first three cervical segments producing suboccipital pain which, when severe, radiates forward into the vertex and orbit. Jostes[4] in 1942 described the technique of laminagraphy in the diagnosis of lesions in the craniovertebral region. His case histories included patients complaining of pain in the orbit, difficulty in swallowing, tinnitus, and vertigo. Special techniques for roentgen-ray visualization of the first and second cervical rings have been described by various authors. In the middle forties a series of cases were described from South America[2] with the chief complaint of headaches and ocular distress. Osteoarthritis of the occipito-atloid joints was given as the underlying disease. Following this, several papers appeared in foreign journals dealing primarily with headache and occipito-atloid lesions. A survey of the indices uncovers but a few titles associating headache with the craniovertebral region.

ANATOMY

Figure 1 shows the craniovertebral joints in median section. It may be noted that the anterior longitudinal ligament is continued upward as the anterior atlanto-occipital membrane. There is a facet on the back of the anterior arch of the atlas which articulates with a corresponding facet on the front of the dens. There is also a facet and synovial cavity where the transverse ligament of the atlas passes behind the dens. The posterior longitudinal ligament is extended upward, well into the skull, as the membrana tectoria.

Read before the Ninth District Medical Society, April 1, 1953, Baytown, Texas, and the Texas Orthopedic Association, April 27, 1953, Houston.

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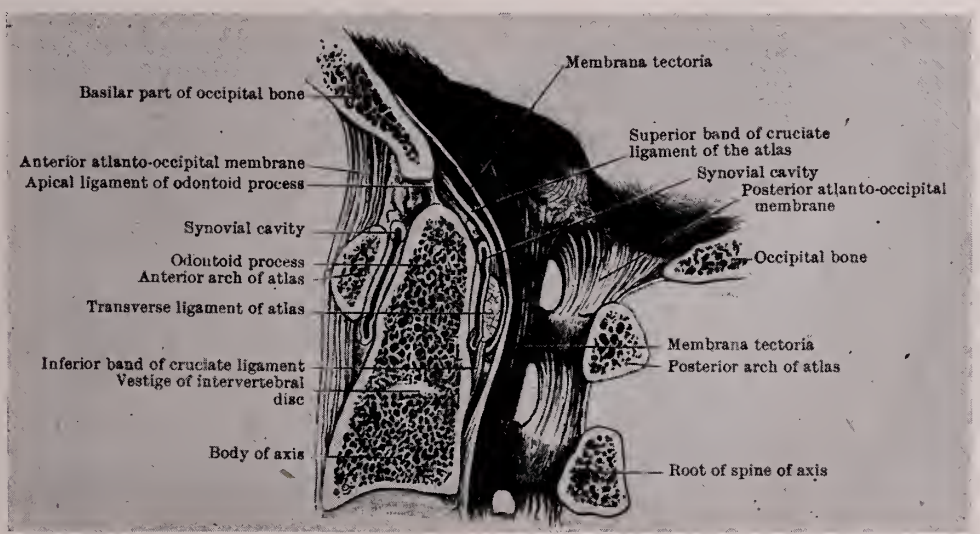

FIG. 1. Median section through the atlanto-occipital and atlanto-axial region. (After Brash, J. C., editor: Cunningham's Textbook of Anatomy, ed. 9, London, Oxford University Press, 1951, fig. 316.)

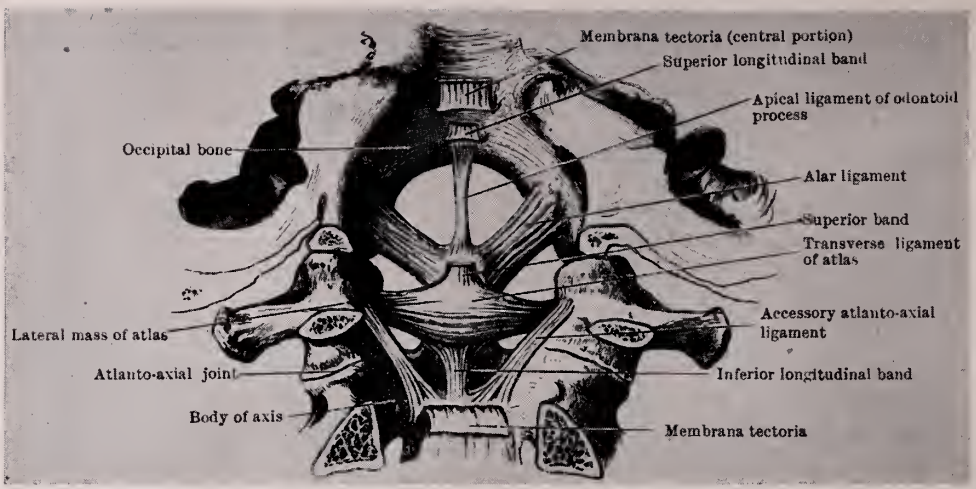

FIG. 2. Dissection from behind of the ligaments connecting the occipital bone, the atlas, and the axis with one another. (After Brash, J. C., editor: Cunningham's Textbook of Anatomy, ed. 9, London, Oxford University Press, 1951, fig. 317.)

Each posterior atlanto-occipital membrane arches over a vertebral artery as it lies on the posterior arch of the atlas.

Figure 2 shows a dissection of the ligaments. The strong transverse ligament of the atlas prevents anterior displacement on the axis. The inferior and superior longitudinal bands serve as check ligaments limiting nodding. The alar ligaments and the accessory atlanto-axial ligaments limit rotation of the occiput on the atlas and of the atlas on the axis, respectively. One can see that motion of the head on the neck is a complex mechanism.

Figure 3 shows the cervical plexus. The trunks of the first and second cervical nerves are closely related to the capsules of the occipito-atloid and atlo-axial joints, respectively. Each hypoglossal nerve passes close to an occipito-atloid joint. The communicating arch from the first to the second cervical nerve supplies afferent and efferent connections with the sympathetic and parasympathetic systems. A recurrent meningeal branch reenters the skull. The second and third cervical nerves contribute fibers to the ansa hypoglossi, accessory nerve, the occipital and auricular nerves, and the anterior cutaneous nerve of the neck.

Figure 4 shows the vertebral artery arising from the subclavian and ascending through the foramina transversaria of the sixth through the first cervical vertebrae. Here it courses over the posterior arch of the atlas against the capsule of the occipito-atloid joint to enter the skull by the foramen magnum lateral to the medulla. It pierces the dura and arachnoid to lie in front of the medulla and lower border of the pons. Within the skull vertebral arteries from each side unite to form the basilar artery, which extends upward and forward to end by dividing into the posterior cerebral arteries. The cerebellar, pontine, and posterior cerebral arteries are part of the vertebral system. It is readily apparent that autonomic phenomena secondary to irritation of the vertebral arteries might have widespread distribution.

PATHOLOGY

The variations which are found in the craniovertebral area suggest that it is transitional, though per-

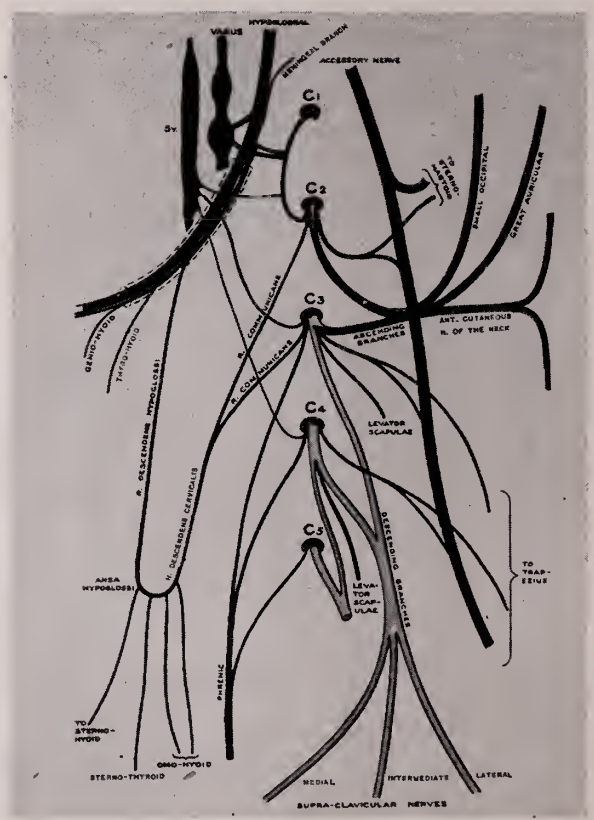

FIG. 3. The left cervical plexus. (After Brash, J. C., editor: Cunningham's Textbook of Anatomy, ed. 9, London, Oxford University Press, 1951, fig. 919.)

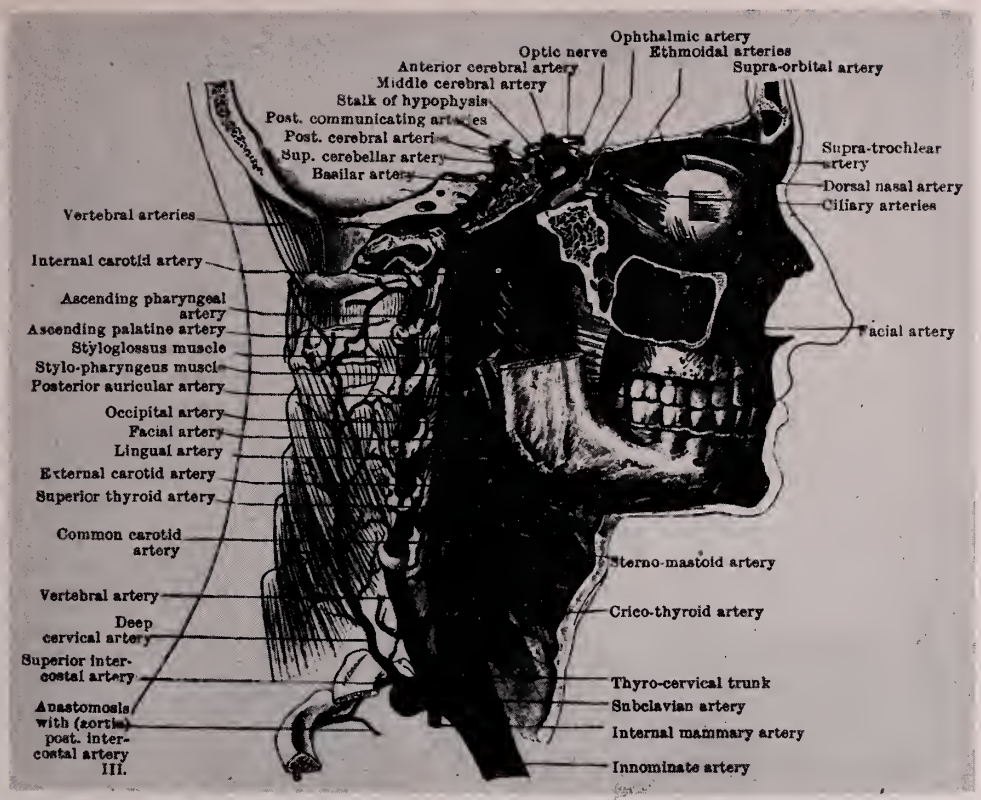

FIG. 4. The vertebral artery and main branches. (After Brash, J. C., editor: Cunningham's Textbook of Anatomy, ed. 9, London, Oxford University Press, 1951, fig. 1083.)

haps not to the same extent as the lumbosacral region. The two most common variations are manifestation of the occipital vertebra (fig. 5a) and assimilation of the atlas (fig. 5b). Other anomalous conditions seen in the craniovertebral region are bipartite or double facets on the occipital condyles, a midline anterior tubercle on the occiput articulating with the dens, incomplete fusion of the posterior arch of the atlas, a shift in position of the occipital condyles, and other forms of asymmetry.[3]

Suppurative processes in the upper part of the neck may spread by extension to involve the craniovertebral joints. Osteoarthritis of the craniovertebral joints appears to be fairly common. Involvement of the craniovertebral joints by rheumatoid arthritis has not been described; however, there is no reason that these joints should be exempt. Fractures and ligamentous tears in the craniovertebral region result in a derangement of the intricate mechanical system and, in time, degenerative changes. Disorders of function without anatomic changes, such as chronic postural strain, are the cause of some of the symptoms to be described.

Further study might reveal that the craniovertebral region is in many respects analogous to the lumbosacral region, with headache being the counterpart to sciatica. A review of the anatomy of the region demonstrates that inflammation of the ligaments and membranes about the craniovertebral articulations could cause distant pain. The cause of this symptom complex is probably the irritation of the sympathetic plexus surrounding the vertebral arteries. If this is true, it provides an explanation of the causalgic type of pain and autonomic phenomena. Anyway, there

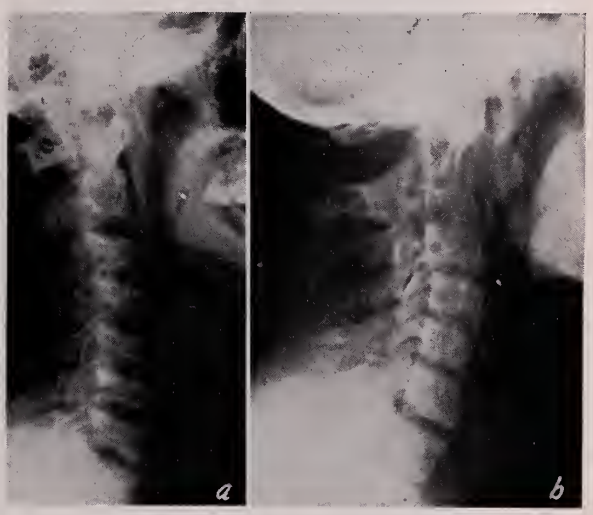

FIG. 5a. Congenital variation in the craniovertebral region which may represent "manifestation" as described by anatomists.
b. Congenital variation in the craniovertebral region which probably represents "assimulation" as described by the anatomists.

are multiple possible mechanisms by which lesions in the craniovertebral region might produce the symptom complex to be described.

HISTORY AND EXAMINATION

Patients with headaches as part of the craniovertebral syndrome usually give a history of past trauma to the head or neck or of severe infection about the neck. The patient may complain of headache in the temporal or orbital regions. On questioning, however, it can be brought out that the headaches usually start with a feeling of tightness and aching in the suboccipital region. The pain is often neuralgic in character. The headaches frequently develop during sleep, and many patients relate that they cannot use a firm pillow. Sustaining the head in a strained position and constant readjustment of head balance precipitate attacks. Ocular symptoms include photophobia, lacrimation, conjunctival injection, and pain around the orbit. Aural symptoms include earache and popping or buzzing in the ear. Occasionally patients have pain in the region of the throat. Intermittent attacks of acute torticollis are common. Dizziness and mild vertigo are frequently mentioned, but never syncope. Usually the precipitating stress immediately precedes the attack. The attacks may be infrequent or may occur almost daily. Many of the patients find that certain positions of the neck tend to aggravate or relieve the pain and discover trick maneuvers for partial relief. Because of the ocular symptoms, many have had frequent changes of glasses without benefit. Psychoneuroses develop in some as a result of chronic pain with uncertainty as to its cause.

Patients with the craniovertebral syndrome have tenderness beneath the occipital protuberance and behind the mastoid processes. They may have tenderness beneath the superior nuchal ridge and be-

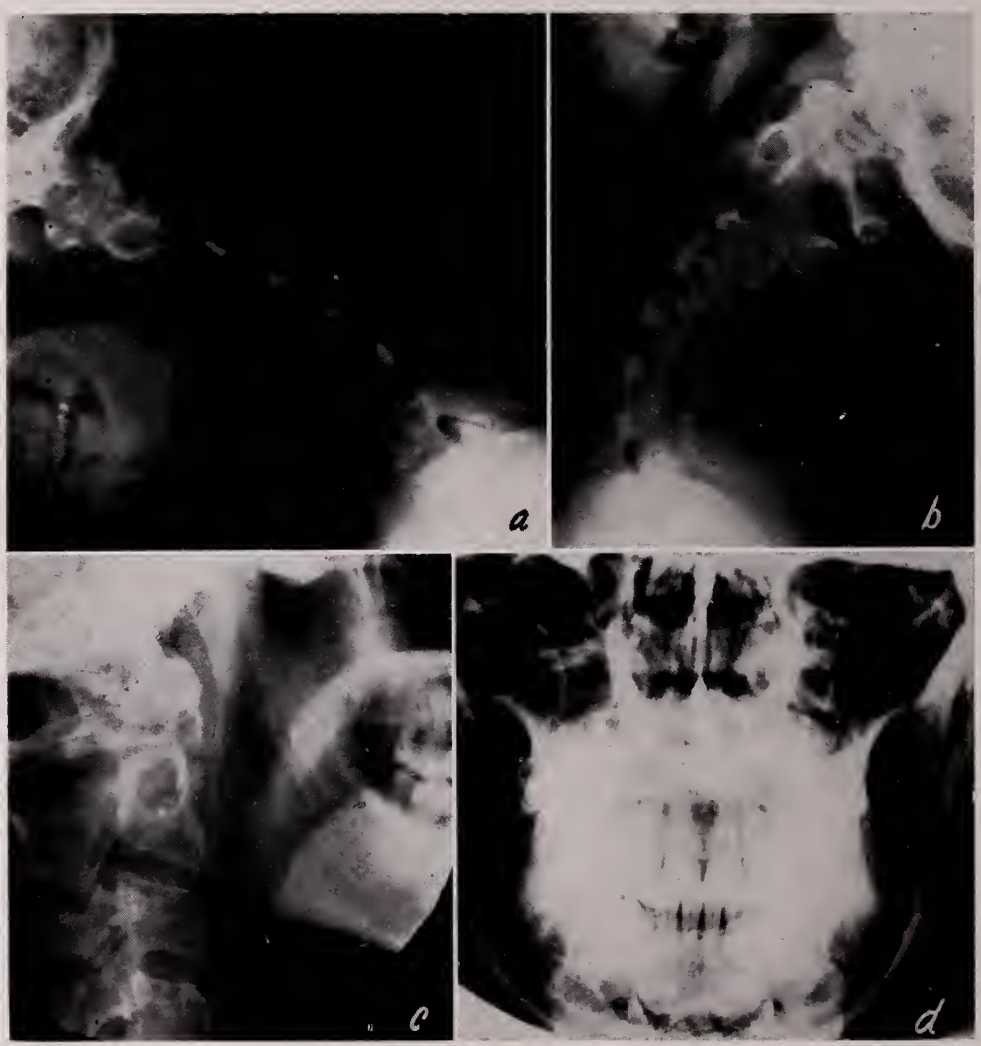

FIG. 6a and b. Case 1. Lateral views of the cervical spine in flexion and extension.

c and d. Case 2. Coned lateral and postero-anterior views of the craniovertebral joints.

tween the scapulae. There is limitation of flexion and extension. Limitation of rotation and lateral bending is usually asymmetrical. Hypesthesia of the scalp or face is inconstant. Crepitation of the cervical spine frequently can be demonstrated at will, and the compression test is generally positive. The autonomic phenomena during acute attacks may be dramatic. However, if the patient is seen between attacks, there may be few physical findings.

Frequently the symptom complex associated with osteoarthritis of the cervical spine, namely, suboccipital and neck pain radiating into the shoulder and arm, is also manifest. The craniovertebral syndrome indicates a pathologic condition at the junction of the skull and neck. The cervicobrachial syndrome indicates involvement of the lower cervical vertebrae.

Difficulties encountered in adequate roentgen-ray demonstration of the craniovertebral joints undoubtedly account for the lack of interest in this region. The usual routine roentgenography fails to demonstrate lesions that might be significant; therefore, careful positioning, technique, and interpretation should be employed. If more of these cases are carefully studied, the following roentgen-ray findings

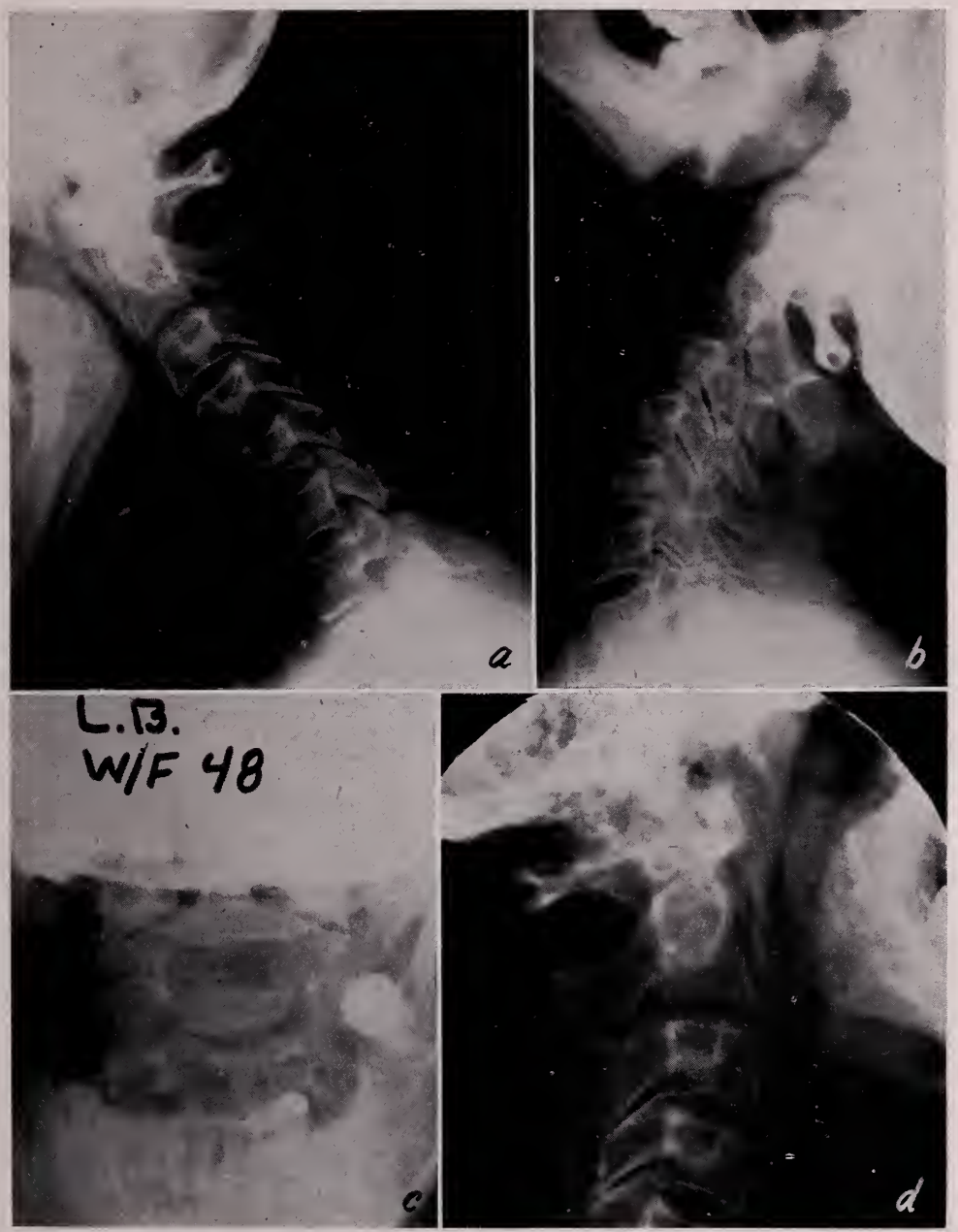

FIG. 7a and b. Case 2. Lateral views of the cervical spine in flexion and extension.

c and d. Case 2. Coned anteroposterior and lateral views of the craniovertebral joints.

may prove to be significant: (1) a range of motion of less than 1 cm. between the posterior arch of the atlas and the base of the occiput on films made at 72 inches; (2) when motion is reduced at the occipito-atloid joint, an increased range of motion, with subluxation, at the median atlo-axial joint; (3) osteoarthritic changes about the atlo-axial and occipito-atloid joint; (4) calcification of the posterior occipito-atloid membrane over the vertebral artery; (5) ossification of the anterior occipito-atloid membrane; (6) narrowing and marginal lipping in the antero-posterior projection of the occipito-atloid and atlo-axial joints; and (7) subluxations of these joints. These findings are often disregarded because they are so common in roentgenograms of persons past middle life. Cervical films of young persons without head or neck complaints rarely show them. When static or acute stresses are added to these structural imperfections, they must be considered a cause for symptoms.

TREATMENT

Treatment is not always easy. Many patients are discouraged and anxious because of previous failures and conflicting diagnoses. Reassurance and explanation help to alleviate nervous tension. Mephenesin, salicylates, and vitamins are useful. Analgesics may be necessary for short periods.

Rest, manipulation, heat, and irradiation form the basis of treatment. Rest is provided by means of a Thomas collar and special pillows. Manipulative therapy is most conveniently and safely applied by means of the canvas head halter. Intermittent vertical traction, with restricted flexion, extension, and lateral motion, is highly beneficial. Horizontal traction up to 7 to 10 pounds is restful. Prolonged periods of continuous cervical traction are not desirable as they frequently aggravate the complaint and produce increased nervous tension. Heat, in any form, hastens the patient's response. Roentgen-ray therapy is worthy of trial in selected cases. Once the patient has become convinced that something can be done for him, he should be instructed in the tech-

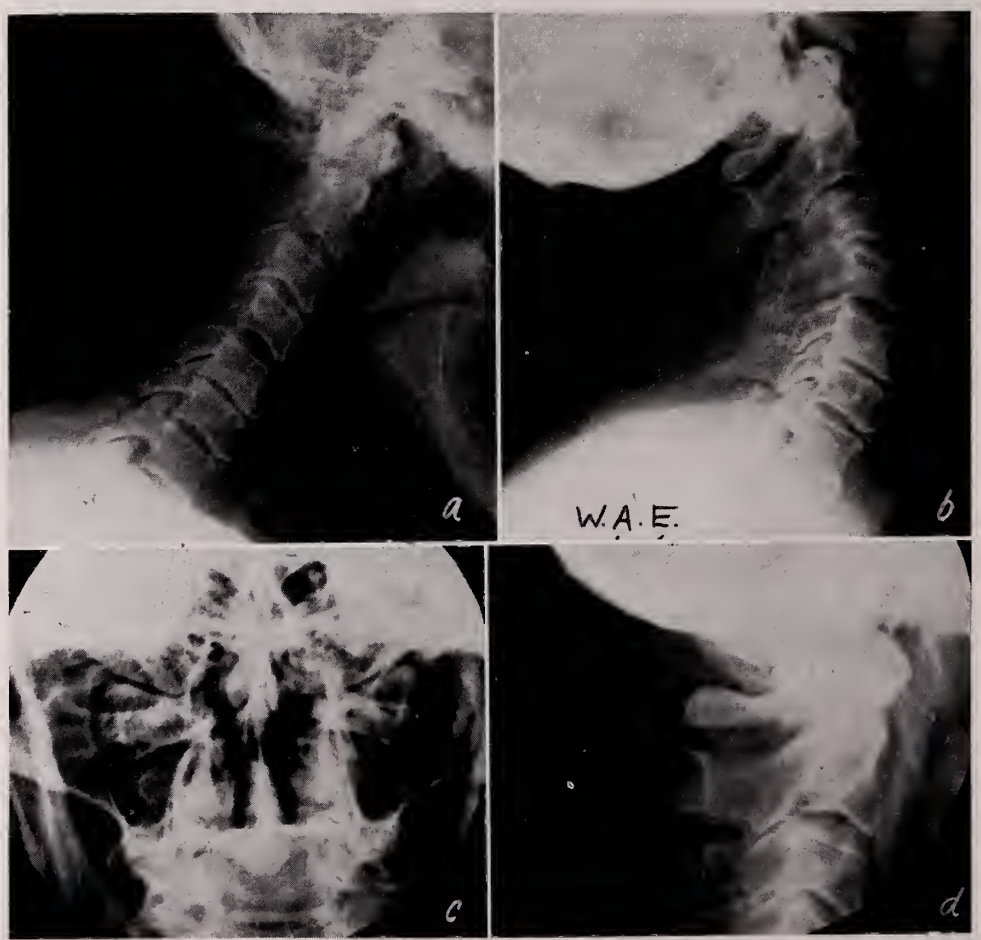

FIG. 8a and b. Case 3. Lateral views of the cervical spine in flexion and extension.

c and d. Case 3. Coned postero-anterior and lateral views of the craniovertebral joints.

niques of treating himself at home and advised that ordinary aspirin is his medication of choice. By judicious self management and avoidance as much as possible of the precipitating activities, these patients obtain satisfactory results from conservative treatment.

ILLUSTRATIVE CASES

These cases were selected to try to demonstrate some of the findings encountered. Unfortunately, features discernible on the original roentgenograms have been partially obscured in reproduction.

CASE 1.—O. A., a white woman aged 29, complained of severe neck pain. She had suboccipital and frontal headaches and complained of pain in her throat. There was crepitation in the ears. Neurologic examination was negative. There was marked tenderness over the occipito-atloid joint. Neck motion was markedly limited in all directions. The patient was provided with a cervical brace and started on traction, experiencing considerable relief. Roentgenograms in flexion and extension (fig. 6a and b) revealed no motion at the occipito-atloid joint. Lateral views coned on the occipito-atloid joint (fig. 6c) revealed calcification of the anterior ligament. The postero-anterior view (fig. 6d) revealed narrowing of the atlo-axial joint, particularly on the right, with spur formation on the left. The occipito-atloid joints were symmetrical but the joint spaces were narrow.

CASE 2.—L. B., a white woman aged 48, complained of pain between the shoulder blades with occasional paresthesia into the left arm. She also complained of suboccipital headache radiating into the frontal and orbital regions. This patient gave the story of receiving a severe jolt while riding in a car and being relieved of a headache with which she was suffering at the time. Examination revealed moderate limitation of cervical motion in all directions. Neurologic examination revealed mild hypesthesia over the left little finger. Her reflexes were equal and normal. Lateral roentgenograms of the cervical spine in flexion and extension (fig. 7a and b) revealed some reduction of motion at the occipito-atloid joint with superior subluxation of the median atlo-axial joint and degenerative changes. The coned anteroposterior and lateral views (fig. 7c and d) showed the degenerative changes better. This patient obtained satisfactory relief with local heat, salicylates, and a neck pillow. Explanation and reassurance contributed greatly to this patient's improvement.

CASE 3.—W. A. E., a white man aged 60, complained of suboccipital and frontal headaches present since an automobile accident about a month previously. There had been some conjunctival injection and photophobia on the left. Examination revealed tenderness from the suboccipital region to the spinous process of the second thoracic vertebra. Flexion was limited. Lateral bending and rotation were asymmetrical. Lateral roentgenograms of the cervical spine in flexion and extension (fig. 8a and b) revealed reduced motion at the atlo-occipital joint with a superior subluxation at the median atlo-axial joint. Postero-anterior projection of the atlas (fig. 8c) revealed a mild subluxation on the right with marginal lipping. The diagnosis of traumatic aggravation of craniovertebral and cervical osteoarthritis was made and the patient improved on mephenesin, salicylates, and head traction.

CASE 4.—M. J. S., a white man aged 31, complained of intermittent occipital and orbital headaches occasionally associated with ocular symptoms. There was mild discomfort on full flexion but clinically no limitation of motion. Lateral rotation was reduced asymmetrically. Lateral views of the cervical spine in flexion and extension revealed reduced motion at the occipito-atloid joint with superior subluxation at the median atlo-axial joint. Coned views of this region (fig. 9) revealed partial ossification over the vertebral artery. There was hypertrophic lipping at the lower margins of the median atlo-axial joint. There was also narrowing of the lateral atlo-axial joints, most marked on the left. This patient improved with heat, salicylates, neck pillow, and head halter traction.

My experience is based on private patients on whom systematic follow-up examinations have not been accomplished; therefore, a compilation of end results is not possible at this writing.

COMMENT AND SUMMARY

There is a definite symptom complex of suboccipital pain which, when it becomes severe, radiates toward the vertex and orbit. When it becomes intense, the headache and ocular symptoms may overshadow the suboccipital complaints. Frequently there are manifestations indicating involvement of the autonomic nervous system. In many of these patients, the symptoms can be shown to be due to arthropathy

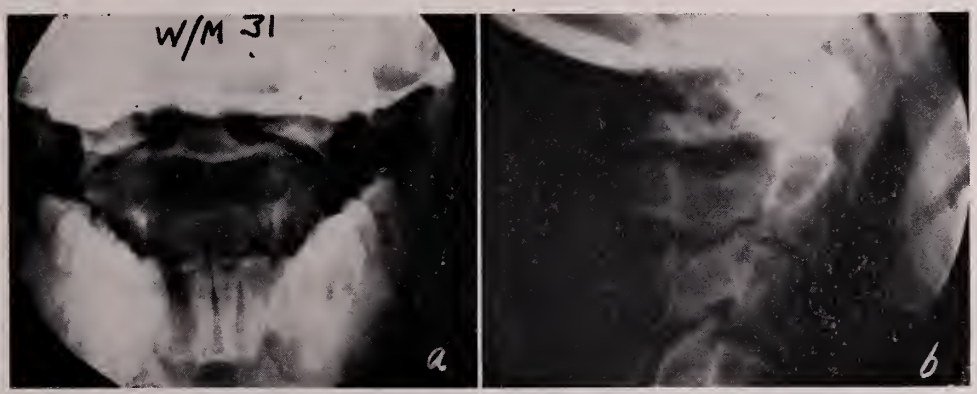

FIG. 9a and b. Case 4. Coned anteroposterior and lateral views of the craniovertebral joints.

of the occipito-atlo-axial joints. Others may be due to postural dysfunction without anatomic derangement. "Craniovertebral syndrome" is suggested as a name for this symptom complex. Whatever the cause, many of these patients respond to traction, heat, rest, mephenesin, and salicylates. The possibility of rheumatoid involvement in the craniovertebral region should not be overlooked as further studies along this line might help to clarify the etiology of idiopathic migraine.

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Mysoline in Epilepsy

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A CLINICAL investigation of a new anticonvulsant drug, Mysoline,† was undertaken at Parkland Hospital in December, 1951. The first month of the investigation was under the direction of Dr. Thomas Farmer, formerly of Southwestern Medical School of the University of Texas,‡ using hospitalized patients. Then the project was moved to the Parkland Hospital Epilepsy Clinic under my direction. Experiences in the past twenty-six months have given considerable evidence that Mysoline is a relatively nontoxic, effective anticonvulsant drug.

Mysoline chemically is 5-phenyl-5 ethyl hexahydropyrimidine-4: 6-dione. It is closely related to phenobarbital but belongs to a chemical type that has not been used previously as an anticonvulsant drug. The first report on the clinical use of this drug was prepared by Handley and Stewart.[2] Other references are listed in the bibliography.

Patients chosen for this study had been known by me for periods ranging from six to twenty-six months. During this time various anticonvulsants had been used including Dilantin, Mesantoin, phenobarbital, Mebaral, Tridione, and Milontin. For this study 30 patients were chosen out of a total of some 140 patients regularly attending the clinic. An additional group of 18 private patients also were included. These 48 patients were not considered as being under control with previous medications. This method of selection gives a new drug a rather rigorous trial, but it is not always feasible to change a well controlled epileptic patient to a new drug of unknown value.

The patients were started first on Mysoline in gradually increasing dosage with a gradual decrease in previous medication over a period of about two weeks. It was found that the effect of Mysoline could be noted within a week in most cases. The dose varied from 1 to 9 tablets per day (250 mg. in each tablet). The average patient required 4 tablets per day. It is desirable to use the least medication that will give control; hence variations in the amount used occurred. It was found that small children were able to tolerate 3 tablets per day as well as an adult.

It was observed that certain patients seemed to become quite drowsy when Mysoline was being used along with Dilantin and phenobarbital during the change-over period. Further reduction of Dilantin and/or phenobarbital obviated this difficulty.

RESULTS

A total of 48 patients have been observed over a period of six to twenty-six months. Of these 48 patients, 42 are still taking Mysoline. The other 6 have been dropped from the study for various reasons. Three of these 6 received no benefit from Mysoline. The other 3 failed to return for follow-up visits.

Of the 45 patients who have participated in this trial satisfactorily, 32 obtained excellent results; 10 were improved; and 3 were unimproved.

AGE AND SEX

The youngest patient in this series was 3 years old and the oldest 58 years; 15 patients were less than 15 years of age; 28 were between 15 and 40 years of age; and 5 were past 40. Twenty-two were male and 26 female.

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†Mysoline was furnished by Ayerst, McKenna, and Harrison, Ltd., New York.

‡At present Dr. Farmer is with the University of North Carolina Medical College, Chapel Hill.

DOSAGE

Wide variations in the amount of Mysoline needed and tolerated occurred. No attempt was made to increase the dosage to toxic levels. The upper dose limit was set by the results obtained. It was found that when the maintenance dose was reached, the patient could remain under control without having to increase the dose further.

Mysoline was used alone in 11 out of the 48 cases. In the other 37 cases, it was combined with phenobarbital, Mebaral, Dilantin, or Mesantoin. The average patient required 3 tablets per day. However, many required 5 or 6, and 1 patient, 9 per day. It was noted that smaller doses of Mysoline were needed when it was combined with one of the other anticonvulsants.

When Mysoline was used alone, 8 patients had excellent results, 1 was improved, 1 showed no change, and 1 was dropped from the study because of failure to take medication regularly. Table 1 gives the results of various combinations.

TABLE 1.—*Results of Medication with Mysoline Alone and in Combination in 48 Epileptic Patients.*

Medication	Excellent	Improved	Poor	Unknown
Mysoline	8	1	1	1
Mysoline + phenobarbital	1	1	1	0
Mysoline + Dilantin	5	2	0	0
Mysoline + Phenobarbital + Dilantin	7	1	1	0
Mysoline + Mebaral	5	0	0	1
Mysoline + Mebaral + Dilantin	5	5	0	1
Mysoline + Mesantoin	1	0	0	0
	32	10	3	3

It should be understood that all 48 of the patients were uncontrolled on previous standard medication. This means that they were either changed from their previous medication to Mysoline or else Mysoline was added to the list. In all cases when Mysoline was added to the regimen, the other medications could be reduced. It appears that Mysoline alone or combined with a hydantoin or with Mebaral gave the best results. Table 1 shows that 32 out of 48 patients obtained excellent results.

TYPES OF SEIZURES

Although the absolute classification of the type of seizure may be impossible since the physician rarely ever witnesses an attack, an attempt was made to break the patients down into categories: grand mal, petit mal, focal seizures, and psychomotor epilepsy.

In evaluating the results with Mysoline in relation to the type of seizure, it was found that the greatest reduction in number of seizures occurred with grand mal and with psychomotor attacks. Out of 19 patients having grand mal seizures, 16 experienced complete relief from the seizures. These patients were taking Mysoline alone or in combination with Dilantin or with phenobarbital and Dilantin.

With the type of seizure considered to be petit mal, 9 out of 12 patients reported profound reduction in spells and 2 reported about 75 per cent reduction. In general, Mysoline plus Dilantin and phenobarbital gave the best results. Mysoline alone was beneficial in only 1 out of these 12 cases.

In the patients with focal seizures, including the post-traumatic group, brain tumor, temporal lobe seizures, and minor motor attacks, only 5 out of a total of 15 patients were completely relieved of attacks. In 2 cases, the medication had no beneficial effect. In the other 8 patients about 80 per cent reduction in spells occurred. It therefore appears that the symptomatic convulsive group with focal seizures may be benefited the least.

There were 2 patients with psychomotor seizures. In both cases, Mysoline alone produced a complete cessation of attacks, and this happy situation has continued to exist for more than a year in both cases. In 1 of these cases, as many as one seizure daily had been occurring on previous medications up to toxic levels. Phenurone was not tried in either case.

TOXIC EFFECTS

Practically all anticonvulsant drugs will produce toxic effects if used in large enough amounts. Mysoline is not an exception, but it appears that its anticonvulsant action is great enough that relatively nontoxic doses may control seizures. Out of these 48 patients only 2 developed what they considered to be serious side effects. In both cases, marked drowsiness occurred after the first tablet was taken, and the patients refused to continue the medication. However, the drug was readministered to both patients later without the same trouble.

Ten patients noted an undesirable reaction consisting of drowsiness, dizziness, slight ataxia, and in 1 case, diplopia. One patient experienced a sharp increase in irritability and suspiciousness. This ceased in about four days after medication was reduced. Only 1 patient experienced nausea. Toxic effects were noted when 4 to 6 tablets were taken daily. The side effects developed within a week after the drug was started. In all cases these complaints ceased after reduction of the dosage. Consequently, after the proper dose was established, Mysoline was well tolerated without side effects.

Repeated urinalyses and blood counts failed to reveal any abnormalities. No skin rash was noted. Where gum hypertrophy had been present from Dilantin, the addition of Mysoline permitted reduction of the Dilantin so that the hypertrophy improved.

Many patients who had been taking large doses of phenobarbital and Dilantin without control of seiz-

ures were well pleased with the results obtained when Mysoline was substituted for all or part of their previous medication. In many patients as little as 1 of the 250 mg. tablets of Mysoline along with Dilantin or Mebaral produced excellent results. They felt that they were much more alert and capable of going about their duties on Mysoline. This is a subjective improvement, but it is of great significance to any person with epilepsy.

SUMMARY

Mysoline, a new anticonvulsant drug, appears to have definite usefulness in the control of epileptic attacks of all varieties.

Mysoline may greatly enhance the effectiveness of barbiturates and hydantoins when used in combination with them.

It appears to be a relatively nontoxic drug and it did not produce any known serious side effects in a group of 48 patients.

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Medical Arts Building.

Neomycin-Erythromycin Ointment in the Treatment of Pyodermas

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SINCE it is apparent to date that no single antibiotic is effective against all strains of pus-forming organisms, a combination must be sought which will cover the majority of strains of gram-positive and gram-negative bacteria. The object of this paper is to help corroborate, in a minor way and from a strictly clinical standpoint, the extensive in vitro and in vivo work with the combination of neomycin and Erythromycin in pyogenic infection of the skin done by Livingood.[1] He found by in vitro tests that the combination of neomycin and Erythromycin was potentially superior to other antibiotic combinations. Erythromycin, which was derived from Streptomyces erythreus and first described by McGuire,[3] is extremely effective against hemolytic Staphylococcus and hemolytic Streptococcus, particularly those strains which have been resistant to other antibiotics. Since neomycin is effective against all gram-negative organisms, it was decided to use a combination of these two antibiotics for the treatment of pyogenic infections of the skin.

In addition to having superior bactericidal properties, an ideal combination should give a low sensitization rate when locally applied and should be composed of agents that are not being routinely used parenterally since this last factor seems to increase the sensitizing powers of the antibiotics. If in vitro sensitivity tests could be executed on each organism isolated from a pyoderma and from the results the specific antibiotic selected and used, the cure rate of lesions would be greatly enhanced. However, this is impractical and uneconomical in the majority of cases, and this leads to a trial and error system. Sulfonamides, penicillin, streptomycin, Aureomycin, Chloromycetin, polymyxin, bacitracin, and neomycin are all very potent antibiotics, and most have a rather broad spectrum of activity, but no single one is effective against all strains of gram-positive and gram-negative organisms.

Livingood and Mullins[2] found that neomycin was extremely effective in Micrococcus pyogenes var. aureus (Staphylococcus aureus hemolyticus, coagulase positive) infections; very good against Proteus, Pseudomonas, and other gram-negative bacteria; but only moderately effective against certain strains of hemolytic Streptococci. Polymyxin B was a superior agent in Pseudomonas infections but relatively ineffective against the other gram-negative organisms. Neomycin was a good over-all agent against both gram-negative and gram-positive organisms but stiill left something to be desired; that is certain strains of hemolytic Streptococci were very resistant. Chloromycetin was used effectively systematically, but we did not evaluate its local properties. The efficacy of Terramycin locally has been well shown in the work by Wright.[4]

In the series reported in this paper, four separate ointment bases were used containing 4 mg. per gram each of neomycin and Erythromycin. Parabens, meth-

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The Neomycin-Erythromycin preparations utilized in this study were furnished by the Upjohn Company, Kalamazoo, Mich.

yl, and so forth and N-butylparahydroxy-benzoate were added to three of the ointment bases to inhibit Monilia albicans, which sometimes occurs following the use of these antibiotics. It is still not definitely known whether the sterile field created by these antibiotics allows the growth of Monilia or the monilial growth is actually enhanced by these drugs. The first and second bases were a mixture of mineral oil, petrolatum, and lanolin. The third base was plain petrolatum, and the fourth was a cholesterolized base without wool fat. All except the first contained parabens.

As shown by table 1, there were 88 cases in the series, and they were principally primary pyodermas and secondarily infected dermatoses. Primary pyodermas, such as impetigo contagiosa, ecthyma, folliculitis, and acute paronychia, responded readily to treatment in periods varying from two to seven days with the majority clearing in three to four days. In 1 case of severely infected, denuded stasis dermatitis of the lower legs, which had existed and been subjected to many therapeutic agents for forty-two days previously, there was complete healing in five days. The cases of impetiginized dermatitis were contact dermatitis, dermatophytosis, eczematous dermatitis, and so forth which presented secondary infections that had to be eradicated before the basic disease could be treated. Surgical wounds following minor surgery were dressed with these preparations, and no secondary infections occurred. Certainly this small number of cases has no great statistical significance but deserves further investigation.

TABLE 1.—*Results of Treatment of Pyodermas with Neomycin-Erythromycin Ointment.*

Diagnosis	No. Cases	Results		
		Excellent†	Fair‡	Poor§
Recalcitrant pustular eruption (dermatitis repens)	2	1		1
Folliculitis	16	15	1	
Impetiginized dermatitis*	26	19	5	2
Impetigo contagiosa	13	13		
Chronic paronychia	1			1
Acute paronychia	3	3		
Folliculitis decalvans	1	1		
Cheilitis	2	2		
Impetiginized stasis dermatitis	3	2	1	
Acne necrotica miliaris	1	1		
Vegetative pyoderma	1	1		
Majocchi's granuloma	1	1		
Kerion celsi	1	1		
Ecthyma	3	3		
Furunculosis	1	1		
Surgical removal sites	7	7		
Varicella	1	1		
Impetiginized herpes labialis	1	1		
Rheumatoid ulcers	1	1		
Hidradenitis	1			1
Nummular eczema	1			1
Pyogenic granuloma	1			1
Total	88	74	7	7

*Secondarily infected eczematous dermatitis, superficial fungi, and so forth.
†Healed within 2 to 7 days.
‡Healed within 10 to 12 days.
§Healed in more than 2 weeks or no improvement.

The four different ointment bases were equally divided among the cases and were routinely applied three times daily. Not a single case of primary irritation or sensitization was observed although many of these cases were vulnerable to such an occurrence. Livingood[1] has observed primary irritation but no sensitization in a small number of his series, but this irritation was found to be due to the ointment base. No cases of moniliasis were observed in the series reported here even though many of the cases of eczematous dermatitis would have served as a suitable invasion site for Monilia albicans.

There were approximately 250 cases which are not included in this series upon which these ointments were used to evaluate the possibilities of primary irritation or sensitization. None in this particular group showed either of these untoward reactions, and the respective pyogenic elements were readily eradicated.

CONCLUSIONS

Eighty-eight cases of primary pyoderma or impetiginized dermatitis were treated with ointments containing 5 mg. per gram each of neomycin and Erythromycin. Various ointment bases were used to determine the one which was least likely to give irritation or sensitization, but no significant difference was noted.

Excellent results were observed in less than seven days in the majority of cases, particularly the primary pyodermas.

No cases of moniliasis were observed, and no cases of primary irritation or sensitization were found.

Although this is a small series of cases, this combination appears superior in cutaneous pyogenic infections to any single or combination of antibiotics that I have had an opportunity to use to date.

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Bureau of State Services

The Bureau of State Services, the principal operating arm of the service for federal-state, interstate, and international health activities, has been reorganized by the United States Department of Health, Education, and Welfare. The number of operating divisions has been cut from sixteen to six and includes the Divisions of General Health Services, Special Health Services, Sanitary Engineering Services, International Health, Dental Public Health, and the Communicable Disease Center, Atlanta, Ga.

EFFECT OF A COBALT-IRON MIXTURE ON THE ANEMIA OF PREMATURITY

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THE action of cobalt in stimulating normal marrow to produce a polycythemic state[3, 4] suggested its possible use in the anemia of prematurity. The effect in such a group of patients not only could give information regarding the value of cobalt but also might possibly help in a better understanding of its mode of action. It was with these points in mind that the present study was undertaken. The results to date are promising enough to warrant a presentation of them at this time.

MATERIALS AND METHODS

The study group was composed of 38 premature infants in the Parkland Hospital premature unit.* They were placed on the basis of serial admissions in one of three groups: Group 1, 12 prematures who received no special medication and acted as a control group. Group 2, 10 prematures who received 75 mg. of ferrous sulfate in a 0.6 cc. mixture every day. Unfortunately the number in this group is too small for significant observations. Group 3, 16 prematures who received 0.6 cc. daily of a cobalt chloride–ferrous sulfate mixture, a commercial preparation† containing 40 mg. of cobalt chloride and 75 mg. of ferrous sulfate per dose.

Blood counts were obtained by heel puncture at approximately weekly intervals while the babies were in the premature unit. Follow-up studies were done at ten day intervals whenever possible after discharge from the unit. Unfortunately the number seen as follow-ups was small and will not be included beyond the sixty day period in the present report. The babies were closely observed daily for ill effects of the medication while at the premature unit and when they returned for check-ups. None of them showed harmful effects despite the large doses. However, it should be noted that during the study mild diarrhea was noted sporadically in the premature unit. The incidence of cases was as great in the control group as in the cobalt-iron group. A few of the babies receiving the cobalt-iron preparation have been followed for more than 100 days with no ill effects noted.

Hemoglobins were read as oxyhemoglobin in the Evelyn photoelectric colorimeter. Two red blood cell counts were done on each patient using United States Bureau of Standard certified equipment. Hematocrit levels were obtained in heparinized capillary tubing which was sealed on one end and centrifuged in special tubes at 3,000 rpm for thirty minutes and measured with a microscopic vernier. The average of two or three capillaries was used for each determination. Reticulocyte counts were made from dry cover slip preparations stained with brilliant cresyl blue stain; 500 cells from each cover slip were averaged and the results were expressed as percentages.

The determinations for all infants in a group were averaged for each time period as shown in the tables. Unfortunately the numbers in each group finally became so small that data beyond a sixty day interval were not significant. The standard deviation of the means for each time period and the significance of the differences of the means between the control and the treated group were calculated by use of the following formulas:

$$(1)\quad \text{Standard Deviation of the Mean} = \sqrt{\frac{\Sigma d^2}{n(n-1)}}$$

$$(2)\quad X = \frac{M_1 - M_2}{\sqrt{SD_1^2 + SD_2^2}}$$

Σ = sum of
d = difference of a single determination from the mean
n = total number of determinations in a given instance
M = mean value
SD = standard deviation
X = significance of the difference of the means

X was then converted into a P value (probability of X being due to chance*) by consulting the table of ordinates of the normal distribution in Fisher and Yates.[2]

RESULTS

Weight.—Table 1 shows the mean weights for each time period expressed as a fraction of the mean initial weight. It can be seen that the group receiving the cobalt-iron did not gain as rapidly as the control group. The differences in the eleven to

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†*Roncovite supplied by Lloyd Brothers.*

**For example, a P value of .01 could be interpreted as indicating that the probability of the difference observed being due to chance is 1 in 100.*

twenty day period are significant, indicating that the cobalt-iron group did not gain as fast as the control group. However, the differences at later ages do not show significance, suggesting that the early effect of the cobalt-iron is overcome with continued growth.

TABLE 1.—*Mean Weight Gain of Premature Infants.*
(Expressed as fraction of average birth weight.)

Group	Time in Days 0-10	11-20	21-30	31-40	41-50
Control	1.06	1.25	1.44	1.58	1.81
Co-Fe	1.03	1.15	1.31	1.54	1.68

Hemoglobin.—The results of hemoglobin determinations are shown in table 2, where the first differences are observed in the twenty-one to thirty day interval. At this point a difference in the means can be noted; it is not yet significant but indicates a trend established more clearly in the next time interval when the average values show highly significant differences. It is of some interest that the differences observed in the forty-one to fifty day period are not as great as the intervals immediately before or after. This may be because the small number of prematures in the control group influenced the significance of the values. However, there can be no doubt that the average hemoglobin values in the other time periods beyond forty-one days are greater in the cobalt-iron treated group.

TABLE 2.—*Mean Hemoglobin Determinations.*

Group	Time in Days 0-10	11-20	21-30	31-40	41-50	51-60
Control						
Gm./100 cc.	18.4	15.5	12.9	11.2	11.0	9.9
No. detns.	10	10	10	8	5	8
S. D.	±.602	±.12	±.632	±.451	±.444	±.328
Co-Fe						
Gm./100 cc.	17.9	15.6	14.2	13.4	12.0	12.3
No. detns.	12	13	15	9	13	8
S. D.	±.927	±.670	±.713	±.482	±.672	±.762
X	.....	.....	1.36	3.34	1.25	2.89
P	.....	.....	.158	.001	.182	.008

TABLE 3.—*Mean Hematocrit Determinations.*

Group	Time in Days 0-10	11-20	21-30	31-40	41-50	51-60
Control						
%	48.2	42.6	35.0	28.6	30.1	28.4
No. detns.	10	10	10	8	5	8
S. D.	± 3.15	± 2.88	± 2.06	± 1.85	± 1.29	± 1.21
Co-Fe						
%	55.3	42.7	40.6	37.7	33.2	32.5
No. detns.	12	13	15	9	13	8
S. D.	± 2.24	± 2.01	± 0.25	± 2.66	± 1.64	± 1.77
X	.....	.....	2.53	2.80	1.48	1.92
P	.....	.....	.016	.008	.132	.063

Hematocrits.—The data in table 3 show the mean hematocrit values, which show agreement with the hemoglobin determinations in that the cobalt-iron treated groups show higher hematocrit values at twenty-one days and that this difference is significantly larger except for the forty-one to fifty day interval when the P value is greater than 0.05. Again, the lack of significance here may be due to the small number of observations in the control group.

TABLE 4.—*Mean Erythrocyte Determinations.*

Group	Time in Days 0-10	11-20	21-30	31-40	41-50	51-60
Control						
Millions/cu. mm.	5.06	4.51	4.09	3.47	3.58	3.45
No. detns.	11	12	12	8	5	8
S. D.	±.539	±.756	±.633	±.560	±.381	±.746
Co-Fe						
Millions/cu. mm.	5.35	4.88	4.42	4.47	4.12	3.87
No. detns.	13	17	18	11	13	9
S. D.	±.792	±.639	±.562	±.569	±.669	±.744
X	.....	.....	.....	1.25	.....	.....
P	.....	.....	.....	.185	.....	.....

Red Blood Cell Counts.—The mean values of red blood cell counts in the control and the cobalt-iron treated groups are shown in table 4. Even though the hemoglobin and the hematocrit values give significant differences between the control and the cobalt group, the red blood cell counts do not. The only time interval in which differences of any magnitude can be noted is from thirty-one to forty days. However, when the difference is tested for significance, none obtains.

TABLE 5.—*Mean Reticulocyte Determinations.*

Group	Time in Days 0-10	11-20	21-30	31-40	41-50	51-60
Control						
%	2.0	2.2	1.4	3.0	2.3	2.6
No. detns.	9	10	9	6	4	7
Co-Fe						
%	1.9	1.4	1.4	2.3	4.0	1.9
No. detns.	11	12	13	6	9	6

Reticulocytes.—Data on reticulocytes are shown in table 5. The maximum response in the control group occurred during the thirty-one to forty day interval and in the treated during the forty-one to fifty day interval. These are average figures, and it is possible that with more data these figures will change. However, the degree of reticulocyte response is never very great and lags by twenty days behind the first detectable differences in hemoglobin values.

SUMMARY

The cobalt-iron treated group show less of a drop in the hematocrit and hemoglobin values than the control group. The lack of difference in the red blood cell counts of the two groups points more to an effect on cell volume rather than number and indirectly refutes dehydration as a possible explanation of the differences observed in the hemoglobin and hematocrit figures. The fact that the maximum reticulocyte response occurs ten days after the hemoglobin changes are first noted is of considerable interest. It appears that the greater hemoglobin and hematocrit values in the cobalt-iron group could be

due to the continued presence of red blood cells that in the control group have been destroyed. The idea that cobalt interferes with erythrophagocytosis has been postulated by other investigators[1] and supported to some extent by observations of Rohn and Bond.[5] Whether or not this is a factor in the premature infant must await further studies which are in progress.

The mode of action appears to be a dual one in delaying the red blood cell breakdown as well as in actually stimulating marrow as postulated by others.[3, 4] The mechanism of stimulation is of considerable interest; in addition to the factors of absorption and utilization of iron, the problem of fetal-adult hemoglobin is encountered in the premature and should be elucidated, for the opinion has been held that formation of adult hemoglobin is not as efficient as usual in the presence of large amounts of fetal hemoglobin.

CONCLUSION

Preliminary observations on a group of 12 premature infants who received no special medication and 16 prematures who received a commercial preparation of cobalt chloride–ferrous sulfate shows significantly greater values in the mean hemoglobin and hematocrit levels of the treated group.

It is a pleasure to acknowledge the excellent technical assistance of William Gollihar, Mrs. J. T. Long, Ace Powers, and William Terry.

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COAGULATION TIME AND PROTHROMBIC ACTIVITY

Laboratory Tests in Controlling Anticoagulant Therapy

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THE estimate of prothrombin by present methods is not precise but sufficiently accurate for clinical work. The reporting of "prothrombin time" in seconds does not reflect the true relation of the activity of these substances as there is not a constant relation between the number of seconds required for plasma clotting and the amount of prothrombin-like substances present in the patient's blood. Rather this relation varies at different concentrations and, in addition, may be materially altered in the individual laboratory and between various laboratories according to the thromboplastin and the control patient used as a reference.

When laboratories first began routine prothrombin determinations several years ago, some reported the "per cent of normal" based on the simple calculation of patient's time in seconds divided by control time in seconds. This was erroneous as it assumed a linear relationship between prothrombin and seconds. In actual fact, the relationship forms a curve with the critical portion of the curve placed directly at the level of the therapeutic range. For these reasons more laboratories now are reporting the results in "percentage of prothrombic activity." This is based on constructing the control curve for each new batch of thromboplastin or for any change in laboratory technique and applying the time obtained for each patient to this variable curve. It is intrinsically different from the old report method of "per cent of normal" and easier to use clinically than time in seconds. It is of note that not all of the prothrombin in blood is in an active form and, in addition, factors other than prothrombin may act as prothrombin as determined by present laboratory methods; hence, the term prothrombin time is thus replaced by prothrombic activity.

The normal value of prothrombic activity is 70 to 100 per cent. The therapeutic maintenance level is 15 to 35 per cent. The results are reported from 100 per cent to 10 per cent of prothrombic activity as the nearest multiple of 5 per cent and below 10 per cent of prothrombic activity as "less than 10 per cent."

Vitamin K is (1) formed in the bowel via the flora, for the most part, (2) absorbed by the intestine, and (3) converted to prothrombin by the liver. A defect of any of these steps leads to a decreased prothrombin activity of the blood plasma. Also, caffeine (coffee, tea, cola drinks) will increase the ac-

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tivity, and salicylates (including aspirin) have about one-twentieth the anticoagulant effect of Dicumarol and decrease the activity (lengthen the time).

It follows that a person in need of anticoagulant therapy may already have a low prothrombic activity. Without knowledge of this the physician may prescribe the usual dosage of anticoagulant based on weight and reduce the activity to "less than 10 per cent," subjecting the patient to hematuria or possible fatal cerebral hemorrhage.

No anticoagulant can be prescribed safely without the previous knowledge of the ability of the blood to control hemorrhage.

BEGINNING TREATMENT

Once the prothrombin activity is known, dosage of any of the Dicumarol-like drugs (Dicumarol, Tromexan, Cumopyran, Phenylindanedione, and so forth) is given, according to prothrombic activity, weight, and previous response, if known. As there are wide variations of response, daily estimations of the prothrombic activity are required until the patient is completely stabilized. With the newer trends toward very prolonged therapy (many months and years) the determinations may eventually decrease from daily to every second day, every third day, every fourth day, every fifth day, every week, every ten days, every two weeks, or every month.

The individual response differences are striking at times: normal prothrombic activity in a patient given one average initial dose of anticoagulant may drop to the hemorrhagic level (less than 10 per cent). Exceptional patients bleed in the therapeutic range; hence an occasional urine determination for red blood cells (microscopic examination) and hemoglobin (benzidine and guaiac tests) may be prudently requested. Bleeding practically always appears first in the form of hematuria from Dicumarol-like drugs. On the other hand some patients do not show lowering of prothrombic activity until two to three times the usual dose has been taken.

It is desirable, as a rule, to have anticoagulant effect induced as soon as the diagnosis of thrombosis is made. Some may be misled into a sense of comfort after the dose has been prescribed, yet the thrombus continues to grow until the effect of the drug has reached a satisfactory level. Dicumarol may take two to five days. Tromexan is better at eighteen to twenty-four hours and Cumopyran at twenty-four to thirty-six hours. Phenylindanedione is usually complete in its anticoagulant effect in twenty-four hours. Heparin given intravenously acts immediately. Some workers in the field give heparin intravenously with a Dicumarol-like drug, thus handling both immediate and prolonged requirements of the patient.

Heparin therapy is never controlled with determinations of prothrombic activity; though heparin may decrease the activity, it does so sporadically and the relationship is not stoicheiometric. Heparin therapy is controlled only by coagulation time determinations. Dicumarol therapy is controlled only by prothrombic activity determinations.

The patient may have a Lee-White coagulation time determination made immediately upon hospital admission and heparin given intravenously; the effect is immediate. Normal Lee-White coagulation time is five to twelve minutes (depending on the diameter of the tube the laboratory uses, coating with silicone, and so forth). The therapeutic range (with heparin) is two and one-half to three times the normal or a maximum of thirty-six minutes.*

Whereas heparin given intravenously has an immediate anticoagulant effect, this effect lasts only about four to six hours. With heparin given intramuscularly the effect begins within about one hour and lasts four to six hours. Depo-solution heparin lasts eighteen to twenty-four hours. Therapy with heparin as a rule is more expensive than that with Dicumarol-like drugs. However, some claim that vasodilatory and analgesic actions of heparin are valuable side effects.

THERAPEUTIC SCHEME

Manifestly, with the wide choice of modern anticoagulant drugs many schemata are available to the physician according to his desires. An example of one such schema providing both immediate and prolonged therapy would be as follows:

A patient is admitted as an emergency and the diagnosis of myocardial infarction is established. A coagulation time determination (Lee-White) "Stat" and a prothrombic activity test are ordered. The coagulation time is eight minutes and the prothrombic activity is 80 per cent. One hundred mg. of aqueous heparin is administered intravenously immediately and 100 mg. of Depo-solution heparin is given in the buttocks. In addition 150 mg. of Cumopyran is given orally. The first heparin is given to have an immediate effect and last four hours; the second heparin will cover for up to twenty-four hours; by then, the Cumopyran will have taken over. Additional doses of Cumopyran are based on the prothrombic activity determinations, keeping in mind that the second determination may be unduly low because of the irregular and unpredictable depression caused by the doses of heparin. Hence, proportionate larger doses may be offered the second

**The number of tubes used in the Lee-White method varies and is a technical requirement of the method of procedure. It has no bearing on the clinical problem.*

day and the third. Most workers prefer to stabilize the patient onto a single morning dose of oral anticoagulant. For Tromexan the dosage may be 1,200, 900, then 600 mg. daily; some claim greater ease of stabilization and fewer laboratory determinations for this product. Phenylindanedione has a usual initial dose of 200 mg. (divided morning and night), 300 mg. for the patient weighing more than 70 Kg.; the maintenance dose varies from 25 to 100 mg. depending on the laboratory report.

The well known cumulative effect may be observed as a failure of the prothrombic activity to be diminished for a few days even on a presumably adequate dosage of Dicumarol-like drug. It may be tempting for the physician to become impatient and order an overwhelming dosage. Once the response begins there may be a severe depression of the prothrombic activity that has been ascribed to a peculiar reaction on the part of some patients which seems as if a threshold level must be reached before effect is noted. On the other hand some are sensitive, and a small dose goes a long way.

The laboratory report sheet may show the determinations in a saw-toothed pattern indicating that the drug is markedly toxic to the patient's production of prothrombin, but at the same time the patient shows unusual ability later to detoxify the drug. It may be wise in these cases to try another type of anticoagulant. Many saw-toothed patterns have been induced by patients not taking the pills even though the nurse gives the medicine on schedule. One patient denied this accusation while daily the "red pills" were taken out of the wastebasket from her room. Some have hidden them in a purse, drawer, or pillow case or even had a relative take them home. One patient saved them for three days, then took them all at once. Those who advocate heparin claim the advantage of confirmed administration of drug (unless the new heparin linguets are employed). Patient understanding is essential. Some research teams have a physician place the drug in the patient's mouth, then examine the mouth afterwards. The laboratory has been held in error for a sudden rise in prothrombic activity when it was forgotten to withhold coffee from the diet (or at least until the morning blood sample has been drawn). One patient had his wife bring in a large dose of aspirin and the laboratory was held inaccurate for a sudden low percentage. Another was a rheumatic patient on salicylate therapy which was not taken into account.

If the coagulation time is increased to more than thirty-six minutes or the prothrombic activity is "less than 10 per cent," the most prudent course is simply to withhold therapy until the values return to therapeutic range. Examinations of the urine are indicated. In the event that untoward results are expected from such low levels, whole blood may be administered to counteract either heparin or the Dicumarol-like compounds. However, whole blood, as well as the specific anti-anticoagulants, tends to raise the prothrombic activity out of therapeutic range and induce the "swinging of the pendulum" which is exceptionally difficult to stabilize and frequently results in the patient's having been without therapy for a few days before stabilization is reached again.

Vitamin K is the specific drug to combat overdosage of Dicumarol-like compounds. The most positive and predictable results are obtained with the fraction known as vitamin K_1; 10 to 200 mg. may be given intravenously or intramuscularly.

With heparin overdosage, whole blood, protamine sulfate, or toluidine blue may be used in that order of preference. Protamine sulfate in particular is readily available and may be administered intravenously using from 50 to 100 mg.

LOWERING MORTALITY

It is a general feeling that the patient who comes to autopsy from overdosage of drug is the personal responsibility of the physician in charge of the case. Although this is so, this occurrence is so rare as to be almost nonexistent nowadays. Surely the greater error is in the other direction where less than adequate therapy is given or maintained and the patient goes on to die of the "natural course of his disease." In the latter case the physician may feel that he has done all that is possible and releases himself psychologically from responsibility. Several large series of cases suggest that more radical anticoagulant therapy should be used on a broader scale to obtain the minimal mortality rates from certain types of clotting diseases. If anticoagulant therapy is used, it is urged that adequate levels by laboratory control be maintained. The physician may well ask himself whether or not he would want anticoagulant therapy for his own "coronary" and what scheme he would want followed for himself.

Dr. Joseph H. Gast, professor and chairman of the Department of Biochemistry, Baylor University College of Medicine, Houston, Texas, is thanked for his guidance in the preparation of this article.

MUSCULAR DYSTROPHY RESEARCH

A grant of $5,000 was made to Southwest Foundation for Research and Education, San Antonio, by the National Muscular Dystrophy Research Foundation for the project entitled "Individual Metabolic Patterns for Families Having a History of Muscular Dystrophy." Biochemist Roy B. Mefferd is supervising the project.

Physicians wishing moderate grants-in-aid may apply to the executive secretary of the foundation, 709 Main Street, Liberty, Texas, announces Dr. A. L. Delaney, Liberty, president.

CASE REPORTS

EXTREME SUPRAVENTRICULAR TACHYCARDIAS IN INFANCY

Etiologic Factors and Report of a Case Associated with Rhabdomyomas of the Heart and Sepsis

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SINCE Hubbard's comprehensive review of the syndrome of paroxysmal tachycardia in young infants,[7] the literature has become replete with case reports pertinent to the subject. No less than 65 case references, many of them in foreign literature, were encountered in the preparation of this paper. The following case will serve to focus attention on the possible role of infection and especially of primary cardiac lesions in the extreme supraventricular tachycardias of infancy.

CASE REPORT

Baby A. was the product of a normal nine months' gestation in a gravida 4, para 3 mother. She presented as a frank breech, delivery was spontaneous and uncomplicated, and the infant was apparently normal at birth. The obstetrician had observed no fetal tachycardia. The baby weighed 2,976 Gm. at birth, and the temperature shortly after delivery was 99 F. by rectum. Shortly before I first saw the infant, she became mildly cyanotic and was placed in oxygen in an incubator. When I saw her first, about twelve hours after delivery, she was slightly cyanotic even in oxygen. Though rather lethargic, she responded well to stimuli.

The pertinent findings on physical examination were a rapid, shallow, rather irregular respiration, and a heart rate in excess of 200 beats per minute (accurate count not possible) with a regular rhythm. No thrills or murmurs were present. No abnormalities in either lung field were noted on percussion or auscultation. The abdomen was slightly distended with gas, with no masses or resistance to palpation notable. The neuromuscular reflexes were normal for a newborn infant, and the anterior fontanel was not tense or bulging. Skin turgor was good. Genitalia were not remarkable. There was a slightly raised, 2 by 3 cm., light-reddish nevus on the volar aspect of the left forearm.

Lumbar puncture was attempted on two different occasions, but gross blood (thought to be of traumatic origin) was obtained each time. A digitoxin preparation (Crystodigin, Lilly), 0.02 mg., was given orally, to be repeated every six hours for four doses. Lactose water was started orally in small amounts. When she was seen later that day, the general condition of the infant was thought to have improved somewhat. Oblique and anteroposterior films of the chest with barium in the esophagus, on the second day of life, revealed no evidence of cardiac enlargement, no abnormality of the heart and great vessels, and clear lung fields. An electrocardiogram made at that time revealed right axis deviation, supraventricular tachycardia with auricular and ventricular rates of 300, P waves absent, and a QRS interval of 0.04 second. S_1 was deep and tall R waves were present in leads V_1 and V_2. "Saw-toothed" waves were noted in V_2. The electrocardiographic interpretation was supraventricular tachycardia with possible 1:1 flutter.

Toward the end of the second day of life the baby began to regurgitate and the extreme tachycardia persisted; 0.02 mg. of Crystodigin were administered intravenously, and the baby was transferred to a hospital for sick infants. At no time during the forty-eight hour stay in the hospital of birth was the infant febrile.

Upon admission to the second hospital (about one hour after the intravenous Crystodigin) the cardiac rate was noted to be about 190, with regular rhythm. No murmurs or thrills were present, and the heart was not enlarged on physical examination. Cyanosis was moderate. The lung fields were clear. The liver edge was palpable about 1 cm. below the right costal margin, but no edema was noted. The neck was supple, and the anterior fontanel was not under pressure. The cry was suggestively shrill.

Admission laboratory work, including a complete blood count and urinalysis, revealed no abnormalities except 3 plus albuminuria.

On the morning after admission the heart rate was 120; the patient was acyanotic and appeared well. Temperature was 100 F. by rectum. For the following forty-eight hours the patient continued to progress favorably, took feedings eagerly, and was removed from oxygen completely toward the end of that time. The temperature ranged from 98 to 102.8 F. by rectum. Maintenance doses of Crystodigin, 0.01 to 0.02 mg. orally, and prophylactic penicillin, 400,000 units intramuscularly, were given daily.

On the fourth hospital day the patient suddenly had a right-sided convulsion of about one minute's duration, and bright, frothy blood appeared at the mouth. The eyes deviated to the right, and the right fist was clenched tightly. Abdominal distention became marked, and the liver was thought to have descended 3 cm. below the right costal margin. The spleen was not palpable. The heart rate was 140, and chest examination revealed no abnormalities except decreased breath sounds in the left base. There were no rales. Neither edema nor cyanosis was present, but

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ecchymoses appeared in rapid succession on the extremities, chest, and buttocks. There were no petechiae, and a tourniquet test was reported negative. With subsidence of fever (rose to 102 F. by rectum at onset of the attack), the patient experienced another convulsive seizure, associated with laryngospasm and cyanosis. The extremities were observed to be tonically extended, the feet plantar-flexed, and the fists clenched. More ecchymoses developed, and gross bleeding from the nose and mouth appeared afresh. Gross blood was obtained on attempted spinal tap.

Shortly after onset of the first convulsive episode, blood specimens were drawn for culture and other laboratory procedures, including typing and crossmatching preparatory transfusion, and a calcium preparation,* vitamin K, and Aureomycin were administered intravenously. Laboratory data revealed a bleeding time in excess of fourteen minutes and a Lee-White clotting time of nine minutes. Prothrombin time was 100 per cent of normal. Before further studies could be carried out, the patient died.

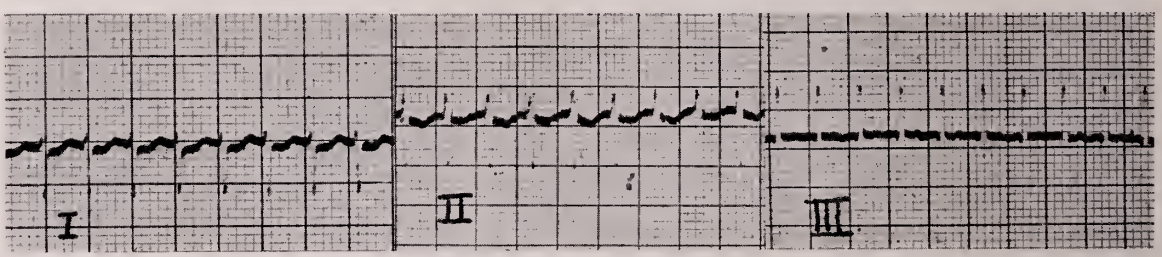

FIG. 1. Standard lead tracings on the second day of life. (See text for full electrocardiographic interpretation.)

Autopsy Findings.—The pertinent findings at necropsy were small petechiae over the moderately protuberant abdomen and extensive ecchymoses of the trunk and extremities.

The brain was markedly edematous and bulged out of the cranial vault. A greenish-yellow, plastic exudate was present in the subarachnoid space over the dorsolateral surfaces of the cerebral hemispheres and at the base. Microscopically there were scattered petechiae within the brain substance. Pseudomonas aeruginosa and Aerobacter aerogenes (thought to be contaminants) were cultured from the spinal fluid, although one broth culture of meningeal exudate cultured at autopsy yielded gram-positive cocci in chains on a stained smear only.

The adrenal glands were diffusely hemorrhagic, the microscopic detail being obliterated by hemorrhagic necrosis (Waterhouse-Friderichsen syndrome).

The heart weighed 20 Gm. and presented on its anterior surface a flattened, plaquelike area of soft grayish-white tissue, 1 cm. in diameter and 3 to 4 mm. thick, together with two smaller grayish-white nodules on the epicardial surface near the apex of the heart. The myocardium was somewhat flabby and a pale brownish-red. The foramen ovale could be probed but was closed by a thin fibrous flap. Multiple sections showed multiple, varying-sized areas of vacuolated, so-called spider cells arranged in small ovoid-shaped groups scattered throughout the thickness of the myocardium and in the trabeculae carnae as well. Microscopically a moderate degree of myocardial hypertrophy was noted. The lungs were not fully aerated, and gross examination revealed large areas of intraparenchymal hemorrhage. Fibrin was deposited over the pleural surfaces of the upper and lower lobes of the right lung. Microscopic sections of the right lung showed small foci of pneumonic consolidation associated with the presence of numerous large foamy macrophages and purulent exudate within the lumens of the small bronchi.

Given, after due consideration, with complete awareness of its potential hazards in a digitalized patient.

DEFINITION

The term "supraventricular tachycardia"[8] encompasses any tachycardia in which the impulses arise in the auricles or above the bundle of His. The term "extreme supraventricular tachycardia" (rates of around 200 or more in the infant) is used here to designate a supraventricular tachycardia other than one of simple sino-auricular nodal origin.

The extreme supraventricular tachycardias of infancy include more especially paroxysmal auricular tachycardia and auricular flutter, the accurate differential diagnosis of which is not always possible, even with the aid of electrocardiography.

ETIOLOGY

Etiologically, the extreme supraventricular tachycardias of infancy lend themselves to classification as follows:

I. Primary (idiopathic, functional, spontaneous)—due to autonomic dysfunction.[1, 3]
II. Secondary.
  A. Due to infection involving organs other than the heart (systemic or remote infections).
  B. Due to lesions confined to the heart.
    1. Inflammatory lesions of the heart.[15]
    2. Tumors of the heart
      a. Sino-auricular nodal tumors.[13]
      b. Rhabdomyomas.
    3. Structural abnormalities (congenital heart disease).
    4. Idiopathic cardiac hypertrophy.[1]
  C. Due to anesthesia.[13]
  D. Due to trauma—skull fracture.[18]

In a review of any phase of the subject of extreme supraventricular tachycardias in infancy, one cannot help being impressed by the fact that the majority of cases are not associated with any demonstrable organic disease (primary or idiopathic). However, the simultaneous occurrence of infection with those tachycardias is too frequent to be mere coincidence. Noteworthy is the fact that a dozen or so varieties of infectious disorders have been found associated with tachycardias in infants under 1 year of age.[4, 6, 7, 10, 12, 14, 16, 19] In a given in-

fant, many different types of infection may act as incitants to tachycardia.[4]

The case here presented is thought to be the third reported case[5, 18] of rhabdomyoma of the heart associated with tachycardia in infancy, up to the time of Crowell and Rice's report.[5] One other case[17] presented an arrhythmia "of a type presenting the potential hazard of auricular tachycardia." Miller[11] more recently pointed to the possible association of congenital rhabdomyoma of the heart with arrhythmia, noting the cases referred to by Crowell and Rice and mentioning one of his own. According to Crowell and Rice's review of the subject, only 69 cases of congenital rhabdomyoma of the heart were available in the literature as of January, 1950, with 55 per cent of these occurring in infants less than 1 year of age.

FIG. 2. The heart opened at autopsy. On the right, at least three plaquelike masses are seen on the epicardial surface. These are the larger rhabdomyomas.

It is generally conceded that in order for rhabdomyomas of the heart to be implicated in tachycardia, they must either involve the conducting system, afford an aberrant communication between auricle and ventricle, or serve as an ectopic focus.

Among the known cases of tachycardia associated with congenital rhabdomyomas, Wegman and Egbert's case[18] showed an auriculoventricular bundle "obliterated by tumours." In Crowell and Rice's case,[5] 3 tumor masses were found, involving the interventricular septum, the left ventricular wall, and the posterior edge of the mitral valve. Sussman and Stasney's case,[17] associated with arrhythmia presenting "the hazard of auricular tachycardia," had "several nodules in the heart," the "largest in the right atrium." In the case here presented the conducting system was definitely involved both above and below the bundle of His by small nodules. The large nodules did not involve the conducting tissue.

Despite the contention of some[5] that congenital rhabdomyomas of the heart are of little clinical significance, it seems striking that in all reported cases of these tumors in which electrocardiography was done, arrhythmias were associated.[11] It is true that there is little which is distinctive insofar as the clinical picture presented by congenital rhabdomyomas of the heart is concerned, but the possibility of such a lesion should always be entertained in the differential diagnosis of the infantile arrhythmias, especially if otherwise unexplained cardiomegaly is present in the absence of cyanosis. However, cyanosis may be present. Murmurs are rare unless the lesions are present on the valve leaflets. One feature which might be of indirect assistance in suspecting the lesion is the frequent coexistence of other conditions, notably tuberous sclerosis; brain tumors; harelip; cleft palate; cysts and tumors of the kidney; congenital malformations of the pancreas, kidneys, and lungs; and tumors of the skin.[2, 5, 18] Obviously many of these lesions are in themselves difficult to recognize clinically, especially in infancy. This case presented a nevus of the left forearm.

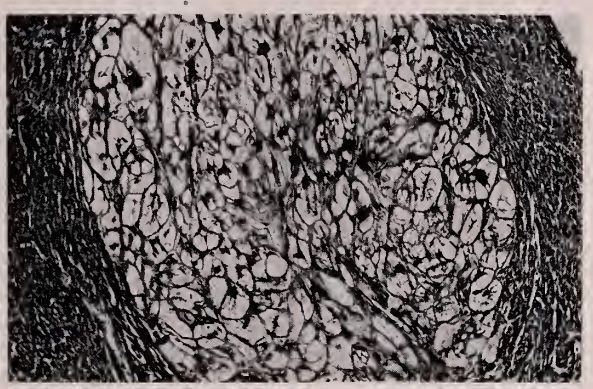

FIG. 3. A small microscopic focus illustrating the typical vacuolated or "spider-cell" appearance of an ovoid-shaped cell mass. (Such foci not recognized in the gross were seen on section to be scattered throughout the thickness of the myocardium.)

Congenital heart disease as a possible etiologic factor in extreme supraventricular tachycardia in infancy is found fairly frequently in reference material.[5, 13, 20] Levine,[9] reviewing the literature and inquiring of hospitals and doctors in the Los Angeles area, obtained information on some 100 cases of paroxysmal tachycardia in infancy and found associated congenital heart disease in less than 10 per cent.

COMMENT

The case here presented is representative of the secondary type of infantile tachycardia, being asso-

ciated with both infection and primary lesions of the heart. It is of interest to note that the tachycardia apparently responded to digitalis treatment, even in the presence of both factors. The infection, apparently suppressed earlier by antibiotic therapy, was fulminant in its terminal manifestations. It was probably present at birth. Fever, seen in this infant, is a common accompaniment of extreme tachycardia in infants. Especially in the absence of failure, however, one should be extremely hesitant to ascribe its presence to the tachycardia until an exhaustive search has been made for infection, even though, as in this instance, the infant shows dramatic improvement following relief of the tachycardia. It is not possible to say decidedly that the infection in this infant played a causative role in the tachycardia, especially since tumors of the heart were coexistent. Its presence can only be pointed out. However, it is believed that the tumors in this infant's heart, located as they were, were definitely instrumental in producing the tachycardia. It is noteworthy that cardiomegaly was not a feature of this case.

SUMMARY

A case of extreme supraventricular tachycardia in a newborn infant, associated with sepsis and rhabdomyomas of the heart is presented.

The role of infection, and of certain primary cardiac lesions in the extreme supraventricular tachycardias of infancy is reviewed briefly.

The author wishes to recognize the valuable assistance of Dr. R. L. Moore as consultant in this case, and to express his appreciation to Drs. Gilbert Forbes, professor of pediatrics, and R. L. Moore for their helpful criticism in the preparation of this paper and to Dr. Alice Smith for her preparation of the pathologic data.

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PERNICIOUS ANEMIA TREATMENT

By the administration of vitamin B_{12} through inhalation or use of a nasal spray pernicious anemia can be treated effectively and inexpensively, Dr. Raymond W. Monto and Dr. John W. Rebuck, Detroit, report in the February *Archives of Internal Medicine.*

The doctors state that 12 patients who had a return of the disease after its apparent cessation were successfully treated by this method, and in 20 other patients the symptoms of the disease were held in abatement for periods up to eighteen months with the same treatment. The doctors point out that this method of therapy has produced no evidence of toxicity or sensitivity.

DOCTORS IN SERVICE

Results of the first year's survey of physicians leaving active military service have been issued by the American Medical Association's Council on National Emergency Medical Service. A total of 3,948 questionnaires completed between July 15, 1952, and August 1, 1953, shows that the average time spent in the service was 24.7 months. The survey also indicates that the average tour of duty in the United States was 7.6 months and the average tour of foreign duty was 17.1 months. Fifty-one per cent felt that staffing was adequate, and 29 per cent felt there was overstaffing. Of the physicians assigned to domestic duty, 53.4 per cent were engaged in treating military personnel, 28.3 per cent in treating military dependents, and 18.3 per cent in treating "other." Of those assigned to overseas duty, 51.8 per cent treated military personnel, 23.8 per cent treated dependents of military personnel, and 24.4 per cent treated "other."

Questions regarding the type of medical care provided for other than military personnel revealed that in the Army and Navy the most frequent type was outpatient care, and in the Air Force the most frequent type of care was in the field of obstetrics and gynecology.

The doctors answering the survey believed that the national and local medical associations could better serve their members in the service by personal visits by civilian doctors to evaluate grievances, invitation of military doctors to civilian medical meetings, assistance in locating positions after discharge, assistance in preventing evasion of military service, distribution of questionnaires to physicians in the service, and provision of specialists for clinical conferences.

Asterol Encephalopathy

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TREATMENT of fungus infections of the skin and scalp with a new compound, Asterol dihydrochloride (2-dimethylamino-6-[beta diethylaminoethoxy]-benzothiazole dihydrochloride) was first reported in 1951.[1, 2, 7]

Initial accounts were promising,[1, 2, 6, 7] and the effectiveness of the drug fairly well established. However, reports since 1952[3, 4, 5, 8] have indicated that in infants and young children there may occur toxic manifestations which preclude the advisability of the use of Asterol in this age group. It should be pointed out that the manufacturers of this product clearly indicate on the containers that "Asterol should not be used in infants."

CASE REPORT

A 7 week old white boy was admitted to the hospital June 26, 1953, at 2 a. m. with generalized convulsive seizures which had begun about 10:30 p. m. the preceding evening. The infant had been treated for a diaper rash appearing to be of fungus origin with Asterol dihydrochloride powder for the previous six days. Treatment had been conscientious, and the rash was almost entirely cleared on admission of the patient to the hospital.

Prior to admission the patient had four distinct generalized convulsive seizures. These were described as being of sudden onset, both tonic and clonic, involving first the face and then the extremities and trunk, and lasting about two minutes each. There were no other difficulties and no preceding fever, infection, or trauma. On admission, the patient appeared acutely ill, with temperature normal. The head circumference was 37 cm.; the chest at the nipples and at the eighth rib was 35 cm. The anterior fontanel was soft and slightly depressed. The neck was supple; pupils were slightly dilated and reacted rather sluggishly to light. Examination of the ears, nose, and throat was negative. The lungs were noted to have a few wet coarse rhonchi throughout. Examination of the abdomen was negative. Skin examination revealed the clearing, dry, and scaling intercrural rash. Neurologic examination elicited hypoactive knee jerks but was otherwise physiologic.

Laboratory work revealed a normal hemogram and normal urinalysis. Analysis of fluid from a lumbar puncture was reported as yielding 4 cells, 3 lymphocytes and 1 polymorphonuclear leukocyte; 65 mg. of sugar per 100 cc.; 186 mg. of chlorides per 100 cc.; and 125 mg. of total protein. On June 27 the serum calcium level was reported as 5.75 mg. per 100 cc. Roentgenograms of the skull and chest were reported as completely negative. Bilateral subdural taps on June 27 were normal.

The patient continued to convulse at intervals after admission and was placed on phenobarbital by mouth and hypodermic injection as required for control. About six hours after admission generalized hyperreflexia became evident. Seizures continued at varying intervals even after administration of phenobarbital and were precipitated frequently by handling, feeding, and other disturbances. Temperature remained normal throughout the period of hospitalization.

On July 2, while the patient still was having episodes of convulsions, an electroencephalogram was obtained by Dr. John Skogland, which was reported as follows: A tracing was made with 12 scalp and 2 ear (reference) electrodes. Although the patient was given no sedative, he fell asleep. Adequate examination was carried out with the infant both awake and asleep. Awake, all leads showed a considerable amount of low voltage fast activity (approximately 20 to 24 waves per second) but with 5 to 7 per second waves and occasional 1 to 2 per second base line undulations intermixed in random fashion. Asleep, all leads at first showed chiefly 3 to 6 per second waves intermixed with much low voltage fast activity. In deeper sleep, irregular 2 to 4 per second high voltage waves appeared in addition to 5 to 7 per second moderate voltage waves and some low voltage fast activity (approximately 20 waves per second). Neither awake nor asleep were there any waves which were definitely pathologic. Impression—normal electroencephalogram for this age.

On July 1, six days after onset, the seizures became less frequent and less severe, and on July 2 the last seizure occurred. There has been no recurrence of seizures since, even after phenobarbital was discontinued completely on July 4.

A repeat lumbar puncture on July 1 was reported as revealing 1 cell (lymphocyte); sugar 59 mg. per 100 cc.; chloride 120 mg. per 100 cc.; protein 40 mg. per 100 cc. A recheck neurologic examination July 29 was completely negative.

DISCUSSION

A total of 6 reported cases in which toxic encephalitis has occurred with or following the use of Asterol dihydrochloride[3, 4, 5, 8] have been found in the literature. In all cases no other cause could be attributed and recovery was complete after cessation of the drug. Manifestations have consisted of convulsions, visual hallucinations, delirium, muscular weakness, and ataxia alone or in combination. In all cases tremors or convulsions were evident, and in those children above infancy, psychic disturbances as well were manifest, a fact which seems to indicate the generalized toxicity of the drug.

Age range of cases previously reported has been 10 weeks to 4 years. Symptoms have commenced not earlier than seven days and in one case as long as fifty-three days after beginning Asterol medication and have subsided in three to seven days after the drug was discontinued. All laboratory examinations, including spinal fluid studies, were usually

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within normal limits in all cases. The elevation of the spinal fluid protein and chloride levels in our case was an interesting finding, but we think not incompatible with a diagnosis of Asterol intoxication. Electroencephalographic changes were found in the 2 cases in which this examination was done; they reverted to normal by the seventh day after discontinuation of the drug.

It has been estimated vaguely that 1 in 1,000 children of all ages receiving treatment with Asterol is susceptible to toxic manifestations,[8] and the literature seems to bear out the fact that the younger the patient the more likelihood of toxicity.

SUMMARY

Another case of apparent Asterol intoxication encephalopathy is reported, this in a 7 week old white boy in whom the pattern of illness follows closely that of previous cases described. Onset of convulsions occurred on the seventh day of treatment and recovery was apparent on the seventh day following discontinuation of the drug with management consisting only of measures to control symptoms.

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4. Goldstein, N.: Encephalopathy Occurring During Topical Use of Asterol, J. Pediat. *42:*726-727 (April) 1953.

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7. Stritzler, C.; Fishman, I. M.; and Laurens, S.: Treatment of Tinea Capitis with New Antifungal Compound; Preliminary Report, A.M.A. Arch. Dermat. & Syph. *63:*606-610 (May) 1951.

8. Wilson, J. W.; Levitt, H.; Harris, T. L.; and Heiligman, E. M.: Toxic Encephalopathy Occurring During Topical Therapy with Asterol; Report of 2 Cases, J.A.M.A. *150:*1002-1004 (Nov. 1) 1952.

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, San Antonio, May 3-5, 1954. Dr. George Turner, El Paso, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, San Francisco, June 21-25, 1954. Dr. Edward J. McCormick, Toledo, Ohio, Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice. Dr. U. R. Bryner, Salt Lake City, Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. Bayard Carter, Durham, N. C., Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Montreal, Canada, May 3-5, 1954. Dr. Emile F. Holman, San Francisco, Pres.; Dr. Paul C. Samson, 2938 McClure St., Oakland 9, Calif., Secy.

American Association of Genito-Urinary Surgeons, Shawnee-on Delaware, Pa., May 26-28, 1954. Dr. Vincent J. O'Conor, Chicago, Pres.; Dr. Norris J. Heckel, 122 S. Michigan Ave., Chicago 3, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 9-11, 1954. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists. Dr. M. Murray Peshkin, New York, Pres.; Dr. Fred W. Wittich. 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, San Francisco, June 17-20, 1954. Dr. Alvis E. Greer, Houston, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians. Dr. Leroy H. Sloan, Chicago, Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 4, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-18, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress on Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chairman.

American Congress of Physical Medicine and Rehabilitation, Washington, D. C., Sept. 6-11, 1954. Dr. William B. Snow, New York, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association. Dr. Louis A. Brunsting, Rochester, Minn., Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, San Francisco, June 18-19, 1954. Dr. J. M. Ruffin, Durham, N. C., Pres.; Dr. H. Marvin Pollard, 1313 E. Ann St., Ann Arbor, Mich., Secy.

American Gynecological Society, Hot Springs, Va., May 20-22, 1954. Dr. Richard W. TeLinde, Baltimore, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association. Dr. E. Cowles Andrus, Baltimore, Pres.; Dr. William H. Bunn, 44 E. 23d St., New York 10, Secy.

American Hospital Association, Chicago, Sept. 13-16, 1954. Mr. Ritz E. Heerman, Los Angeles, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Boston, May 25-27, 1954. Dr. LeRoy A. Schall, Boston, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7. N. Y., Secy.

American Neurological Association, Atlantic City, N. J., June 14-16, 1954. Dr. Roland P. Mackay, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, Glacier Park, Mont., June 16-18, 1954. Dr. William L. Benedict, Rochester, Minn., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, Bretton Woods, N. H., June 6-9, 1954. Dr. A. R. Shands, Jr., Wilmington, Del., Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Buck Hill Falls, Pa., May 3-5, 1954. Dr. Rustin McIntosh, New York, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, Los Angeles, June 2-5, 1954. Dr. Wendell Green, Toledo, Ohio, Pres.; Dr. Stuart T. Ross, 131 Fulton Ave., Hempstead, N. Y., Secy.

American Psychiatric Association, St. Louis, May 3-7, 1954. Dr. Kenneth E. Appel, Philadelphia, Pres.; Dr. R. Finley Gayle, 6300 Three Chopt Rd., Richmond 21, Va., Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Cincinnati, Oct. 25-30, 1954. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Washington, D. C., Sept. 6, 1954. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culhertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Cleveland. Dr. Howard C. Naffziger, San Francisco, Pres.; Dr. R Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, New York, May 31-June 3, 1954. Dr. J. A. Campbell Colston, Baltimore, Md., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1954. Dr. William R. Lovelace, Alhuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Atlantic City, N. J., May 17-21, 1954. Mr. Mark H. Harrington, Denver, Pres.; Mr. Kemp D. Battle, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nashville, Pres.; Dr. George G. Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum, New Orleans, May 9-11, 1954. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, 1954. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Oklahoma City, Sept. 27-29, 1954. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secy.

Tri-State Medical Assembly, Fall, 1954. Dr. Joe D. Nichols, Atlanta, Pres.; Dr. Broox C. Garrett, 940 Margaret Pl., Shreveport, La., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice, Galveston, Sept. 9-11, 1954. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris, 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 11-12, 1954. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association, San Antonio, May 2-3, 1954. Dr. George L. Gallaher, Harlingen, Pres.; Dr. J. S. Minnett, 2512 Welborn, Dallas, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, San Antonio, May 2, 1954. Dr. Henry H. Hoskins, San Antonio, Pres.; Dr. Walter C. Brown, 1733 S. Brownlee Blvd., Corpus Christi, Secy.

Texas Club of Internists. Dr. Joseph F. McVeigh, Fort Worth, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, San Antonio, May 2, 1954. Dr. Maurice Barnes, Waco, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, San Antonio, May 2, 1954. Dr. Raymond L. Gregory, Galveston, Pres.; Dr. Edmond K. Doak, 501 Hermann Professional Bldg., Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas, Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Heart Association, San Antonio, May 3, 1954. Dr. Joseph McVeigh, Fort Worth, Pres.; Miss Roberta Miller, 412 Fidelity Union Life Bldg., 1511 Bryan St., Dallas, Executive Secy.

Texas Hospital Association, Houston, May 18-20, 1954. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, San Antonio, May 2, 1954. Dr. James Blair, San Antonio, Pres.; Dr. John L. Otto, John Sealy Hospital, Galveston, Secy.

Texas Orthopedic Association, San Antonio, May 3, 1954. Dr. Edward T. Smith, Houston, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, Oct. 22-23, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society. Dr. Jack Kerr, Dallas, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 13-16, 1955. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Houston. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, San Antonio, May 3, 1954. Dr. William E. Crump, Wichita Falls, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred H. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Mineral Wells, 1955. Dr. Charles N. Burrows, San Antonio, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 3, Executive Secy.

Texas Society of Anesthesiologists, San Antonio, May 2, 1954. Dr. James B. Rohinett, Jr., Houston, Pres.; Dr. C. R. Allen, John Sealy Hospital, Galveston, Secy.

Texas Society of Gastroenterologists and Proctologists, San Antonio, May 3, 1954. Dr. Cecil O. Patterson, Dallas, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, San Antonio, May 3, 1954. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Galveston, April 15-16, 1955. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Corpus Christi, 1954. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg., Corpus Christi, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society. Dr. T. D. Young, Sweetwater, Pres.; Dr. Francis Hood, Sweetwater, Secy.

Third District Society, Borger, April, 1955. Dr. M. C. Overton, Jr., Pampa, Pres.; Mrs. Cassie Atherton, P. O. Box 693, Amarillo, Executive Secy.

Fourth District Society, San Angelo, Oct. 14, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July, 1954. Dr. Y. C. Smith, Sr., Corpus Christi, Pres.; Dr. Robert J. Sigler, 1126 Third Street, Corpus Christi, Secy.

Seventh District Society, Austin, June 18, 1954. Dr. Benjamin Clary Bates, Austin, Pres.; Dr. William McLean, 4618 Burnet Road, Austin, Secy.

Eighth District Society, Victoria, September, 1954. Dr. Howard Z. Fretz, Wharton, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society. Dr. Thomas H. Giddings, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. Edmund D. Jones, Beaumont, Pres.; Dr. O. W. Harris, Jr., Liberty, Secy.

Eleventh District Society, Jacksonville, Fall, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society. Dr. Neil Buie, Marlin, Pres.. Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society. Dr. Mal Rumph, Fort Worth, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society, Denton, June 1, 1954. Dr. J. W. Atchison, Gainesville, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society. Dr. Bain Leake, Gladewater, Pres.; Dr. George Tate, Longview, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas. Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco. Dr. Walter B. King, 2320 Columbus Ave., Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Feb. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Sept. 22, 1954. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, July 19-21, 1954. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls, April, 1955. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, June 21-23, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

American Heart Association

Chosen as a director-at-large on the board of directors of the American Heart Association for a two-year term was Dr. George R. Herrmann, professor of medicine at the University of Texas Medical Branch, Galveston. Dr. Herrmann was elected at the thirtieth annual meeting of the American Heart Association held in Chicago, April 1-4.

Dr. Alfred W. Harris, Dallas, was elected to represent the Section on Clinical Cardiology; Dr. Paul V. Ledbetter, Houston, will represent the Scientific Council; and Dr. Edgar M. McPeak, Houston, will represent the Council on Community Service and Education. All three will serve one-year terms.

Members of the Texas Medical Association who previously were elected to represent the Texas Heart Association on the national assembly for two-year terms include Dr. Robert M. Barton, Dr. Merritt B. Whitten, and Dr. Henry M. Winans, Dallas; Dr. J. C. Crager, Beaumont; Dr. Herrmann; Dr. Charles C. Stone, Galveston; Dr. Joseph F. McVeigh, Fort Worth; Dr. Ledbetter; Dr. Joseph Kopecky, San Antonio; Dr. George W. Parson, Texarkana; Dr. Kleberg Eckhardt, Corpus Christi; Dr. Victor E. Schulze, San Angelo; and Dr. Walter B. Whiting, Wichita Falls.

Texas doctors attending the Chicago meeting as alternate delegates were Dr. Harris; Dr. Robert E. Leslie, El Campo; Dr. Malcolm H. Wyatt, Pampa, and Dr. McPeak.

Dr. McVeigh, president of the Texas Heart Association, and Dr. Herrmann, president-elect, were among the honor guests at a special dinner for presidents of affiliated heart associations at the convention. Speakers at the dinner were former Vice-President Alben W. Barkley and Mrs. Barkley, who is a vice-president of the American Heart Association.

Surgeons Regional Meetings

The Rocky Mountain Division of the United States Section of the International College of Surgeons will have a regional meeting in Salt Lake City, Utah, July 22 and 23, under the chairmanship of Dr. N. Frederick Hicken of Salt Lake City.

AMA Headquarters Visitors

The number of physicians and medical society executives touring American Medical Association headquarters during 1953 more than doubled the number in 1952. All out-of-town physicians visiting in Chicago are invited to tour the AMA building.

NATIONAL MEETINGS

The third annual *Symposium on Tuberculosis and Other Chronic Pulmonary Diseases for General Practitioners* will be at Saranac Lake, N. Y., July 12-16. Additional information about this meeting, which is approved by the American Academy of General Practice for twenty-six hours of formal credit, may be obtained from Dr. Richard P. Bellaire, Chest Disease Symposium, P. O. Box 2, Saranac Lake.

The thirty-second annual scientific and clinical session of the *American Congress of Physical Medicine and Rehabilitation* will be held September 6-11 at Washington, D. C. Sessions will be open to members of the American Medical Association. Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2.

The program of the first annual meeting of the *Academy of Psychosomatic Medicine,* which will be held in New York, October 8-9, will be on the psychosomatic aspects of surgery. Those interested in presenting papers should write to Dr. Benjamin Raginsky, 376 Redfern Avenue, Montreal, Canada. Applications for fellowships and associationships in the academy should be sent to Dr. Ethan Allan Brown, Secretary, 75 Bay State Road, Boston 15.

The Inter-Society Cytology Council will meet in Boston, November 12-13. Those wishing to present papers should contact Dr. John B. Graham, Chairman of the Program Committee, 32 Fruit Street, Boston, before July 15. For additional information about the meeting contact the Secretary-Treasurer, Inter-Society Cytology Council, 634 North Grand Boulevard, St. Louis.

INTERNATIONAL MEETINGS

The Pan American Association of Ophthalmology will meet June 17-21 for its third Interim Congress in Sao Paulo, Brazil. Scientific papers will be presented by doctors from the United States, Canada, Central America, and South America. Meetings at the same time in Sao Paulo will be the eighth Brazilian Congress of Ophthalmology and the nineteenth International Congress of Oto-Neuro-Ophthalmology. Physicians are invited to all of the scientific meetings. Additional information may be obtained from Lois Stice, 2 East 103 Street, New York 29.

The Third International Poliomyelitis Conference will be September 6-10 in Rome. The National Foundation for Infantile Paralysis is one of the sponsors. Additional information is available from the Secretariate of the Third International Poliomyelitis Conference, 6 via Lucullo, Rome, Italy.

The Pan-Pacific Surgical Association meeting will be held October 7 and 8 in Honolulu. All doctors are invited to attend. Further information may be obtained from Dr. F. J. Pinkerton, Director General, Pan-Pacific Surgical Association, Suite Seven, Young Building, Honolulu, T. H.

AMERICAN COLLEGE OF CARDIOLOGY

Three members of the Texas Medical Association will receive fellowships in the American College of Cardiology at a convocation scheduled for May 28 in Chicago. They are Dr. Albert P. Sparr, Vernon; Dr. Alexander Axelrod, Houston; and Dr. Clive R. Johnson, Fort Worth.

Members of the Association who were admitted previously to the American College of Cardiology are Dr. Olin B. Gober, Temple; Dr. Franz V. Grunbaum, Houston; Dr. Conrad C. McDonald, Tyler; Dr. Neill Simpson, Waco; Dr. Frederick W. Steinberg, San Antonio; Dr. James B. Stubbs, Galveston; and Dr. W. H. Wheir, Amarillo.

Texas Tuberculosis Association

Officers elected at the forty-fourth annual meeting of the Texas Tuberculosis Association held April 9-10 at Dallas are Mrs. Joella Terrill Butler, Wichita Falls, president; Arthur G. Schroeder, Victoria, first vice-president; Dr. Elliott Mendenhall, Dallas, second vice-president; J. W. Butler, Houston, secretary; Dr. Z. T. Scott, Austin, treasurer; and Dr. Robert B. Morrison, Austin, assistant treasurer.

Other members on the executive committee include Dr. David McCullough, Kerrville; Dr. W. D. Anderson, San Angelo; Dr. John W. Middleton, Galveston; Mrs. Arturo Flores, Eagle Pass; and Joe Bogel, Port Arthur. The entire executive committee will serve until April, 1955, when the next annual meeting of the organization will be held in Galveston.

Participants in the program include the following members of the Texas Medical Association: Dr. James A. Bethea and Dr. J. Edward Johnson, Austin; Dr. John S. Chapman and Dr. J. E. Miller, Dallas; Dr. Ralph E. Gray, Lake Jackson; Dr. Henry R. Hoskins, San Antonio; Dr. Thomas R. Jones and Dr. Austin E. Hill, Houston; Dr. John W. Middleton, Dr. Theodore C. Panos, and Dr. Caroline W. Rowe, Galveston; and Dr. Samuel Topperman and Dr. C. B. Young, Tyler.

Dr. Esmond R. Long, Philadelphia, director of medical research for the National Tuberculosis Association, spoke twice to the group. His subjects were "The Tuberculosis Research Program Supported by the Christmas Seal" and "Some Basic Consideration in the Chemotherapy of Tuberculosis."

The Texas Trudeau Society, meeting with the Texas Tuberculosis Society, elected Dr. John W. Middleton, Galveston, president. Other officers elected are Dr. John Chapman, Dallas, vice-president; Dr. S. J. Greer, San Antonio, secretary-treasurer; and Dr. Elliott Mendenhall, Dallas, member of the advisory board to the American Trudeau Society.

SOUTHWESTERN MEDICAL SCHOOL

Southwestern Medical School of the University of Texas has recently been awarded $21,654 in grants from the United States Public Health Service, National Institute of Health. These grants are for research in adrenal steroids on acid-base equilibrium, with Dr. Donald Seldin as principal investigator; for research on effect of experimental neurosis of gastric activity, with Dr. Alvin Shapiro as principal investigator; for research on plasma disappearance curves in experimental hypertension in dogs, with Dr. John Vanatta as principal investigator; and for research in pharmacology on Mannich bases and their quaternary derivitatives, with Myron Slomka, Ph. D., as principal investigator.

Dr. A. I. Brande will be the principal investigator for research on the factors responsible for the toxic and lethal effects of bacterial endotoxins. A United States Army contract reimbursable to a maximum of $18,400 was received for this research.

Dr. Allen Reid has been awarded a $5,000 grant by the American Cancer Society for investigation of the relationship of a naturally occurring metabolic inhibitor to the cancerous state.

Recent guest lecturers at Southwestern Medical School included Dr. Charles H. Best, University of Toronto; Dr. Priscilla White, Tufts College Medical School; Dr. Robert F. Pitts, Cornell University Medical College; Dr. Henry W. Brosin, University of Pittsburgh School of Medicine; Dr. Robert Good, University of Minnesota Medical School; and Dr. Robert Aldrich, University of Oregon Medical School.

PERSONALS

Dr. James McCraine, Dallas, was one of the fourteen named recently by Governor Allan Shivers to compose an advisory committee to survey Texas facilities for mental health care. After studying the facilities and programs now available in the state for research and training in mental health problems, the committee is to make recommendations on the situation.

Dr. Harry M. Little, Houston, spoke on "What a Guidance Center Does, and What You Can Do for It" at the third annual meeting of the Austin Community Guidance Center on March 1. Dr. Little is director of the Houston Guidance Center.

Dr. G. B. Stephenson, Beaumont, was recently presented a ten-year service pin and scroll at a meeting of the Jefferson County chapter of the National Foundation for Infantile Paralysis. Dr. Stephenson has been chairman of the chapter's medical advisory board continuously since 1941 with the exception of three years he spent in the Navy.

Dr. John G. Young, professor of clinical pediatrics at Southwestern Medical School of the University of Texas, Dallas, spoke at Abilene Christian College's 1954 Bible Lectureship.

Dr. B. A. Hallum, winner of the Brady Junior Chamber of Commerce "outstanding young man of the year" award, missed the breakfast at which he was to be presented the official scroll and gold key when an early morning emergency called him away. He received the award later.

Dr. James Hook's mother died March 5. Dr. Hook is from Fort Worth.

Dr. Julian Wilson O'Bryant and Miss Eloise Chain were married on February 21 in Texas City.

Dr. and Mrs. Terrill M. Trimble, Fort Worth, are parents of a boy, Charles Thomas, born March 16. Also parents of a son, born February 1, are *Dr. and Mrs. J. J. Martinez,* San Antonio.

New parents in Houston, as announced by the *Bulletin* of Woman's Auxiliary to Harris County Medical Society, are *Dr. and Mrs. Thomas Kennerly, Dr. and Mrs. Clarence Kaiser,* and *Dr. and Mrs. George Eden.*

According to the *Alumni Bulletin,* University of Texas Medical Branch, Galveston, *Dr. and Mrs. W. B. Neely,* Bellville, are parents of a boy, born January 28. Girls were born to *Dr. and Mrs. J. R. Whitehurst,* Houston, February 6; *Dr. and Mrs. J. H. Childers,* Galveston, March 7; and *Dr. and Mrs. G. W. Apple,* Plano, February 8.

MENTAL HEALTH MEETING

The Texas Society for Mental Health met in Waco March 4-6 and installed Charles N. Burrows, Ph. D., San Antonio, president. Dr. Abe Hauser, Houston, is president-elect. Immediate past president of the society is Mrs. Frank Schoonover, Fort Worth.

Plans for a campaign for members during Mental Health Week were made, and a detailed report of the studies that are being made of the care of the mentally ill was made.

Members of the Texas Medical Association and its Woman's Auxiliary who are on the Board of Directors of the Texas Society for Mental Health are Dr. Titus Harris, Galveston; Dr. Harry M. Little, Houston; Dr. R. C. Rowell, Terrell; Dr. John C. Rucker, Jacksonville; Mrs. Robert F. Thompson and Mrs. George Turner, both of El Paso; and Mrs. E. C. Winkelmann, San Angelo.

The next annual conference of the society will be in Mineral Wells.

TEXANS PLACE IN AAPS ESSAY CONTEST

Two Texas high school students were among the six national winners of the essay contest sponsored this year by the Association of American Physicians and Surgeons. David Curry, El Paso, second place state winner, presented the third place essay, and Kate Wood, El Campo, third place Texas winner, was author of the sixth best paper on "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care." Mr. Curry won $100 and Miss Wood $25 as national prizes.

The contest in Texas was sponsored by the Woman's Auxiliary to the Texas Medical Association and was entered by 866 students. The Association donated $1,000 in state and district prizes, and $2,865 was given on the county level by local societies.

Dr. Mal Rumph, Fort Worth, was chairman of the 1954 national contest committee of the Association of American Physicians and Surgeons, and Dr. Charles D. Reece and Dr. Hampton C. Robinson, Houston, were members of the committee. Mrs. A. O. Severance, San Antonio, was chairman of the Auxiliary essay contest committee.

The other national winners are Robert Taylor, Silver City, N. C., first place; Beverly Tarver, San Marino, Calif., second place; Ronald Williams, Winston-Salem, N. C., fourth place; and Frances Thomson, Lake Charles, La., fifth place.

Last year two Texans also were national winners. Janice Hazelwood, Palestine, won $500 as second prize in the national contest, and Joan Carlisle, Henderson, received $250 for the third best essay in the national competition. Miss Hazelwood and Miss Carlisle were the first and second place state winners respectively. The first prize nationally went to Johanna Randall, Los Angeles, in 1953.

The subject for the 1955 competition is "The Advantages of Private Medical Care" and is again being sponsored in Texas by the Woman's Auxiliary.

UNIVERSITY OF TEXAS MEDICAL BRANCH

The Medical Branch of the University of Texas was the first host in the Southwest to the American Association of Anatomists, which met in Galveston April 7-9. The Tissue Culture Club of America met in Galveston, April 5-6.

The American Association of Plastic Surgeons met in Galveston April 21-23. Examinations by the Board of Plastic Surgeons were given to surgeons in the Galveston area preceding the meeting.

The Texas Medical Record Librarians met in Galveston on March 13.

"Medical Psychological Team Work in Care of the Chronically Ill" was the subject of a joint conference with the Josiah H. Macy Foundation of New York, in Galveston, March 30-31.

Dr. Edgar J. Poth, professor of surgery, will present a paper at the fifty-third annual meeting of the American Proctologic Society to be in Los Angeles, June 2-5.

Recent visitors to the Medical Branch were Dr. Lawrence S. Kubie, professor of psychiatry, Yale University School of Medicine, New Haven, Conn.; Hugh Clark, Ph. D., professor of embryology, University of Connecticut; Dr. Herman Lehmann, St. Bartholomew's Hospital and Bart's Medical School, London; and Dr. Eric Odgen, professor of physiology, Ohio State University, Columbus.

Postgraduate Course

The University of Texas Postgraduate School of Medicine will give a course on "The Use of Isotopes in the Clinical Practice of Medicine" June 1-4 from 7 to 9 p.m. in the Auditorium of the M. D. Anderson Hospital and Tumor Institute, Texas Medical Center, Houston. Members of the Academy of General Practice will receive eight credit hours of formal training for attending the course. A lecture on "Medical Applications of Radioisotopes" will begin the program, and other subjects included will be "Use of Radioactive Iodine" and "Uses of Radioactive Colloidal Gold."

LIBRARY SECTION

POLIOMYELITIS

The recent widespread public interest in the role of immunotherapeutic procedures in poliomyelitis makes it essential for physicians to be aware of the uses and limitations of such agents. The gamma globulin fraction from pooled human blood serums has been shown to exert some ameliorating effect upon the degree of paralysis if administered at an interval of approximately five days prior to the onset of symptoms of poliomyelitis. Gamma globulin apparently has no beneficial effect if administered after the onset of symptoms of the disease. It should be borne in mind that globulin prepared from human placental extract exerts no beneficial effect whatsoever in lessening the extent of paralysis. The limitation of supply of gamma globulin precludes the use of mass prophylaxis with this agent in the face of an epidemic except in a restricted locality.

The ultimate answer to the problem of poliomyelitis is to develop a method of active immunization against the different strains of viruses encountered throughout the United States and neighboring countries.

The vaccine developed by Dr. J. E. Salk, Pittsburgh, will undergo extensive clinical trials this year. This vaccine is prepared from killed viruses and the immunity developed to it, in all probability, will be of comparatively short duration. Also, the incidence of reaction to the vaccine must be determined after many thousands of injections, even though early results indicate a rather low reaction rate.

Attempts are being made to attenuate living poliomyelitis viruses and to find a naturally occurring virus that has a low virulence but will give a lasting immunity similar to that obtained from the cowpox viruses to smallpox. This of course will be the ultimate answer to poliomyelitis.

The following articles and editorials in the field of poliomyelitis may be of interest:

ARTICLES

Aufranc, W. H.: Allocation of Gamma Globulin for Polio, J. Pediat. *42:*636 (May) 1953; *42:*777 (June) 1953.

Ball, J. A.: Epidemiological Aspects of Gamma Globulin Prophylaxis in Poliomyelitis, Critical Evaluation, Am. J. Dis. Child. *86:*311-318 (Sept.) 1953.

Casberg, M. A.: Gamma Globulin and Polio, M. Bull. St. Louis University *4:*181 (Dec.) 1952.

Friedewald, W.: Polio—Pathogenesis and Prophylaxis with Use of Gamma Globulin, J. M. A. Georgia *42:*9-10 (Jan.) 1953.

Halverson, W. L., and Drake, R. M.: Gamma Globulin: Status of Availability for Prevention of Poliomyelitis, California Med. *79:*1-5 (July) 1953.

Hammon, W. M.; Coriell, L. L.; and Stokes, J., Jr.: Evaluation of Red Cross Gamma Globulin as Prophylactic

Agent for Poliomyelitis; Plan of Controlled Field Tests and Results of 1951 Pilot Study in Utah, J.A.M.A. *150:*739-749 (Oct. 25) 1952.

Hammon, W. M.; Coriell, L. L.; and Stokes, J., Jr.: Evaluation of Red Cross Gamma Globulin as Prophylactic Agent for Poliomyelitis; Conduct and Early Follow-Up of 1952 Texas and Iowa-Nebraska Studies, J.A.M.A. *150:*750-756 (Oct. 25) 1952.

Hammon, W. M.; Coriell, L. L.; Wehrle, P. F.; Klimt, C. R.; and Stokes, J., Jr.: Evaluation of Red Cross Gamma Globulin as Prophylactic Agent for Poliomyelitis; Preliminary Report of Results Based on Clinical Diagnosis, J.A.M.A. *150:*757-760 (Oct. 25) 1952.

Kampmeier, R. H.: Gamma Globulin in Poliomyelitis, J. Tennessee M. A. *46:*223-224 (June) 1953.

Korns, R. F.: Prevention of Paralytic Poliomyelitis, Recent Research Suggest Cautious Optimism, New York State J. Med. *52:*2231-2232 (Sept. 15) 1952.

Langmuir, A. D.: Evaluation of Gamma Globulin in Prophylaxis of Paralytic Poliomyelitis in 1953, J.A.M.A. *154:* 1086-1090 (March 27) 1954.

Melick, D. W.: Limitations in Use of Gamma Globulin in Poliomyelitis, Arizona Med. *10:*335-336 (Sept.) 1953.

Sabin, A. B.: Gamma Globulin in Prophylaxis of Polio—Critical Analysis of Available Data, Ohio State M. J. *49:* 603-606 (July) 1953.

Sabin, A. B.: Present Status and Future Possibilities of Vaccine for Control of Poliomyelitis, Am. J. Dis. Child. *86:*681-684 (Sept.) 1953.

Salk, J. E.: Recent Studies on Immunization Against Poliomyelitis, Pediatrics *12:*471-482 (Nov.) 1953.

Salk, J. E.: Studies in Human Subjects on Active Immunization Against Polio; Preliminary Report of Experiments in Progress, J.A.M.A. *151:*1081-1098 (March 28) 1953.

Saslow, S.: Polio Vaccination, Ohio State M. J. *49:*607-608 (July) 1953.

Shanholtz, M. I.: Gamma Globulin in Poliomyelitis, Virginia M. Monthly *80:*341-342 (June) 1953.

Turner, G.: Gamma Globulin, Texas State J. Med. *49:* preceding 485 (July) 1953.

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Distribution and Use of Gamma Globulin, Pub. Health Rep. *68:*660-665 (July) 1953.

Distribution and Use of Gamma Globulin, Minnesota Med. *36:*496-498 (May) 1953.

Effective Poliomyelitis Vaccines, New England J. Med. *248:*952-953 (May 28) 1953.

Gamma Globulin and Polio, Brit. M. J. *1:*874-875 (April 18) 1953; Canad. M. A. J. *68:*390-391 (April) 1953.

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Plan for Allocation of Gamma Globulin; Issued April 15, 1953, by Office of Defense Mobilization in Executive Office of President, Pub. Health Rep. *68:*666-668 (July) 1953.

Polio Foundation Warns on Gamma Globulin, South Dakota J. Med. *6:*133-134 (April) 1953.

Polio Vaccines, Lancet *1:*777-778 (April 18) 1953.

Present Prospects in Poliomyelitis, New York State J. Med. *53:*1193-1194 (May 15) 1953.

Statement of National Foundation for Infantile Paralysis on Gamma Globulin and Vaccine, J. South Carolina M. A. *49:*155-156 (June) 1953.

Use of Gamma Globulin, Mil. Surgeon *112:*442-443 (June) 1953.

—CLIFFORD THORNE, M. D., Austin.

BOOKS RECEIVED IN APRIL

Bickers, William: Menorrhalgia; Menstrual Distress, Springfield, Ill., Charles C Thomas, 1954.

Child, Charles G., III: The Hepatic Circulation and Portal Hypertension, Philadelphia, W. B. Saunders, 1954.

Conant, Norman F.; Smith, David Tillerson; Baker, Roger Denio; Callaway, Jasper Lamarr; and Martin, Donald Stover: Manual of Clinical Mycology, ed. 2, Philadelphia, W. B. Saunders, 1954.

Conn, Howard F.: Current Therapy, 1954, Philadelphia, W. B. Saunders, 1954.

Dimond, E. Grey: Electrocardiography, St. Louis, C. V. Mosby, 1954.

Engle, Earl T.: Pregnancy Wastage, Springfield, Ill., Charles C Thomas, 1953.

Farber, Seymour M.: Lung Cancer, Springfield, Ill., Charles C Thomas, 1954.

Faust, Ernest Carroll: Amebiasis, Springfield, Ill., Charles C Thomas, 1954.

Grollman, Arthur: Acute Renal Failure, Springfield, Ill., Charles C Thomas, 1954.

Marriott, Henry J. L.: Practical Electrocardiography, Baltimore, Williams and Wilkins, 1954.

Mayo Clinic: Diet Manual, ed. 2, Philadelphia, W. B. Saunders, 1954.

McKittrick, Leland S., and Wheelock, Frank C.: Carcinoma of the Colon, Springfield, Ill., Charles C Thomas, 1954.

Myklebust, Helmer R.: Auditory Disorders in Children, New York, Grune and Stratton, 1954.

Page, Ernest W.: Hypertensive Disorders of Pregnancy, Springfield, Ill., Charles C Thomas, 1953.

Podolsky, Edward: The Jealous Child, New York, Philosophical Library, 1954.

Pulaski, Edwin J.: Surgical Infections, Springfield, Ill., Charles C Thomas, 1954.

Reich, Nathaniel E.: The Uncommon Heart Diseases, Springfield, Ill., Charles C Thomas, 1954.

Roth, Leon: The Guide for the Perplexed; Moses Maimonides, London, Hutchinson's University Library, 1948.

Serbein, Oscar N., Jr.; Paying for Medical Care in the United States, New York, Columbia University Press, 1954.

World Directory of Medical Schools, Geneva, World Health Organization, 1953.

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Library's "Laundry Kits" Praised

The solution reached by the Memorial Library of the Texas Medical Association for its shipping container problem has received acclaim in the May-June issue of *Special Libraries,* the official publication of the Special Libraries Association. An illustrated item calls attention to the problem faced in shipping material to doctors throughout Texas and then in getting it returned, and to the "laundry kits" of fiber board which have been found satisfactory two-way containers since their introduction some six months ago. The article suggests that other libraries which have loan services by mail might follow the lead of the Texas Medical Association in the use of such handy containers.

CONTRIBUTIONS TO LIBRARY

The Woman's Auxiliary to the Texas Medical Association recently contributed $1,000 to be set up as an endowment fund for the Memorial Library. The Auxiliary's past presidents have donated $340 for the purchase of back issues of journals for the Library.

MOTION PICTURES FOR LOAN

Transthoracic Esophageal Diverticulectomy

16 mm., color, silent, 24 minutes.

This motion picture shows a transthoracic excision of a diverticulum of the lower third of the esophagus. Such an operation has been made feasible by the development of the antibiotics, by easy availability of blood for multiple transfusions, and by skilled physician-anesthetists. The patient in this instance has a large diverticulum immediately above the diaphragm. A one-stage diverticulectomy with immediate repair of the esophagus is presented.

Back to Normal

16 mm., sound, 16 minutes.

The fact that today the loss of a limb, even two limbs, does not mean that the victim need live a life different from normal is emphasized. A man with two artificial legs dances and plays tennis. A child who lost a leg skips and plays with other children. This is an excellent film for nursing classes and physical therapists.

Regional Anesthesia

16 mm., color, silent, 50 minutes.

This film presents the most important clinical phases of regional anesthesia. Abdominal regional block and various methods of subarachnoid block are shown. The transsacral block anesthesia is given in detail. Under cervical plexus block, reduction of an ulnar fracture is shown. Following ulnar and median nerve block, the replacement of a damaged digital flexor tendon with a graft is demonstrated in detail.

Ascorbic Acid and Scurvy

16 mm., sound, 25 minutes.

Ascorbic acid and its relation to scurvy are shown in this film prepared by Dr. Frederick F. Tisdall. The film depicts the history, physical signs, symptoms, diagnosis, and treatment of scurvy. Clinical photographs and roentgenograms are used to illustrate a few typical cases. This film will be of interest to pediatricians and general practitioners.

BOOK NOTICES

[1]Living with a Disability

HOWARD A. RUSK, M. D., *and* EUGENE J. TAYLOR, *in collaboration with* MURIEL ZIMMERMAN, O.T.R., *and* JULIA JUDSON, M. D., *Institute of Physical Medicine and Rehabilitation. New York University-Bellevue Medical Center. 207 pages. $3.50. Garden City, N. Y., Blakiston Company, 1953.*

The authors of this commendable book have collected much widely scattered information on self-help devices to enable the physically handicapped to live as nearly normal lives as possible. The book is addressed primarily to the person with a disability and to those about him responsible for his welfare but also should be useful to the physician in helping him to solve some of the complex problems of rehabilitation which he encounters in his practice.

The book deals with devices other than orthopedic braces and prosthetic appliances and with special living arrangements which have been found helpful in aiding the disabled person to retain his independence. The authors have depicted a large variety of ingenious methods which have been devised, often by the handicapped person himself, to facilitate the performance of otherwise difficult or impossible tasks.

The photographs and drawings are uniformly good, and the book is accompanied by a detailed inventory of the activities of daily living by which the status and progress of the patient can be accurately assessed.

[1]*Ben Walpole, M. D., Houston.*

[2]The Allergic Patient and His World

FLORENCE EASTTY SAMMIS, M. D., M.S.P.H., F.A.A.A., *Assistant Attending Physician in Allergy, Nassau Hospital, Mineola. A Monograph in the Bannerstone Division of American Lectures in Allergy. Edited by* MAX SAMTER, M. D., *Chief, Allergy Clinic, University of Illinois College of Medicine, Chicago. 156 pages. $4.75. Springfield, Ill., Charles C Thomas, 1953.*

The author has presented in compact form a description of the most common allergic manifestations—hay fever, asthma, and allergic skin disorders. The causative agents are discussed extensively. Allergic diagnostic techniques are described and some of the pitfalls are documented. Discussions of the theoretic bases of allergic phenomena are rightfully kept to a minimum. She has accomplished the initial purpose which she set forth in the introduction, "to inform the allergic patient about his problems and aid him in carrying out the instructions and treatment outlined by the physician."

The author has encountered a difficulty inherent in the presentation of a technical subject. While in some instances she has adroitly side-stepped involved discussions that have no place in a book for patients, in many instances the presentation is clouded by involved discussions that go far enough to cause confusion but not far enough to clear up the questions raised. Examples of erroneous concepts resulting from discussions include the impression of migraine. The value of the basic information useful to the patient is somewhat diminished because of some of the resultant confusion and partial misconception formulated by the author.

[3]The Hypertensive Disorders of Pregnancy

ERNEST W. PAGE, M. D., *Associate Professor, Obstetrics and Gynecology, University of California School of Medicine, San Francisco. 108 pages. $3.75. Springfield, Ill., Charles C Thomas, 1953.*

This is a neat little volume. The adjective applies to the format, binding, and editing as well as to the content. The author's authority cannot be questioned. Neither can his honesty and sincerity. The material is well organized and presented in a simple, lucid, and factual manner. In chapter two, devoted to physiologic and bichemical changes, the author deserves credit for achieving his stated purpose, "to present factual data separated from speculation about etiology." The author's classification of the toxemias of pregnancy is similar to that proposed by the American Committee on Maternal Welfare but places deserved emphasis on "recurrent toxemia." A glaring typographical error is the omission of subhead B under class 11 from the classification proposed by the American Committee on Maternal Welfare. In the discussion of etiology, the author admits a justifiable preference for his own theory. The accuracy and comprehensiveness of the factual material, the straightforward presentation, and the suggestions for logical application of known facts to clinical problems combine to make the book one of real merit. It can be warmly recommended

[2]*Jack M. Rose, M. D., Houston.*
[3]*William F. McLean, M. D., Austin.*

to all practitioners who give serious consideration to the problems encountered in the practice of obstetrics.

[4]**Modern Concepts in Medicine**

JULIUS JENSEN, PH. D. *(In Medicine)*, M.R.C.S. *(England)*, L.R.C.P. *(London)*. *636 pages. $11.50. St. Louis, C. V. Mosby, 1953.*

This book is well written, not ultrascientific, but practical and should be of inestimable value to students and general practitioners.

[5]**Dermatology in General Practice**

JACOB HYAMS SWARTZ, M. D., *Assistant Professor of Dermatology, Harvard Medical School and Post-Graduate School; Consulting Dermatologist, Massachusetts General Hospital. Foreword by* C. GUY LANE, M. D., *Professor Emeritus, Department of Dermatology, Harvard Medical School; Consulting Dermatologist, Massachusetts General Hospital, Boston. 581 pages. $11. Baltimore, Williams and Wilkins Company, 1953.*

This is an average sized book on dermatology which is replete with illustrations and diagnostic charts. From the point of view of diagnosis the book is excellent. I used the book for six months in my practice before making this review, and as a general rule I found it an entirely satisfactory place to take dermatologic problems. The one exception was found in diseases of the hands. I think that the author could have gathered together his information better in one place on this particular item. From the point of view of treatment, the textbook was all that could be expected of a book of this size. However, the average general practitioner will find that he has to take some of his more difficult dermatologic problems to some of the more comprehensive texts or to the medical journals.

[4]*W. E. Tatum, M. D., Beaumont.*
[5]*Woodson W. Harris, M. D., Austin.*

[6]**A Guide to Human Parasitology**

D. B. BLACKLOCK, M. D. (Edin.), D.P.H. (London), D.T.M. (Liver.), *Formerly Professor of Tropical Hygiene, Liverpool School of Tropical Medicine, University of Liverpool, and* T. SOUTHWELL, D. Sc., Ph. D., *Formerly Walter Myers Lecturer in Parasitology, School of Tropical Medicine, University of Liverpool. Revised by* T. H. DAVEY, M. D. (Belf.), D.T.M. (Liver.), *Professor of Tropical Hygiene, Liverpool School of Tropical Medicine, University of Liverpool. Fifth edition. 228 pages. $5.50. Baltimore, Williams and Wilkins Company, 1953.*

This book was written as a guide to the general practitioner, for diagnosis and prevention of diseases in man due to animal parasites. Only material pertinent to this premise has been included in order to avoid confusion from unnecessary voluminous information.

The writer assumes that the reader has had no experience in this field, but with the use of this guide can become proficient in the diagnosis of human parasites.

The text is well illustrated, including only points in the parasite's life cycle at which control measures may be applied.

A chapter on the microscope is included, devoting space to its description and use and to instructions in the use of the ocular and stage micrometer. Then follow chapters on the various parasites, grouped according to their classification. The life cycle, distribution, the method of preparing material for examination, and a short note on prevention is presented in each chapter.

The fifth revision has included parasites encountered in the tropics during World War II.

A final brief chapter is devoted to congenital infection and immunity.

This book should be useful to the general practitioner as a concise reference on parasitology, using only apparatus usually found in every office.

[6]*William J. Swann, M. D., Sterling City.*

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION

AMA San Francisco Meeting

A program including almost every phase of medical practice with special emphasis on the results of research and advances in diagnosis and treatment will be given at the one hundred third annual meeting of the American Medical Association in San Francisco, June 21-25.

More than 200 scientific exhibits, including special features on fractures, preceptorships, and blood banks, and 400 technical exhibits will be shown at the Civic Auditorium during the meeting.

The Distinguished Service award will be made by the AMA House of Delegates in the opening session Monday morning in the ballroom of the Palace Hotel, and the new President will be installed at the inaugural meeting at the same hotel Tuesday evening. The ceremony, at which Dr. Walter B. Martin, Norfolk, Va., will be installed, will be broadcast over the American Broadcasting Company's radio network for those who cannot attend the meeting. Also at the nation's largest medical meeting the National Broadcasting Company's television network will carry on-the-scene views of the physicians studying medical advances. This program is expected to have 14,000,000 viewers when it goes on television screens at 8 p. m. Central Standard Time, Thursday, June 24. The world premiere showing of some outstanding films of broad general interest will be given at the Wednesday evening meeting of the AMA at the High School of Commerce Auditorium, where all the scientific meetings will be held. Telecasting of clinics and operations will originate in the San Francisco General Hospital and will be shown in the Drill Hall of the Masonic Temple during the session.

Registration for this five-day meeting will be at the entrance to the Portico of the Civic Auditorium, beginning on Sunday for those who are in San Francisco before the meeting gets under way. General officers of the AMA and members of the House of Delegates may register for the Scientific Assembly at the entrance to the ballroom of the Palace Hotel.

Besides a full schedule of scientific meetings and many exhibits to see, there will be an inaugural ball for the President following the ceremony Tuesday evening; fraternity and alumni associations will have reunion luncheons and dinners throughout the week; and the thirty-eighth golfing tournament will be held on Monday. A full schedule for the Woman's Auxiliary, with headquarters at the Fairmont Hotel, is also planned. Special tours to interesting places in California as well as a trip to Hawaii are being planned for postconvention relaxation.

SURVEY OF TEXAS COUNTY MEDICAL SOCIETIES FOR 1953

Results of a survey covering activities for the year 1953 have provided a basis for the establishment of new programs which will be designed to strengthen membership, attendance, and prestige of the 116 county medical societies in the state. The survey was conducted at the request of the President of the Texas Medical Association, Dr. F. J. L. Blasingame, Wharton. Questionnaires were completed and returned by the secretaries of 90 societies.

An analysis of the survey, along with recommendations, presently is being studied by Dr. Blasingame, the Board of Trustees, and the Executive Secretary of the Association. It is anticipated that several positive programs will be initiated shortly. Methods are being explored for establishing a more effective two-way system of communication between county medical societies and officers of the Association, district councilors, and representatives of the central office.

Almost two-thirds of the membership of the Texas Medical Association is affiliated with the 14 largest county medical societies in the state. Actually, 4,328 of 6,678 physicians (64½ per cent) are members of the 14 societies. Seventy-one of the 116 societies have 25 or fewer members, with a combined membership of only 943, which is 14½ per cent.

The survey revealed a definite correlation between the numerical membership of the county medical society and the percentage of attendance at meetings. The smaller societies attained the highest percentage of attendance, average attendance for societies with 10 or fewer members being 71 per cent. Conversely, the larger societies attracted the least number, average attendance for the 4 largest societies being 15 per cent of total membership.

The number of meetings conducted by county medical societies during the year varied little despite differences in the size of membership. A great majority of societies scheduled 10 to 12 meetings. The lone major variation was reported by the small societies, which, for the most part, held only a few business meetings.

In almost every medical organization, it is not unusual to have at least a few members who never attend a meeting and who contribute little or nothing to the welfare of organized medicine except for their routine payment of dues. Results of the survey indicated that the percentage of "deadwood" in a society increases with the numerical size of membership. More than half of the smaller societies (5 to 10 members) reported that they did not have any members who failed to attend at least one meeting in 1953. On the other hand, very large societies in metropolitan areas listed a relatively high percentage of "deadwood." The 4 largest societies averaged 29 per cent who did not attend a single meeting.

According to the reports of the secretaries, councilors met with only 43 per cent of all societies in the state last year. Sixteen per cent of the smaller societies (5 to 10 members) listed a visit from their councilor. However, several secretaries cited the councilor of the district for his loyalty and interest, and it has been pointed out that failure of county societies to follow up feelers from conscientious councilors may have reduced the number of visits by councilors. Seven of the 10 societies with membership ranging from 100 to 215 reported that councilors attended one or more meetings; the 4 largest county societies—Harris, Dallas, Bexar, and Tarrant—all acknowledged visitations.

The survey also documented the need for establishment of a program of visitations to county medical societies by officers of the Association and representatives of the central office.

Analysis by Size of Society

The results of the survey were analyzed according to numerical membership of county medical societies. Separate studies were made of societies with memberships of 5 to 10, 11 to 25, 26 to 50, 51 to 99, 100 to 215, and 216 to 1,100. These findings follow.

Societies with 10 or Fewer Members.—Twenty of the 116 county medical societies of Texas (17 per cent) have 10 or fewer members. There are 3—Coryell, Freestone, and Hamilton—which have only the minimum number of 5. Combined, these 20 societies have 156 members, representing 2½ per cent of the total membership of the Texas Medical Association.

These societies conducted an average of 2 formal meetings during 1953, although the number varied between 1 and 12. Montgomery County Medical Society recorded the high of 12. Generally, societies which held only 1, 2, or 3 meetings a year were more likely to devote those sessions to business than to scientific programs. More than 25 per cent of these societies held combination business meetings and scientific programs. The analysis revealed that the number of formal meetings sponsored by a society during the year did not necessarily portray the effectiveness of that organization. For example, Dr. H. L. Stewart, Navasota, reported: "Most of the Grimes County membership is together throughout the day. With this small group, many medical problems are discussed without the formality of a meeting."

Attendance at meetings of these societies was generally good. These small societies reported 71 per cent average attendance. Several societies, such as Coryell and Shelby-San Augustine-Sabine, indicated that it was not unusual for all members to be present. An average of only 8 per cent of the total membership of these organizations did not attend a single meeting during the year. More than half of the societies reported that they did not have any members who failed to attend at least one meeting.

Secretaries of these societies reported few visitations from district councilors. Only 2 of the 16 societies (16 per cent) returning questionnaires acknowledged a visitation during 1953 by a councilor.

TABLE 1.—*Summary of Survey of County Medical Societies in Texas for 1953.*

Society Membership	No. of Societies*	Combined Membership*	Average Attendance (%)	Average No. of Meetings	"Deadwood"† (%)	Visited by Councilor (%)
5-10	20 (17%)	156 (2½%)	71	2	8	16
11-25	51 (44%)	787 (12%)	68	12	13	40
26-50	22 (19%)	720 (11%)	49	11	9	25
51-99	9 (8%)	687 (10%)	37	10	10	57
100-215	10 (9%)	1,490 (22%)	38	10	17	70
216-1,100	4 (3%)	2,838 (42½%)	15	15	29	100

*Figures in parentheses represent percentage of total covered by Texas Medical Association.
†Members of a society who did not attend a single meeting in 1953.

Several secretaries suggested the establishment of a speakers bureau for the purpose of strengthening programs of the small societies. Several also pointed out that the limited memberships of their organizations prohibits the invitation of prominent guest speakers. Four societies—Caldwell, Gonzales, Guadalupe, and Hays-Blanco—have found a satisfactory solution to this problem by meeting jointly bimonthly, thus providing a larger audience for speakers.

Societies with Memberships of 11 to 25.—Approximately 44 per cent of the medical societies in Texas (51 of 116 societies) have between 11 and 25 members each. These societies have a combined membership of 787, representing 12 per cent of the membership of the Texas Medical Association.

During the past year, these societies conducted an average of 8 meetings each. Four societies sponsored 12 formal meetings. There was 1 society which had only a single meeting. A great majority of the organizations held combination business meetings and scientific programs. Most of these societies also reported 1 or more social functions.

Attendance at meetings was uniformly good, averaging 68 per cent. Only 5 reporting societies with 11 to 25 members reported average attendance at less than 50 per cent for each meeting. Forty-two per cent of the societies indicated that every member attended one or more meetings during the year. For all societies, however, an average of 13 per cent of total membership did not attend a single meeting. Two societies listed 10 members each who were totally inactive.

Secretaries of 60 per cent of the societies in this group reported that the councilor did not visit them last year. Nevertheless, it is evident that several councilors were extremely active. Palo Pinto-Parker acknowledged that its councilor was present three times.

Several societies noted positive trends in regard to attendance and interest by the membership. The need for meetings with the district councilors and with representatives of the central office was cited by several officers.

Societies with Memberships of 26 to 50.—Approximately 19 per cent of the county medical societies (22 of 116 societies) have memberships which vary from 26 to 50 members. These 22 societies have 720 members, representing 11 per cent of the total membership of the state Association.

These societies conducted an average of 11 meetings during 1953. All but one society staged a minimum of 7 meetings. An outstanding record for the year was achieved by the Hunt-Rockwall-Rains-Delta Counties Medical Society. It sponsored 40 meetings, 38 devoted to scientific programs, 1 to business, and 1 a social affair. Seventy-five per cent of all meetings held by these societies were devoted to a combination of business and scientific matters.

The average attendance at meetings was 49 per cent. The most outstanding attendance record in this classification was claimed by Bowie County Medical Society. It achieved an average attendance of 70 per cent (24 members present from a membership of 35). A typical society in this grouping had 32 members, with an average attendance of 16 at meetings. These societies also had an average of 3 members who did not attend any meetings last year. Six societies reported that they had no "deadwood" at all. On the other extreme, 4 organizations indicated that they had 10 or more members who had not attended a single meeting.

Another debit was the comparatively few visitations made to these societies by district councilors. Only 25 per cent of the reporting secretaries listed a visit to the society by the councilor.

Societies with Memberships of 51 to 99.—Eight per cent of the county medical societies (9 of 116 societies) list the membership roster at between 51 and 99. These 9 societies have a combined total of 687 members, which is approximately 10 per cent of the membership of the Texas Medical Association.

Most of these societies met monthly, with the number of meetings ranging from 8 to 12 and averaging 10 per society. In most instances these societies combined a business meeting with a scientific program. An average of 1 social function annually also was listed by these organizations.

Average attendance at meetings was 37 per cent. The highest average attendance was reported by Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson Counties Medical Society. This society claimed 80 per cent average attendance, representing 50 present of the total membership of 63. These societies indicated that an average of 10 per cent of the total memberships were inactive and had not attended any meetings during the year.

Secretaries of 57 per cent of the societies listed their district councilors as having met with them at least once.

Societies with Memberships of 100 to 215.—Nine per cent of the county medical societies (10 of 116 societies) have memberships ranging from 100 to 215. These 10 societies have a total of 1,490 members, representing 22 per cent of the membership of the state Association.

Most of these societies convened monthly. The actual number of meetings varied between 6 and 18, with an average of 10. El Paso County Medical Society staged a high of 18 meetings, including 16 scientific sessions. Scientific programs predominated over business meetings for societies in this classification, although frequently a portion of the meeting was devoted to each.

Average attendance at meetings was 38 per cent. Championship honors among these societies went to the Taylor-Jones Counties Medical Society, which listed 60 per cent average attendance. El Paso County Medical Society reported a definite "upswing" in attendance at recent meetings. Officers of that society singled out the serving of buffet suppers as an important factor which stimulated attendance.

"Deadwood," those who never attend a meeting, averaged 17 per cent for societies with 100 to 215 members. Again Taylor-Jones compiled an enviable record, listing its nonparticipants at 5 per cent. On the other extreme, 1 large county medical society stated that approximately 40 per cent of its total membership did not attend a single meeting.

Secretaries of 7 out of 10 of these large societies said that their councilors met with them at least once during the past twelve months. Some societies lauded their councilors for meeting with them regularly. Nevertheless, more frequent visitations by councilors was urged by several secretaries.

Societies with Memberships of 216 to 1,100.—Harris, Dallas, Bexar, and Tarrant Counties Medical Societies, the 4 largest in Texas, have a combined membership of 2,838, representing 42½ per cent of the total membership of the state Association.

Harris and Dallas met monthly, while Bexar and Tarrant conducted semimonthly meetings. Types of meetings conducted by each follow:

Society	*Scientific*	*Business*	*Social*
Harris	6	4	0
Dallas	8	1	1
Bexar	15	4	2
Tarrant	10	4	5

The percentage of attendance at meetings of these 4 societies, like most others located in metropolitan areas, was comparatively low. Dallas and Tarrant figured average attendance at 20 per cent during 1953. Bexar listed 16 per

cent average attendance. The secretary of Harris County wrote that attendance varied from 1½ to 4 per cent for scientific meetings, 4½ to 6 per cent for regular business meetings, and 30 per cent for the annual meeting.

These 4 county medical societies reported a high percentage of members who did not attend any meetings during the year. Harris estimated that more than half of its membership did not attend a single meeting. Dallas listed approximately 24 per cent of its membership as nonparticipants; Tarrant 13 per cent. Bexar listed no figure.

The secretary of each society reported that the councilor met with the society at least once during the year.

COUNTY SOCIETIES

Armstrong-Donley-Childress-Collingsworth-Hall Counties Society

March 19, 1954

(Reported by Carter Holcomb, Secretary)

Differential Diagnosis of Chest Pain—Horace Wolf, Amarillo.

Armstrong-Donley-Childress-Collingsworth-Hall Counties Medical Society met for a dinner with the auxiliary on March 19 at Memphis. The third annual meeting of county medical society presidents and secretaries held in Austin in January was discussed.

Dr. Wolf illustrated with case histories his presentation on chest pain.

Baylor-Knox-Haskell Counties Society

February 10, 1954

Baylor-Knox-Haskell Counties Medical Society met February 10 in Munday to hear the telephone broadcast originating in Austin, "Recent Advances in Internal Medicine."

Officers elected at the meeting were C. G. Markward, Knox City, president; J. W. Foy, Seymour, vice-president; R. L. Newsom, Munday, secretary-treasurer; and T. S. Edwards, Knox City, and E. H. Balch, Seymour, delegates.

Bosque County Society

February, 1954

Bosque County Medical Society met in February at the home of V. D. Goodall in Clifton and elected the following officers: R. D. Holt, Jr., Meridian, president; A. N. Pike, Iredell, vice-president; N. E. Dudney, Clifton, secretary-treasurer; and Dr. Goodall, delegate.

Brooks-Duval-Jim Wells Counties Society

February 25, 1954

Stephen Williams, Corpus Christi, spoke to the Brooks-Duval-Jim Wells Counties Medical Society February 25 after a dinner with its woman's auxiliary in the home of Dr. and Mrs. W. H. Newkirk, Alice.

Brown-Comanche-Mills-San Saba Counties Society

March 9, 1954

(Reported by Ned Snyder, Secretary)

Brown-Comanche-Mills-San Saba Counties Society at its March 9 meeting in Brownwood voted to endorse a project of its auxiliary to sponsor a student nurse through three years of training. The person chosen, endorsed by the society, will be one who could not afford training and would be given $200 yearly as a loan. If the nurse practices three years in one of the four counties in the society, the loan will be cancelled; if the nurse does not return to one of the four counties to nurse, she will be required to return the money borrowed when she is able, and the money will be used to aid another student in the same way.

Cameron-Willacy Counties Society

March 15, 1954

(Reported by Harry A. Miller, Secretary)

After a dinner and program of entertainment by the woman's auxiliary on March 15 in Brownsville, Cameron-Willacy Counties Medical Society held a business meeting. The society voted to move the Tumor Clinic from Harlingen to Brownsville if the American Cancer Society will continue to give its support, and a short film on cancer was shown to the society and approved for showing to lay groups.

Dr. Clarence N. Cash, San Benito, was elected to honorary membership.

Colorado-Fayette Counties Society

January, 1954

At a dinner meeting in Weimar during January, Colorado-Fayette Counties Medical Society elected E. T. Williams, La Grange, president. Other officers elected were Willis G. Youens, Weimar, vice-president; August J. A. Watzlavick, Schulenburg, secretary-treasurer; and Lyman E. Ihle, Schulenburg, delegate.

Cooke County Society

February 8, 1954

Louis E. Aiden, Dallas, was guest speaker at the Cooke County Medical Society meeting February 8 in Gainesville.

Dallas County Society

February 9, 1954

(Reported by Glenn D. Carlson, Secretary)

Symposium on Coronary Insufficiency—Howard E. Heyer, Dallas, Moderator.
Acute Coronary Insufficiency—Carleton B. Chapman, Dallas.
Myocardial Infarction—Alfred W. Harris, Dallas.
Effect of Drugs on Coronary Circulation—Andres Goth, Dallas.

At the February 9 meeting of the Dallas County Medical Society the above program was given. New doctors elected to membership were Charles Edward Van Cleave, Jr., Hugh D. Murray, E. C. Brown, Guy B. Fain, William L. Berson, Edward L. Rhodes, Joseph C. Ogle, Irvin Joseph Goldfarb, Joseph B. Gordon, II, Joseph Edward Wilke, Jr., James Emmett Goode, Leonard M. Rifkin, Allen T. Stewart, Jr., and Richard B. Hunter. A student nurse scholarship fund for Dallas County which was proposed by the woman's auxiliary was approved by the society with the provision that approval of the person to receive the scholarship be made by a committee of the society. The purpose of the scholarship fund will be to assist financially young men and women who want to study nursing but are unable to do so because of lack of funds.

March 9, 1954

(Reported by Glenn D. Carlson, Secretary)

Clinical and Investigative Value of Cardiac Catheterization—John A. Osborne, Dallas.
Moderator—Alfred W. Harris, Dallas.

Before the above scientific program was presented, members of the Dallas County Medical Society were dinner guests of the Baylor Hospital medical staff on March 9 in Dallas. Medical economics news was reviewed by the executive secretary of the local society, Mr. Millard Heath. The society voted to take no action on the administration of the Salk poliomyelitis vaccine until further information was received. The public health committee was given additional time to explore the facts regarding the vaccine.

March 23, 1954

(Reported by Glenn D. Carlson, Secretary)

The Dallas County Society met in a special called session on March 23 to consider a report of the public health committee and board of directors concerning the poliomyelitis vaccine field trials in Dallas. Both the committee and the board of directors recommended that Dallas County Medical Society approve the voluntary participation of its members in the proposed voluntary mass vaccination of Dallas second grade children.

Harris County Society

April 14, 1954

Harris County Medical Society held a business meeting April 14 in Houston. It was announced that a series of television programs, entitled "Focus on Health," which have been produced by the society and Houston Public Schools would begin the next Sunday afternoon. James Schofield, assistant dean of Baylor University College of Medicine, Houston, is narrator for the series.

Nueces County Society

March 9, 1954

(Reported by Gerald S. Ahern, Secretary)

Threats to Our Freedom—W. Oliver Harrison, pastor, First Christian Church, Corpus Christi.

Nueces County Medical Society met with its woman's auxiliary March 9 in Corpus Christi and heard the above speech. Plans for the Boys City fund raising campaign in Corpus Christi and tentative plans for mass inoculation of the trial poliomyelitis vaccine were discussed.

Tarrant County Society

March 16, 1954

(Reported by S. W. Wilson, Secretary)

Early Diagnosis and Management of Upper Gastrointestinal Hemorrhage—Charles Terrell, Adolph Kauffmann, Robert D. Moreton, and Charles Robinson, Fort Worth.

The program as outlined above was given at the March 16 meeting in Fort Worth of the Tarrant County Medical Society. Plans for the poliomyelitis immunization program were discussed, and the society approved the use of the vaccine in Tarrant County schools.

April 6, 1954

(Reported by S. W. Wilson, Secretary)

Cancer of Head and Neck—Oscar L. Morphis, Fort Worth.

After hearing the above scientific program, the Tarrant County Medical Society, meeting April 6 in Fort Worth, held a discussion led by John B. Patterson. A report of the legislative committee was given by Ernest E. Anthony, Jr., chairman. The results of a study of proposed national legislation concerning social security and a reinsurance program for health insurance plans were presented to the society.

Dr. Bertha S. McDavitt was voted an honorary member of the society.

Tom Green-Eight County Society

April 5, 1954

(Reported by Joe L. Cornelison, Secretary)

Chronic Cervicitis—William F. Mengert, Dallas.

The Tom Green-Eight County Medical Society met April 5 in San Angelo and heard the above scientific program.

A report on the functions of the committees was given, and it was decided that the secretary should mimeograph a copy of the duties of the committees and send a copy to each member. A report was given on high school athletic care costs.

Travis County Society

April 20, 1954

Travis County Medical Society held a business meeting April 20 at the Texas Medical Association headquarters, Austin.

The following committee reports were made: blood bank, S. W. Bohls; cancer, Dr. Bohls; cerebral palsy, W. W. Kelton, Jr.; diabetes, Henry Renfert, Jr.; emergency call panel, Walter D. Roberts; heart, Thomas M. Runge; legislative, Raleigh R. Ross; mediation, Earl L. Yeaker; and mental health, David Wade. Other reports given were poliomyelitis, Frederick C. Lowry; public health, B. O. White; public relations, David O. Johnson; school health, Cary Legett, Jr.; tuberculosis, J. E. Johnson; and woman's auxiliary, James M. Coleman. A discussion of the proposed amendments of the Texas Medical Association's constitution and by-laws was held.

Washington-Burleson Counties Society

January, 1954

Cancer of Pancreas—L. R. Rodgers, Houston.

The above program was given in Brenham during January at a dinner meeting of the Washington-Burleson Counties Medical Society given by the Milroy Memorial Hospital staff.

Wilbarger County Society

March 2, 1954

The Wilbarger County Society held a business meeting March 3 in Vernon to consider a proposed city garbage disposal plan. F. B. Steele, president, presided over the meeting; the members approved the proposal.

DISTRICT SOCIETIES

Tenth District Society

April 10, 1954

(Reported by Rider Stockdale, Secretary)

Prepartum and Postpartum Hemorrhage—Julius McIver, Dallas.
Laminographs and Other Specialized Roentgen-Ray Techniques—John J. Sazama, Jr., Dallas.
Growth and Development of Infants—C. James Krafft, Dallas.

James C. Klein, Lufkin, was named president-elect of the Tenth District Medical Society when it met April 10 in Nacogdoches, and Dan Spivey, Lufkin, was nominated secretary-treasurer-elect. Serving as president of the society this year is John M. White, Port Arthur; Rider Stockdale, Jasper, is secretary-treasurer.

L. C. Heare, Port Arthur, was chosen as a nominee for Trustee of the Texas Medical Association if a geographical representation is adopted. If the geographical plan is not put into effect, Dr. Heare was nominated to succeed himself as Councilor. Stephen B. Tucker, Nacogdoches, presently Vice-Councilor, was named as nominee for the councilorship if Dr. Heare should become a Trustee.

The scientific program was given as outlined above.

Eleventh District Society

April 15, 1954

Bronchoscopy as Aid to Diagnosis in Lung Disease—Cuthbert Young and J. P. Mullowney, Tyler.
Place of Diet in Management of Heart Disease—Edward D. Futch, Galveston.
Psychiatric Emergencies in General Practice—A. Hauser, Houston.
Recent Advances in Gynecology—Felix Rutledge, Houston.

The above scientific program was heard by members of the Eleventh District Medical Society at the April 15 meeting in Crockett. Auxiliary members held a meeting the same day and met for dinner with the society that evening.

AUXILIARY SECTION

AN ALLY

Because the Texas Medical Association was regularly accompanied by the doctors' wives as "visiting ladies" at its annual meeting, the desirability of coordinating their effort became apparent. The purpose in organizing as an Auxiliary, as stated in the constitution, was "To bring into closer fellowship and sympathy the families of Physicians. To engage in any benevolent and philanthropic work they saw fit—also to extend the aims and purposes of the Medical profession through the Doctors' Wives to the various Women's Organizations which look to advancement in health and health education."*

At the suggestion of Mrs. J. O. McReynolds of Dallas, the first meeting of doctors' wives was called in May, 1917, in Dallas; this group became the Dallas County Auxiliary. News of the activities of this unit spread throughout the state, and organization of other auxiliaries followed the same year—McLennan County in June, 1917, and Bexar in October, 1917. The members working in these county groups felt the need for a "mother auxiliary," and the ladies in attendance upon the annual state medical meeting in San Antonio in 1918 were called together informally to consider the advisability of forming a State Auxiliary. Mrs. H. R. Dudgeon of Waco prepared the platform upon which the state organization was formed, and Dr. E. H. Cary of Dallas, President of the Texas Medical Association at the time, championed the cause of an organizational movement among the doctors' wives.

Current members of the Auxiliary, looking at the formation of a State Auxiliary on that May day in San Antonio in 1918 and at its growth up to May, 1954, with a membership of approximately 4,700, can see the influence the doctors' wives have had as they have worked side by side with their husbands. As the Texas Medical Association has grown in scope and number of members, so has its ally the Auxiliary. In 1943 the membership of the Association was 4,607; in 1953 it had increased to 6,723. In this ten years the membership of the Auxiliary increased from 2,176 to 4,463. There were 61 county auxiliaries in 1943, with a 40 per cent increase in 1953.

Paralleling its growth has been the Auxiliary's progress and influence as reflected in its projects, based upon requests from the Medical Association. One of its first and chief activities has been the distribution of health education literature and dissemination of information pertaining to health. Another has been its effort to alert both its members and the public to the hazards of certain types of legislation and the desirability of adopting other measures relating to health. For example, members of the Auxiliary received credit for materially assisting in the enactment of a minimum standards law in Texas.

In connection with health education and the furthering of health projects, Auxiliary members have worked closely with other health agencies active in the state. Hospitals have benefited by the work of doctors' wives, who have donated equipment, given library service to the patients, and sometimes organized hospital auxiliaries to serve as nurses aides, typists, and hostesses. Service also has been contributed routinely to cancer, tuberculosis, heart, poliomyelitis, diabetes, and other specialized agencies in the health field.

During the past ten years the Auxiliary's work in the area of nurse recruitment has been important. Effective results have been obtained by giving loans and scholarships, by organizing and sponsoring future nurses' clubs, by furnishing speakers and showing motion picture films on nursing, and by arranging tours of hospitals. In these more recent years the Auxiliary has done much also in civil defense, mental health, geriatrics, and development of interest in health matters among high school students by sponsorship of essay contests.

A large percentage of the county auxiliaries maintain some type of benevolent funds, and most contribute to the State Auxiliary's special funds to aid needy physicians and their families, to assist medical students financially, and to help develop a medical library with services readily available to all the doctors in the state.

Through the thirty-six years of its existence, the Woman's Auxiliary has proved itself a willing and helpful ally to the Texas Medical Association. With the inspiration of the past goals reached, its officers believe that the program of service will broaden and that the membership will strive continually to maintain the high ideals of the medical profession and to serve the purposes for which the Auxiliary was organized.

Officers of the Woman's Auxiliary to the Texas Medical Association: President, Mrs. Mark H. Latimer, Houston; President-Elect, Mrs. Joseph H. McCracken, Jr., Dallas; First Vice-President, Mrs. Mal Rumph, Fort Worth; Second Vice-President, Mrs. Harold Lindley, Pecos; Third Vice-President, Mrs. Howard R. Dudgeon, Jr., Waco; Fourth Vice-President, Mrs. Troy A. Shafer, Harlingen; Fifth Vice-President, Mrs. August J. Streit, Amarillo; Recording Secretary, Mrs. P. M. Kuykendall, Ranger; Corresponding Secretary, Mrs. William M. Palm, Houston; Treasurer, Mrs. J. C. Terrell, Stephenville; Publicity Secretary, Mrs. A. H. Neighbors, Jr., Austin; Parliamentarian, Mrs. John E. Hill, Marshall.

**Mrs. W. A. Wood: The Early Years of the Woman's Auxiliary to the State Medical Association of Texas, 1918-1932.*

NATIONAL CONVENTION

Mrs. George Turner, El Paso, will be installed as President of the Woman's Auxiliary to the American Medical Association at its thirty-first annual session, San Francisco, June 21-25. Headquarters will be at the Fairmont Hotel, with the formal opening of the convention being Tuesday morning. Other than business meetings, a tea and a luncheon will be given in honor of the President and President-Elect during the session. Members are also invited to attend the reception and ball in honor of the President of the AMA on Tuesday evening, June 22. The general meetings will end Thursday, with only the officers and committee chairmen meeting Friday morning.

COUNTY AUXILIARIES

The *El Paso County Auxiliary* entertained high school nursing club members and their mothers with a tea on March 25. Other honored guests were the high school nurses and leaders of the three nurse-training organizations of El Paso. Brochures on the forty schools of nursing in Texas, New Mexico, Colorado, and Arizona, prepared by Mrs. W. W. Wollmann and Mrs. Louis Breck, were presented to the nurse adviser of each high school. The auxiliary sponsored in March and again in April two-day sales of articles made by the Lighthouse for the Blind. Mrs. Morton H. Leonard was chairman of the sales. A "Make Your Own" style show and a hobby show highlighted the auxiliary's April 12 luncheon meeting.

The *Bell County Auxiliary* heard Dr. S. W. Thorn, Houston, chairman for the Texas Medical Association of

the American Medical Education Foundation, in Temple on March 12. Mr. N. C. Forrester, Austin, executive secretary, Texas Medical Association, was also a guest at the meeting. A business meeting followed Dr. Thorn's speech. At the February meeting of the auxiliary, Charles F. Mitchell, acting director of the State Mental Health Department, spoke on "Preventive Mental Health." Mrs. R. R. White, Temple, was elected president.

At the March 29 luncheon of the *Harris County Auxiliary* members of the Harris County Society were invited to "Laugh with your Lady," which was the theme of the day. Morris Frank, humorist for the Houston *Chronicle,* was speaker. Dr. Elizabeth Powell, recording secretary of the auxiliary, was honored as Doctor of the Day and presented with a bouquet of red carnations. This is the first time that the auxiliary has chosen a Doctor of the Day in connection with Doctor's Day. Mrs. Jasmine Logan Sadler spoke on "Torch Bearers of Tomorrow" at the February meeting.

The *Wichita County Auxiliary* honored the society with a dinner dance, which approximately 240 members and guests attended, in Wichita Falls February 20.

Another auxiliary honoring the society for Doctor's Day during February was the *Dallas County Auxiliary,* which held a dinner dance on February 13.

Public relations was stressed at the March luncheon meeting of the *Taylor-Jones Counties Auxiliary.* Robert Kennedy, public relations representative from the local utilities company, spoke about the doctor's wife in the community.

The *Navarro County Auxiliary* met in the home of Dr. and Mrs. Louis E. Gibson, Corsicana, on April 2 to hear a discussion on "Safety in Driving," given by Bill Simmons and Charles Blankenship from the Department of Public Safety. The auxiliary decided to send *Today's Health* to teachers of pupils who entered the essay contest sponsored by the auxiliary. Mrs. S. H. Burnett, Corsicana, was elected president at the group's March 5 meeting.

Members of the *Webb-Zapata-Jim Hogg Counties Auxiliary* entertained the three Laredo winners of the essay contest they sponsored with a barbecue on March 17 at the home of Dr. and Mrs. E. M. Longoria. Another auxiliary urging students to enter the contest was Gregg County Auxiliary, which offered prizes of $15, $10, and $5 to the three local winners.

Among auxiliaries which have elected new officers are *Falls County Auxiliary,* which met February 16 at the home of Dr. and Mrs. C. R. Miller, Marlin, and named Mrs. Miller president; *Hunt-Rockwall-Raines-Delta Counties Auxiliary,* which chose Mrs. H. E. Mehmert, Greenville, as president in a February 2 meeting at the home of Dr. and Mrs. F. S. Carruthers, Greenville; and *Cooke County Auxiliary,* which has recently installed Mrs. Ben Fisch, Gainesville, as president.

The *Bosque County Auxiliary* met in the home of Dr. and Mrs. V. D. Goodall, Clifton, and elected Mrs. S. L. Witcher, Clifton, president; Mrs. Joseph Stout, Sherman, was chosen president of the *Grayson County Auxiliary* at a recent meeting; and Mrs. Ivan Readinger, Fort Worth, has been installed as president of *Tarrant County Auxiliary.*

Mrs. E. W. Coyle, San Antonio, State Auxiliary President, spoke on "Our Duties as Good Citizens to Our Husbands and Their Profession," to the *Travis County Auxiliary* at a luncheon meeting February 16. A style show was held before Mrs. Coyle's speech. Mrs. S. W. Bohls, Austin, is president of the auxiliary, and Mrs. G. G. Zedler, Austin, is president-elect.

Mrs. Coyle was honored at a tea by the *Hidalgo-Starr* and *Cameron-Willacy Counties Auxiliaries* during February in Mercedes. Also at the tea was Mrs. A. B. Pumphrey, Fort Worth, past State President.

The *Galveston County Auxiliary* held a coffee honoring members of all women's civic organizations, parent-teacher association members, and school faculty members on February 16. A skit entitled "Johnnie's Toothache," which had recently appeared on television, was presented by a group of elementary school children.

Nueces County Auxiliary members were guests of Nueces County Society at a dinner in Corpus Christi on March 9. W. Oliver Harrison, pastor of the local First Christian Church, was guest speaker.

DEATHS

E. R. CHAPMAN

Dr. Eugene Rhea Chapman, Los Angeles, Calif., formerly of San Antonio, died January 21 in Los Angeles of glomerulonephritis.

Born in Bennett, Iowa, July 16, 1905, Dr. Chapman was graduated from the State University of Iowa College of Medicine, Iowa City, in 1932. He served an internship at Mercy Hospital, Davenport, Iowa, and did his residency at Chicago Lying-In Hospital; he did postgraduate pathology work at Harvard Medical School, Boston.

Joining the Medical Corps of the regular army as a first lieutenant in 1934, Dr. Chapman served during World War II. He was promoted to the rank of major in 1946 and retired as a colonel in 1947. He was chief of the obstetric and gynecology staff of Nix Memorial Hospital and Baptist Memorial Hospital and served as chairman of the department of obstetrics and gynecology at Robert B. Green Memorial Hospital in San Antonio from 1950 to 1953. During this time he was associate professor of clinical obstetrics for Baylor University Postgraduate School, San Antonio branch, and professor of clinical obtetrics and gynecology in the University of Texas Postgraduate School of Medicine, San Antonio branch. He was consultant in obstetrics and gynecology at Brooks Army Hospital and Lackland Air Force Base Hospital. He was a diplomate of the American Board of Obstetrics and Gynecology.

A member of the American Medical Association, Dr. Chapman was a member of the Texas Medical Association through Bexar County Society from 1947 until 1953, when he moved to California.

He was married to Miss Dorothy Kirsten, the singer, May 15, 1951 in New Orleans. She survives, as does a daughter by another marriage, Miss Susan Chapman, New York City.

J. H. AGNEW

Dr. James Howard Agnew, Houston, Texas, died on March 19, 1954, at his home after a long illness.

The son of John H. and Jeannette Belle (Jones) Agnew, Dr. Agnew was born on July 31, 1884, in Pittsburgh. He attended the Findley, Ohio, public schools, and he was graduated from the University of Michigan, Ann Arbor. He received his medical degree from the University of Michigan Medical School, Ann Arbor, in 1910, and interned at University Hospital, Ann Arbor. He was an instructor at the University of Michigan Medical School from 1910 to 1914 and was a professor at the Medical College of Alabama, then

in Mobile, from 1914 until 1917. After serving as a major with the Army Medical Corps during World War I, Dr. Agnew moved to Houston. He practiced there from 1919 until 1940, when he retired. Dr. Agnew had been bedridden since 1946.

An honorary member of the Texas Medical Association since 1947, Dr. Agnew had been a member of the Association and of the American Medical Association continuously since 1920 through Harris County Medical Society, and he

DR. JAMES H. AGNEW

was secretary of the section on Medicine and Diseases of Children in 1924. Former president of the Texas Club of Internists, Dr. Agnew was a life member of the American College of Physicians, a diplomate of the American Board of Internal Medicine, and an honorary member of the staffs of St. Joseph's Infirmary, Methodist Hospital, and Memorial Hospital. He was a member of Sigma Xi, honorary science fraternity, and Alpha Omega Alpha, honorary medical fraternity. He was a member of the Presbyterian Church.

Dr. Agnew was married to the former Miss Lillian Arft in Ludington, Mich., in 1914. He is survived by his wife; his mother, Mrs. John H. Agnew, Houston; a daughter, Mrs. Jeannette Agnew Bickel, Dallas; and two grandchildren, Dallas.

T. W. MARTIN

Dr. Thomas William Martin, a Port Arthur, Texas, radiologist, died on January 15, 1954, at his home of a heart ailment from which he had suffered for years.

Born in Aukland, New Zealand, on May 25. 1888, the son of John Green Martin and Lydia Burroughs (Smith) Martin, he was brought to the United States when a child and lived in Lake Charles, La., until about twenty-five years ago when he moved to Port Arthur. Dr. Martin attended the University of the South, Sewanee, Tenn., and Louisiana State University, Baton Rouge, and was graduated from Tulane University of Louisiana School of Medicine, New Orleans, in 1916. He interned in Charity Hospital, New Orleans. He was in the Army two years, being a major during World War I, was a ship surgeon for Holland-American Lines for eight years, and took his residency in Tuoro Infirmary, Lake Charles, before moving to Port Arthur in 1930.

A member of the Texas Medical Association through Jefferson County Medical Society almost continuously since 1930, Dr. Martin was a member of the Southern and American Medical Associations. He was a member of the Episcopal Church. He was a member of the Texas Radiological Society,

DR. T. W. MARTIN

a member of the Radiological Society of North America, and a board member of the American College of Radiology.

Survivors include his wife; two brothers, John Martin, Port Arthur, and Charles Martin, Lake Charles; and two sisters, Mrs. Grace Browne and Miss Sallie Martin, both of Lake Charles.

He was married to the former Miss Maude Phelps Western on May 12, 1934, in Port Arthur.

R. G. McCORKLE

Dr. Robert George McCorkle, San Antonio, Texas, nationally known as a specialist in the diagnosis and treatment of tuberculosis, died of coronary thrombosis in a local hospital on March 20, 1954.

The son of Henry Leonard and Henrietta K. McCorkle, Dr. McCorkle was born on March 16, 1892, in Dallas. He attended a boy's school in Dallas and was graduated from the Baylor University College of Medicine, then in Dallas in 1916. Dr. McCorkle interned at Robert B. Green Memorial Hospital in San Antonio. After military service during World War I, he was a resident physician at the State Tuberculosis Sanatorium, near San Angelo and later did graduate work at Colorado School of Tuberculosis. He had practiced in San Antonio since 1922. He was medical superintendent of Woodmen of the World Memorial Hospital, San Antonio, a consultant at Brooke Army Hospital; and on the staff of the Santa Rosa, Nix Memorial, and Robert B. Green Memorial Hospitals.

Dr. McCorkle had been a member of the Texas Medical Association continuously since 1918 and was also a member of the Southern and American Medical Associations. President of the Texas Tuberculosis Association at the time of his death, Dr. McCorkle helped organize the Bexar County Tuberculosis Association and was first president of it; he was chairman of the Bexar County Tuberculosis Control Board. Dr. McCorkle was past president of the American Academy of Tuberculosis Physicians; a member of the

American Trudeau Society. National Tuberculosis Association, and National Rehabilitation Association; and a fellow of the American College of Chest Physicians. He was a fellow of the American College of Physicians, a diplomate of the American Board of Internal Medicine, and a member of the International Medical Assembly of Southwest Texas.

DR. ROBERT G. MCCORKLE

He was a member of the Masonic Order, including Travis Council Knights Kadosh and Shrine, Elks Club, Woodmen of the World, Presbyterian Church, Junior Chamber of Commerce, and the Alumni Association of Baylor University College of Medicine, having served as vice-president of the latter organization. An ardent fan of football and track, Dr. McCorkle was a member of the San Antonio Quarterback Club. He formerly collected antique automobiles.

The former Miss Carrie Gireau, whom Dr. McCorkle married in 1921 in San Antonio, died in 1940. He and the former Miss Carolyn McLean were married in San Antonio on August 26, 1950. He is survived by his wife; two sons, Dr. Robert G. McCorkle, Los Angeles, and Henry L. McCorkle, a student at George Washington University School of Medicine, Washington, D. C.; a brother, W. J. McCorkle, Boston; four sisters, Miss Nellie Kline and Mrs. Irene Stone, Dallas; Mrs. Pauline Burch, Cincinnati; and Mrs. Annie Laurie Leonard, Charleston, W. Va.; and four grandchildren.

J. H. McCRACKEN, SR.

Dr. Joseph Hill McCracken, Mineral Wells, Texas, former president of the Texas Medical Association, died on March 18, 1954, of cardiorenal disease.

The son of William M. and Elizabeth Jane (Doak) McCracken, Dr. McCracken was born October 1, 1867, in Springtown. He attended College Hill Institute, receiving a teacher's certificate, and taught school before continuing his education. He was graduated in medicine in 1891 from the University of Tennessee, then in Nashville, where he was recently honored at graduation exercises with a certificate of merit as a tribute to his long medical career. He interned at the University of Tennessee Hospital. Locating first for three years in Pilot Point and Springtown, he had practiced in Mineral Wells for fifty-one years prior to his retirement ten years ago.

Dr. McCracken was elected vice-president of the Texas Medical Association for 1911-1912 and succeeded to the presidency after the death of Dr. David R. Fly. He was elected an honorary member of the Association in 1945. He had served as Councilor of the Thirteenth District from 1903 to 1907 and as president of the district medical society; he was president of Palo Pinto County Medical Society in 1938. Dr. McCracken had been a member of the Texas Medical Association since 1896 and for many years was a member of its House of Delegates. He was city and county health officer for a number of years, a member of

DR. J. H. MCCRACKEN, SR.

the Kiwanis Club, past president of the Chamber of Commerce, and a member of the Presbyterian Church.

Dr. McCracken and the former Miss Mary Sue Wilson were married in Mineral Wells on October 15, 1895. She survives, as do two daughters, Mrs. Margaret Shankle, Fort Worth, and Mrs. Mary Sue Elder, Mineral Wells; a son, Dr. Joseph Hill McCracken, Jr., Dallas; and a sister, Mrs. Mollie Taylor, Fort Worth.

R. R. SHEPPERD

Dr. Robin Royal Shepperd, Bisbee, Ariz., formerly of Llano, died February 9 of pneumonia in Bisbee.

The son of Mr. and Mrs. Arthur Shepperd, Dr. Shepperd was born on February 6, 1917, in Thornton. He attended public school in Liberty Hill and attended the University of Texas in Austin. He was graduated from the University of Texas School of Medicine, Galveston, in 1942. Serving an internship at the Santa Rosa Hospital, San Antonio, Dr. Shepperd began practicing in Flatonia. He practiced a short while in Burnet, and then practiced in Llano for six years, moving to Arizona a little more than a year ago.

A member of the American Medical Association, Dr. Shepperd was a member of the Texas Medical Association from 1944 until 1953 through Lavaca County and later Lampasas-Burnet-Llano Counties Medical Society.

Dr. Shepperd was a member of Phi Beta Pi medical fraternity. a member of the school board of Llano, president of the Jaycee Club, Llano, and a member of the Baptist Church.

Dr. Shepperd and the former Miss Margaret Fain were married in 1940 in Crockett. He is survived by his wife; a

daughter, Sylvia Shepperd; and three sons, Samuel Arthur Shepperd, Rex Shepperd, and Roy Austin Shepperd, all of whom have moved back to Crockett. Also surviving are his mother, Mrs. Arthur Shepperd, Burnet; a sister, Mrs. Marks Kauffman, Georgetown; and three brothers, Dr. Joe Shepperd and Dr. Ray Shepperd, Burnet, and Dr. W. I. Shepperd, Marble Falls.

J. B. JENKINS

Dr. John Bill Jenkins, Waxahachie, Texas, died January 30, 1954, in a Temple hospital of myocardial infarction.

The son of Dr. and Mrs. A. D. Jenkins, Dr. Jenkins was born in Anderson County in 1889. He attended the University of Texas and was graduated from Vanderbilt University School of Medicine, Nashville, in 1915. He served an internship at Scott and White Hospital in Temple. Beginning his practice in Mooreville in 1916, he moved to Waxahachie in 1920 and practiced there until the time of his death.

A member of the Texas and American Medical Associations since 1917, Dr. Jenkins served as president of Ellis County Medical Society in 1937. He was a charter member of the Waxahachie Lions Club, a member of the Masonic Lodge, and a member of the First Methodist Church.

On November 2, 1916, Dr. Jenkins married the former Miss Kathleen Bowman, Mooreville, who survives him. Other survivors include two sons, John Bill Jenkins, Jr., Corsicana, and Joe Mack Jenkins, Bellaire; two brothers, Dr. Jesse G. Jenkins, Temple, and Sparks B. Jenkins, Mexia; and two sisters, Miss Mary R. Jenkins and Miss Winnie E. Jenkins, both of Dallas.

C. R. BERRY

Dr. Charles Richard Berry, Houston, Texas, died on March 7, 1954, in a local hospital of a heart ailment.

Born September 10, 1883, in Sardis, Miss., the son of Julius S. and Maggie Berry, Dr. Berry was graduated from Mississippi College, Clinton, in 1905 and received a master's degree from the University of Mississippi, University, in 1910. He received his medical education at Tulane University of Louisiana School of Medicine, New Orleans, having been graduated in 1912. Serving an internship at Charity Hospital, New Orleans, he was superintendent of Gilmore Sanitarium, Amory, Miss., from 1916 to 1920. He was a member of the surgical staff of Tupelo Hospital, Tupelo, Miss., from 1920 to 1929, when he moved to Houston.

A member of the Texas Medical Association through Harris County Medical Society continuously since 1930, he was a member of the Southern and American Medical Associations. He was also a fellow of the American College of Surgeons. Dr. Berry was a member of the Masonic Lodge, being a Shriner. He was a member of the Baptist Church.

Dr. Berry and the former Miss Ethel Elligson were married in Houston in 1935. He is survived by his wife; a daughter, Mrs. James T. Dukes, Jackson, Miss.; a son, Charles R. Berry, Jr., Houston; and a sister, Miss Linda Berry, Blue Mountain, Miss.

L. L. HANDLY

Dr. Lucius Lamar Handly, Houston, Texas, died at a local hospital on April 9, 1954, of a heart attack.

The son of John Sherrod and Cornelia (Kell) Handly, Dr. Handly was born February 14, 1890, at Pine Bluff, Ark. He attended the Houston public schools and was graduated from the Tulane University of Louisiana School of Medicine, New Orleans, in 1913. On the staff of the Mississippi State Hospital, Natchez, for three years after his graduation, he began practicing in Houston a short time before World War I. He served as a first lieutenant with the Army Medical Corps from 1917 to 1919 and returned to Houston, practicing continuously there until his death. He was a former chief of staff at Methodist Hospital.

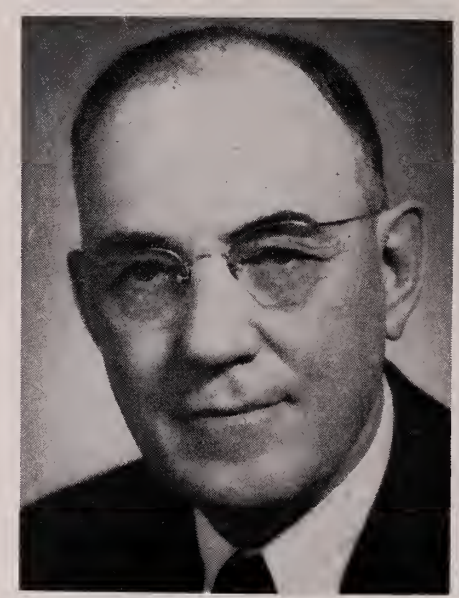
Dr. Handly had been a member of the Texas Medical Association and the American Medical Association through Harris County Medical Society continuously since 1917. He was a member of Alpha Kappa Kappa medical fraternity. Dr. Handly attended the Presbyterian Church and was an avid amateur photographer.

He was married to the former Miss Anna Hafernick in Houston on March 25, 1929. He is survived by his wife; a daughter, Mrs. Helen Handly Felton, Beaumont; a son, John Lucius Handly, Houston; and a brother, Roger Q. Handly, Houston.

J. H. SMITH

Dr. Jerome Hartzly Smith, Jr., San Angelo, Texas, died on March 1, 1954, of acute heart failure.

Dr. Smith was born October 17, 1888, in Aurora, Neb., the son of Mr. and Mrs. Jerome H. Smith, Sr. He attended public school in Lincoln, Neb., and was graduated from the University of Nebraska there. He received his medical education at the Nebraska College of Medicine, Omaha, having been graduated 1928. Dr. Smith practiced two years in Lincoln, was in Lubbock for five years, and moved to San Angelo in 1935. He had been a staff member of the Shannon Memorial Hospital there since 1935.



DR. JEROME H. SMITH

A member of the Texas Medical Association and the American Medical Association continuously since 1931, Dr. Smith was president of the Lubbock-Crosby Counties Medical Society in 1934. He was a member of the Texas Radiological Society American College of Radiology, and the Radiological Society of North America. He served during World War I and was on the examining board during World War II. Dr. Smith was a Scottish Rite Mason and a member of the Rotary Club.

He and the former Miss Leanora F. Stadler were married in Scottsbluff, Neb., on March 29, 1915. He is survived by his wife; one daughter, Mrs. L. R. Gunter, Bryan; and two brothers, Herbert H. Smith, Lincoln, and Dr. Phillip T. Smith, St. Paul, Minn.

President's Page

OUR COUNTY MEDICAL SOCIETIES

Our county medical societies constitute a basic and fundamental part of organized medicine. In my judgment, they are not measuring up adequately to their opportunities and responsibilities.

Group approval, utilizing the prestige drive which is so strong in motivating men, is very influential in American medicine. Acceptance by his colleagues is the most coveted professional asset a physician can have; and disapproval usually is a dreaded curse. A physician is best known and evaluated by his immediate professional colleagues who observe him day by day and who come to learn of his character and skills.

Membership in good standing in the county society is a prerequisite to state and national professional affiliations, as well as the requirement of admission to most specialty societies, boards of certification, and hospital staff appointments. Thus, the significance of county society membership is apparent. Once attained, it is often taken for granted by the average physician, who may treat this membership with a certain amount of indifference.

The minimal obligations of membership are ethical conduct and payment of dues; but, if a physician is to meet these obligations more completely, he must serve. The preservation of the rights of the profession and the advancement of scientific knowledge are efforts that need and deserve the active participation of every member.

A recent survey of our county societies in Texas showed that attendance at meetings is poor. Almost all societies reported several of their members did not attend a single meeting during 1953. A few societies indicated as high as 50 per cent of their membership was not active.

Increasing attendance and stimulating interest of the membership is principally the responsibility of the county society. Effort on a local

level is essential to strengthen the prestige of the county society. Nevertheless, the Texas Medical Association can and should assist the 116 component societies to help themselves.

A plan has been formulated, and approved by the Advisory Committee to the President, to increase visitations to county medical societies by officers of the Association and by representatives of the central office staff. Only 4 per cent of the county societies were visited last year by an officer of the Association other than a councilor. Visitations by the central office staff were reported to be only 8 per cent.

An effort will be made during 1954-1955 to have an officer of the Association or a staff member to meet with each of the 116 county medical societies, or at least all those groups which are willing to extend invitations. This visitation program will be accomplished by a team composed of the President, President-Elect, Vice-President, Legal Counsel, Public Relations Counsel, Executive Secretary, and Assistant Executive Secretary, supplemented by other officers of the Association as well as individual members who are known to possess special knowledge for a particular occasion.

I have written to the president of each county society informing him that we should appreciate an opportunity to meet with his group on any assigned date during the year. The purpose of our visitations will be to gain first-hand information on the problems confronting the society. Our team will report on current activities, programs, and problems which are vital to organized medicine.

Several societies, particularly the smaller ones, have sounded a call for help on their scientific programs. We shall endeavor to provide that assistance.

The Texas Medical Association will make a determined effort in 1954-1955 to aid county societies to strengthen their membership, attendance, programs, and prestige. Our objective is to help each society to become in its community the most potent force in health and medical activities.

J. J. L. Blasingame, M.D.

TPTR diagnotes

REPORT OF COMMITTEE ON PUBLIC RELATIONS: Tabulation of annual session press coverage shows gratifying results (4 advance releases, 82 stories and interviews, 36 pictures, and 12 wire releases). The 98 story, 36 picture total may prove to be the largest coverage of a state association meeting in the nation.

Initial business meeting of the President's Advisory Committee saw 100 per cent attendance. Committee's function will be advisory, but it will serve to coordinate and disseminate information. President Blasingame pointed out and underscored that actions taken by the group were in no sense binding on the Association, but mainly an effort to get all functioning committees and councils to work hand in glove on projects which are of mutual importance.

FROM OVER THE STATE: Some county societies have found a sure-fire way of increasing attendance in dinner meetings, with their auxiliaries serving the meal. In many cases, the allied groups meet jointly for fellowship and a covered dish meal, then adjourn to separate meeting places for business sessions.

When Harris County doctors were honored guests at their Auxiliary's "Doctor's Day Celebration," hostesses found themselves honoring one of their own members, Dr. Elizabeth Powell, lecturer in pathology at Baylor University College of Medicine and a member of both groups. Luncheon lecturer, newspaper columnist Morris Frank, fulfilled program title, "Laugh with Your Lady," with his witticism and pertinent remarks.

Recognizing the effectiveness of good PR at the grass roots level, county medical societies across the state are looking to means of strengthening their local PR committees, and are setting forth new projects for the coming year.

Several years ago, the Smith County Medical Society changed its constitution to provide the society with a president-elect. At that

time, the group changed its PR committee to consist of the president, president-elect, and past president. Society members feel that this arrangement has made their public relations more constant in the expression of society views and thus more workable; also found it enhances their press relations and keeps officers informed of PR events over a three-year period. By rotating officers, at no time is there a new, inexperienced committee guiding society public relations.

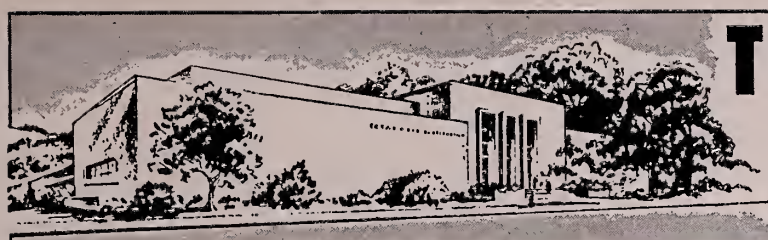
Travis County Medical Society is setting up a series of special project subcommittees chaired by members of its committee on public relations. Each major project will have its particular set of workers with members of the parent committee guiding endeavors and acting as coordinator on the over-all program. Subcommittees will direct their efforts toward television, public forums, liaison with local civic groups, and special anniversary medical newspaper section.

ON THE NATIONAL SCENE: A series of four AMA pamphlets designed for distribution to the general public now coming off the press. These readable leaflets get across an important health message with a minimum of copy and will provide excellent material for distribution at fairs, in doctors' reception rooms, and as stuffers in statement and other mailings. Titled "Why Wait," "Health Today," "Quack!" and "On Guard," the leaflets deal with selection of a family doctor, medical progress, medical quackery, and the drug evaluation program of AMA's Council on Pharmacy and Chemisty. Will soon be available in quantity at central office, Austin.

The Hartford County (Conn.) Medical Association is keeping pace with the time by adapting one of its public relations projects to this globe-trotting age. A new exhibit entitled "If You're Traveling to Europe - " listing information on necessary immunization and other medical aspects of traveling abroad was prepared by Hartford physicians for the 1954 travel show sponsored by the Hartford Times. To tie in with the exhibit, a special checklist was developed to help travelers prepare themselves medically for their trips. The checklist gives information about securing medical aid overseas, preparing medical kits, and many other travel tips. Texas societies might adapt this checklist for travelers to Mexico.

TIP OF THE MONTH

For some firsthand information on current public relations problems confronting the medical profession and what to do about them, plan now to attend AMA's Third Public Relations Institute, September 1 and 2 at Chicago's Drake Hotel. This workshop-styled meeting, devoted mainly to an exchange of suggested public relations techniques, is of particular interest to state and county executives and PR personnel of these societies as well as PR chairmen.



TEXAS State Journal of Medicine

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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TRIBUTE TO THE DOCTOR

The archetype of the country doctor with his kindly smile and black bag, going from house to house in every kind of weather to minister to the minds and spirits as well as to the bodies of his patients, is so familiar as to need no description. However, a word picture of such a doctor as known and loved by his wife, recently widowed, creates anew the faith that the real physician is called to his profession and fulfills his mission only through service to his fellows.

The following excerpts from a letter speak of one doctor, but they might speak of many:

One of the finest things I can say for Dr.———— is that 35 years ago he gave up one of the brightest futures a young doctor could have before him in the city, because he felt that with his wide range of knowledge he could use it to a better advantage in helping humanity in a smaller town. . . .

He installed a very complete office for general examination and treatment. Laboratory, Xray, Diatherm, Sine Wave, Ultra Violet and so on, which really brought modern medicine and treatment of that day to many, many people. He was interested and devoted to both civic and medical progress. His practice years covered two important eras in medicine and civic advancement. He delighted in using the new discoveries in equipment, drugs, and convenient hospitals to save life. But contended before this era the saving of life was more on the doctors initiative and ability . . . .

During the early years of his practice hospitals were more distantly located and inconvenient to reach. It meant all night vigils in farmers and ranchmen homes. Numbers of times swiming swollen rivers on horseback and pulling muddy roads to reach the patients. But he loved every muddy mile and all the people who lived along them and was honored and loved in return.

By grapevine or somehow the folks always knew that the Dr. had to be at a certain place. When the roads were impassable at places, there was always someone there with a team to pull us through. Of all the teams I think a pair of little spanish mules did the best job taking the car through with mud flying all directions. I suppose that I helped in many ways. Chiefly, on OB cases keeping the frightened husbands on their feet by grinding coffee, (I can smell the aroma now) and helping with the midnight feast which was as important as spanking the baby. . . .

I remember one night when the unsuspecting parents were told their croopy, two year old baby boy had little chance with an advanced case of diptheria. A tube was fished out of the little black bag (which was always, to me, like pulling rabbits out of hats). was inserted in trachea to keep the child alive until anti toxin took effect, which was about daylight. Today, the person is manager of one of the big base

ball league teams. Now those things are simple but 30 years ago to be called in and find a child dying with diptheria, knowing what the little medicine bag held, your courage to act and God's Will were your only resources, was entirely different. When you came out of it you felt a little closer to that family and a little closer to God. I remember once my husband saying, "Thats when a doctor wants to quit doctoring and go to preaching."

A TEXAN GOES TO THE TOP

Texans are doffing their ten-gallon hats this month to a lady who is keeping the Lone Star State on the national map. Mrs. George Turner, of El Paso, long a beloved and respected member of the Woman's Auxiliary to the Texas Medical Association and successively holder of most of the offices it affords, is being installed in San Francisco as President of the Woman's Auxiliary to the American Medical Association, the highest honor doctors' wives can attain.

Mrs. Turner, proud of her husband and daughters and ever ready to work toward and share in their achievements, has found time consistently through the years to learn the program and organizational aspects of the medical Auxiliary and, indeed, to help mold them. She comes to her present office with a broad understanding of the medical profession and its problems and of how best the Woman's Auxiliary can assist in their solution.

Her fellow Texans are proud of Mrs. Turner, congratulate the National Auxiliary upon its choice of leadership, and offer her their support and best wishes during the coming year.

APPOINTMENT AT THE POLLS

Many years ago our ancestors fought for the right to life, liberty, and the pursuit of happiness. They also fought for something which we often overlook as an important part of an adult's life—the right to vote. Every doctor—as a businessman, the head of a family, and a citizen—owes it to his community, his state, and his federal government to express his wishes regarding the elected government officials for the coming years. This year the people of Texas will elect Congressmen and a Senator to represent them in Washington. They will elect a Governor, other state officers, 16 State Senators, and 150 members of the House of Representatives. It is the duty and privilege of each doctor to vote for the persons who he feels are best fitted to represent him in the Texas and United States lawmaking bodies.

July 24, the date of the first primary for both the Democratic and Republican parties, should be remembered by each doctor as the day when one of his most important appointments is to go to the polls and vote. Those who plan to be on vacation or out of town on that day may cast absentee ballots from July 4 to July 20. The second primary will be on August 28, with absentee balloting permissible from August 8 to August 24.

The general election will be November 2. Put these dates on your calendar—they are appointments which no doctor can afford to miss.

JUNE AGAIN

The perennial transactions of the annual session of the Texas Medical Association and the official membership roster for the year appear in this issue of the JOURNAL. Both are commended to the membership for perusal and for filing as references during the year.

It should be noted that the mailing addresses appearing with the membership list herein are considerably more recent than those in the directory recently distributed to physicians who were members of the Association in 1953 (the current list being up to date as of early June). In cases of doubt or special significance, the directory listing might be checked advantageously against the information in the JOURNAL.

Because of an effort to reevaluate the special committees of the Association as previously constituted and, if advisable, to revise them, publication of the officer and committee list for the year will be delayed.

ORIGINAL ARTICLES

Medical Problems, Unsolved and New

GEORGE TURNER, M. D., El Paso, Texas

THE solution of medical problems is involved in one way or another with our relationships with nonmedical groups of people. This is what we term external public relations. Our job in this field at the state level is concerned with the continuous presentation of thought inspiring material, thereby focusing the right kind of thinking on objectives that achieve the best medical care. During this time of political uncertainty and individual unrest, it has been said that we are living in the "thin of the thick of things." This makes it a privilege to stand firm but fair and honest in doing our utmost to mold public opinion to the conviction of the best course to follow in providing medical care. This is no time for Chamberlainism, and we cannot afford, because of the responsibility upon us, to become an umbrella brigade with limber wrists and capitulating hearts.

I think there is ample evidence that public opinion is more susceptible at the present to the acceptance of "welfare state" projects than it was a year ago. Whether or not this tendency toward less and less freedom of enterprise will increase is the urgent problem that confronts all doctors today. With this basic assumption as a foundation, let us consider specific problems that need our tireless effort toward solution. It is not my purpose to suggest what may be done about them, for this is the task of all of us working together. It is a task which has consumed years and promises to consume many more.

In this area of public opinion there seem to be three fundamental concepts maintained to a greater or less degree in the mass mind of the public. These concepts take the form of demand and concern the cost of medical care, the availability of medical care to all regardless of their ability to pay, and the atmosphere that must combine efficiency with warmth and friendliness in each individual doctor's office.

These are the motivating drives in the mass mind, and we see them express themselves in precise and specific forms of action, which in our society must take place at the ballot box and in our legislative halls.

VETERANS' MEDICAL CARE

We see the specific problem in Congress today of medical care for veterans with nonservice connected disabilities. Doctors feel that sufficient Veterans Administration hospitals have been constructed and are now in operation to care for all service connected cases and see no reason why American taxpayers should finance the medical care of a veteran whose illness is due to alcoholism or some other condition which has absolutely no connection with our armed service. This opinion is not shared by doctors alone. Mr. Holman Harvey writes in the March, 1954, issue of the *Readers Digest* under the title "Must We Follow the VA Route to Socialized Medicine?" that the American people had better decide soon whether or not they want free government medical care, for it is descending upon them with bewildering speed. If left to themselves, the veterans, through their powerful lobby in Washington, largely unknown to the American public, can be counted on to sweep aside the few remaining safeguards of existing law and bring a state of socialized medicine into being for every man who ever wore or will wear a United States uniform. If such designs are carried out, socialized medicine may in the end be foisted upon a people who do not want it by a lobbying abuse of the natural sympathy of the American public toward war veterans, Mr. Harvey believes.

A comprehensive observation of the amount of medical care furnished by the Veterans Administration as of now and the number of doctors working for the Veterans Administration can be seen in a comparison with the total amount of medical care furnished by the membership of our Texas Medical Association. The number of doctors working for the Veterans Administration and the membership of the Texas Medical Association are approximately the same—6,400.

HEALTH INSURANCE

A second specific concern is seen in potential government subsidy in health insurance. Included in the administration's national health program is a plan for reinsuring prepaid health insurance. As explained by the Department of Health, Education, and Welfare, the program would protect the insurance carrier against bad experiences by paying up to 75 per cent of abnormal losses. Ostensibly, the purpose of such a plan is to encourage carriers to experiment in fringe and more risky health coverages. The project would be started with a federal appropriation of $25,000,000

President's Address delivered at the Opening Exercises, Texas Medical Association, Annual Session, San Antonio, May 3, 1954.

with the objective of making the fund self-sustaining within five years. The Department of Health, Education, and Welfare would administer the project by fixing all reinsurance rates and cancelling contracts for cause. Private insurance companies, voluntary nonprofit associations such as Blue Cross and Blue Shield, and other voluntary groups could participate if approved by the secretary of the department.

It has been pointed out that private companies in the health insurance field already reinsure each other, just as life insurance companies do. With the government entering this field, one of two things would happen. It either would be self-supporting as suggested or else it would lose money. If it is self-supporting from fees, there would be no advantage over the private reinsurance plans now operating. If it loses money—which is more likely—we will have a government subsidy for health insurance ready to be expanded into a full scale, national compulsory health insurance corporation.

The more experience we have with health insurance, the clearer it becomes that the most helpful plan is a voluntary one in which the insured is protected from unexpected and damaging medical care expense but pays minor medical bills himself as a part of his calculated cost of living. A policy containing a $50 deductible clause with all the small print, gimmicks, and concealed deceptions left out would constitute a substantial and helpful safeguard in medical care. It is desirable to tell the buyer exactly what the policy includes and what he can expect for his premium money.

Many of the activities we are doing, we must continue to do and do better, in the area of public services. Our efforts in rural health must be enlarged, and we must acknowledge a growing demand for local health forums. We must not be afraid to provide medical leadership at the community level. There is a strong likelihood of an increasing indigent medical care problem, and we must recognize this need to inform better our own communities of their responsibilities, as well as ours, in this field.

EDUCATION BY TELEVISION

The utilization of television by county medical societies to present a positive picture of American medicine and further health education ranks in importance with the establishing of good press relations. At least one thirty-minute program each week sponsored and directed by each county medical society where television facilities are available is no doubt one of the best means of presenting topics of general medical interest to television audiences, which constitute a large segment of our population. Many types of presentation, including speakers, forums, panels, interviews, and even dramatic programs, may be used. A combination of one or more of these types with an occasional film strip may be worked into the show.

Two county societies in Texas have led the way in the use of television. Last year Harris County Medical Society adopted a definite policy for appearances on television by members of the society. The Houston policy outlines regulations regarding physicians' appearances, scripts, and introductions and points out that "organized medicine should make full use of the television media." The Lubbock-Crosby Counties Medical Society presents a regular weekly one-half hour program devoted largely to a question and answer forum. The only other medical television programs with which I am familiar and on which doctors appear are those given in fund-raising campaigns by special service organizations such as the American Cancer Society and American Heart Association. I mention these latter efforts only to praise them and wish to urge a wide-awake county medical society television program.

NURSE RECRUITMENT

Our Woman's Auxiliary is doing a fine job of helping in our nurse recruitment program, an effort which should be continued with vigor, but I feel that the type of information being given to prospective students of nursing should be expanded to include training for all other medical associates. These specialists include the pharmacists, medical technologists, physical therapists, x-ray technicians, mental health associates, ophthalmic associates, dieticians, occupational therapists, medical artists, dental associates, public health associates, public health educators, health inspectors, hospital administrators, medical social workers, medical secretaries, medical librarians, vital statisticians, and industrial and skin hygienists. A booklet illustrating and describing these fields of medical interest and listing the Texas schools offering these courses could easily be prepared and made available for prospective students. The Michigan State Medical Society has prepared for use in Michigan a completely informative twenty-six page booklet on medical associates.

PHYSICIAN-HOSPITAL ASSOCIATION

The question of physician-hospital association and the practice of medicine by hospitals perhaps can be solved by closer cooperation and the working together of the Texas Medical Association, Texas Hospital Association, and hospital insurance carriers. It has been pointed out that a corporation cannot be licensed to practice medicine, but only an individual who has met all legal requirements for special education and certification by examination can be so licensed. Pub-

lic welfare requires that the physician must be a free agent and that the physician-patient relationship must not be submerged or controlled by those ineligible for a license.

It would appear clear, therefore, that in order to offset hospital encroachment into the practice of medicine a lease arrangement should be made by the hospital with a licensed physician to furnish special services such as radiology, pathology, clinical laboratory services, and others included under our medical practice act as constituting the practice of medicine. The lease should be vested with complete freedom for the physician to exercise his independent judgment in the professional operation of his department. The arrangement should permit the physician in charge of the department to be directly responsible to the patient and make possible the paying of the fee for professional services directly to that physician. Under such an arrangement, the hospital could not hold itself out to the public as a corporation offering professional medical services.

OSTEOPATHY

The question of the relationship between regular medicine and osteopathy has been actively under study during the past year with joint committee meetings of representatives from the American Osteopathic Association and American Medical Association. A proposal to remove the stigma of "cultism" from the practice of osteopathy, to permit close cooperation of doctors of medicine and doctors of osteopathy in the practice of the healing arts, and to permit doctors of medicine to teach in osteopathic schools are three important points of consideration. The ultimate effect of such close association would be a merger of the two groups or the absorbing of osteopathy by regular medicine. Osteopathic schools have improved their teaching and expanded their curriculums, yet the scope of their instruction is in no way comparable to the requirements exacted of students in our regular medical colleges. Any consideration of merger at this time would seem premature from the standpoint of educational attainment and because of the lack of any concrete evidence that the osteopaths themselves desire to have the stigma of "cultism" removed.

The following quotation is from an editorial in the *Journal of the American Osteopathic Association,* September, 1952: ". . . the American Osteopathic Association reaffirms, in the strongest terms possible, its policy of maintaining a separate, complete and distinctive school of medicine. This reaffirmation is founded in the belief that only as a separate and distinct school of the healing arts can the osteopathic profession fulfill its duty to the public." The 1953-1954 Chicago school's catalogue states in part: "Emphasis is placed on the study of diagnosis, amplifying the generally employed methods by the interpretation of symptoms in terms of the osteopathic concept."

PUBLIC HEALTH SERVICES

Our public health services constitute a valuable adjunct in community medical care through an organized effort in the prevention of disease. This is accomplished by the application of sanitary engineering methods, quarantine, vaccination, and case finding. A realistic cooperation should be continued with the officers entrusted with the application of these helpful health measures. Other problems of deep interest and requiring continued effort are the improving of nursing care, strengthening and supporting medical education through our American Medical Education Foundation or in any private manner desired, and emphasizing the public service importance of the individual doctor concerned with our code of medical ethics. Another clearly defined major problem concerns the strengthening of our own interassociation relations. The leaders of medicine in Texas today and tomorrow must find a way to insure increasing interest, attendance, and activity within every county medical society in the state. Our lines of communication from the thoughtfully charted policies of organized medicine to the individual practicing doctor demand more and more attention.

These are some of the questions we must raise with ourselves for solution — questions stemming from currents and eddies of public opinion, the problems imposed in our necessary public services, and the tasks confronting us in strengthening our own pattern of organization.

Suite 6A, 1501 Arizona.

Coconut Water for Intravenous Solutions

Coconut water may prove to be a source of body fluid replacement in remote areas or under emergency military conditions, preliminary studies have shown, according to an article in the February *Archives of Surgery* by Dr. Ben Eiseman, Denver.

Dr. Eiseman stated that 21 persons have received a total of 26 intravenous infusions of coconut water without any serious reactions, and that animal experiments with coconut water have shown no adverse effects. The preliminary studies have been carried out in Bangkok, Thailand, and in St. Louis.

The coconut water is obtained by withdrawing the fluid from the nut through a tube inserted in the eye of the nut. The fluid is then filtered to drain off any particles of coconut meat. Dr. Eiseman stressed that the present study was too limited to make definite conclusions, but that further study is warranted.

MEDICAL LEADERSHIP

F. J. L. BLASINGAME, M.D., Wharton, Texas

ON behalf of the entire membership of the Texas Medical Association, I should like to express appreciation for the accomplishments of the past year to our retiring President, Doctor George Turner, and to the other officers of our Association, and to the staff of our central office. Our thanks and gratitude go to you. Your work has left a challenge to all who succeed you.

Last year in Houston in accepting the office of President-Elect, I remarked that it was my hope to help to implement and extend the effectiveness of our Association to our profession and to the public. I re-state and renew that hope at this time.

In elevating me to the presidency, the Association has bestowed a high honor upon me; and I am humble and grateful for this trust and confidence. I pledge my best efforts; and, with the continued help of the membership, I am confident that our Association can have another good year.

The Texas Medical Association has a great heritage and has served useful purposes for more than a hundred years. I can see no need for recommending radical departures from past policies; but I am convinced that many of the intended functions and services of our Association can and should be improved.

In the public interest, leadership in health matters should come primarily from the medical profession. Only physicians possess the necessary technical information and skills, have the experience and judgment, and, lastly, but not least, hold to the philosophy that assures our society the best results in the application of medical knowledge.

In matters scientific, all is well; and men and women of medicine are for the most part respected and unquestioned leaders. But in matters socio-economic as applies to medicine all is not well; and leadership in health affairs is constantly being challenged. Naturally, in a competitive society such as we have in America, other groups will absorb this leadership if the medical profession is not vigilant and jealous of its responsibilities. The public must be persuaded that it is in its interest to let this leadership remain with the medical profession and not pass to the politician, the commercialist, or some irresponsible vocal segment of society.

In my judgment, the Texas Medical Association, properly implemented, can serve as an organization through which, in the public interest, our professional leadership in medical matters, scientific and socio-economic, can be maintained.

Address of the President-Elect delivered at the General Meeting. Luncheon, Texas Medical Association, Annual Session, San Antonio, May 5, 1954.

ADVISORY COMMITTEE

Inasmuch as the President can establish special committees, I have taken the initiative to form an Advisory Committee to the President. Because I believe in the soundness and wisdom of group effort and because I feel our Association needs further coordination of efforts, I have created this committee. Ready and free discussions by it of policies of our Association and problems confronting it should lend to decision and action.

This committee will be composed of the President-Elect, Vice-President, Speaker of the House of Delegates, chairman of the Board of Trustees, chairman of the Board of Councilors, chairman of the Council on Medical Defense, chairman of the Council on Medical Jurisprudence, chairman of the Council on Scientific Work, chairman of the Council on Medical Economics, chairman of the Council on Medical Education and Hospitals, chairman of the Committee on Public Relations, and President of the Woman's Auxiliary.

Let me repeat in the beginning for the sake of clearness that this Advisory Committee is in no way to usurp the functions of any other officer, council, or committee of the Association but is to serve in an advisory capacity and in an effort to coordinate.

During the coming year, I anticipate that there will be four to eight meetings of this committee, probably in Austin. I have contacted the members of this committee, and they have agreed to give of their time and energy to try to implement the program of our Association. I shall depend heavily on the advice and decisions of this committee; and I am appreciative of the help its members have offered.

SCIENTIFIC EFFORTS

Our Association is and must continue to be primarily a scientific organization. Our annual session programs must be strengthened and made the outstanding scientific experience in the lives of Texas physicians. Our Board of Trustees has expressed a willingness to expend the necessary funds to stage such a program, and our Council on Scientific Work will endeavor to develop a strong and stimulating program built around a large number of outstanding guest speakers and a series of educational scientific exhibits.

In connection with medical education in Texas, we must press hard to help our medical schools and their

faculties to continue to improve the training of physicians. Our Council on Medical Education and Hospitals can be counted on to work diligently on its problems. We must continue our interest in the Texas Chapters of the Student American Medical Association and in the American Medical Education Foundation.

These and many other scientific efforts are the primary and fundamental functions of our Association and merit continued study and attention.

LIAISON EFFORTS

In my opinion, we should improve our liaison efforts.

We need to exchange ideas with members of the allied professions. I have in mind dentists, pharmacists, nurses, technicians, and hospital administrators. These groups need our advice and guidance, and we should be more aware of their points of view.

It is to the advantage of medicine that its problems be widely understood throughout our society and its services appreciated. It is in this realm that good public relations are essential.

At this particular time our Committee on Public Health has an excellent opportunity to coordinate further our efforts with those of the Texas State Department of Health. I am certain that our Committee on Public Health will take advantage of this opportunity.

Our state hospital program is in need of our continued help.

COUNCILS AND COMMITTEES

I should like to make some comments regarding our various councils and committees. Each of these has been established in the past after much thought and debate and designed to meet a need of our profession or perform a function for our Association. It is necessary, if our program is to be effective, that these segments of our organization carry out their responsibilities with dispatch. In making nominations to fill vacancies in councils and committees I have made an attempt to select individuals who can be counted on to take their responsibilities seriously.

As you know, the special committees are appointed annually by the President. I plan to ask the Advisory Committee to the President to consider our present special committee set-up. It may be a few weeks before the final decisions regarding these special committees are reached.

I will consider it one of my responsibilities as your President to stimulate and coordinate the work of the various councils and committees. A letter is planned shortly to each officer inquiring into his continued interest in the assignment and asking further for a statement of the officer regarding his willingness and determination to do the job he has accepted. I plan to be moderately persistent in my efforts to stimulate interest, and I shall not be timid in reminding a member who does not work that there are other members who are willing to do so. Such an effort on my part is to be made solely for the purpose of attempting to get more participation by our members in the affairs of our Association and to implement its program.

AREAS OF CONCERN

Even though our membership is at an all-time high, I feel that genuine interest in the affairs of the Texas Medical Association appears to be wanting in its members in many instances. Quite frankly, all is not well with our parent organization. There is a problem of geography; and it is physically difficult for the various members to meet and develop a sense of unity. Specialty societies, the Academy of General Practice, and hospital staff meetings occupy the physician's limited time and energy. In three large cities of our state have been developed outstanding clinical assemblies which hold excellent programs. Yet, important as all of these organizations and gatherings be, none is so necessary and important in the general public interest and especially to the medical profession as the parent organizations of county, district, and state societies and the American Medical Association. It is essential that physicians see to it that these basic organizations get the priority of attention they deserve and remain strong and alert.

Our component societies need the attention of the Texas Medical Association.

Should our district societies be continued? If so, what can be done to enhance their usefulness?

In regard to county medical societies, I asked the central office some months ago to make up a questionnaire and mail it to each of the 116 county medical societies; 89 of these societies (77 per cent) replied. Inquiry was made as to the number of members in 1953, number of meetings, the average attendance, visits of district councilors, visits by other officers of the Texas Medical Association, and visits by representatives of the central office staff.

A few of the facts from these reports from the county medical societies will be of interest: 102 of our county medical societies contain 35 per cent of our membership while 14 county societies contain 65 per cent of our membership. The attendance percentage-wise is lowest in the larger societies, ranging down to 15 per cent. The county societies wrote that they felt in general that the councilors should take a greater interest. According to the returns on our questionnaire, the councilors met with only 43 per cent of our societies in the state in 1953. I respect the replies of the secretaries. Nevertheless, I cannot help

but wonder how many county medical societies failed to reply to letters from those councilors who were anxious to make visitations. The survey also showed that, unfortunately, only a handful of societies were visited by an officer of the Association, other than a councilor. Because of lack of manpower in proportion to the task at hand, the central office staff visited only 8 per cent of all county medical societies last year.

A report of this survey will be published shortly in the JOURNAL* and is worthy of study. It indicates that much can and should be done by the Texas Medical Association to try to strengthen membership, attendance, prestige, and programs of the county medical societies. In fact, *it is in this direction I plan to direct my primary attention as President.*

I regret to say that too much indifference by our profession exists toward our county medical society membership; and it is timely that each of us reexamines his attitudes and habits toward his county medical society to see if the deserved respect and allegiance exist. The essential feature which makes the county medical society important is the fact that it is the organization which is depended upon to estimate the day-by-day worth of a physician—who, like all men, is best known by his immediate colleagues who can evaluate his character and professional skill. The physician having attained local approval in his county medical society, much else follows easily in American medicine so far as membership is concerned—not only state and national but most specialty societies, fellowships, and boards. In fact, although a physician may have a legal right to practice his profession, if he cannot attain local approval of his confreres, he usually cannot reach his fullest satisfactions in his professional work and has a deficiency that is a serious handicap.

Since the county medical society is so important to every physician, it behooves him to come to realize this fact and to take advantage of it. One of the greatest services our State Association can do is to help county medical societies become more aware of their importance and to encourage them to become more vital in local affairs and supply leadership in medical matters. Such an accomplishment statewide can have great benefit to the public and the medical profession.

I believe that most physicians will admit that the county medical society is the weakest spot in American medicine—though there is much reason to feel that the weakness is less than it was a few years ago. There has been some awakening, but not enough.

Like other physicians, I believe in local effort; and, in medical organization, it means county society effort. We must assist these county societies to help themselves. Much can and must be done in this aspect of our program.

IT IS I

In a recent mailing by the Foundation for Economic Education, Mr. Leonard E. Read quoted the following verse:

"And so I hold it is not treason
To advance a simple reason
For the sorry lack of progress we decry.
It is this: Instead of working
On himself, each man is shirking
And trying to reform some other guy."

Each of us needs further self-examination and rededication.

Finally, it is the individual man that counts—in medicine as in other human endeavor. Our profession has a Hippocratic Oath. "Do I have it?" is the question each must ask. Our profession has its Code of Ethics. "Do I have it?" is the question. It is in this realm of sound basic philosophy that men of medicine can and must offer leadership. In these trying and confused times I covet for our profession qualities that will give such stature and steadfastness to us that we can serve as leaders not only for our chosen profession in matters medical but in the privileges and responsibilities of citizenship as well.

105 Hawes Street.

*EDITOR'S NOTE: *A report of the county society survey appeared in the May, 1954, Journal, pages 312-314.*

CAT SCRATCH DISEASE

One hundred and sixty cases of cat scratch disease, a relatively new disease which may resemble infectious mononucleosis, tuberculosis, tularemia, malignant tumors, and infected cysts were reported in the April 10 *Journal of the American Medical Association* by Dr. Worth B. Daniels and Dr. Frank G. MacMurray, Washington, D. C.

The doctors reported that the majority of patients afflicted with the condition had had some contact with cats and were in the younger age groups. Many of the patients had skin lesions that persisted from two weeks to two years, the doctors stated. Eighty per cent of the patients had symptoms of infection such as chills, headache, generalized aching, weakness, nausea, abdominal pains, and fever. They stated that a definite diagnosis of cat scratch disease was made by means of a specific skin test. Although the symptoms will disappear spontaneously, the doctors believe that use of some of the antibiotics may be beneficial in treatment of the disease.

Traveling Atomic Energy Exhibits

Mobile exhibits on atomic energy are available from the American Museum of Atomic Energy, Post Office Box 117, Oak Ridge, Tenn. The exhibits, carried by truck trailer, are offered for conventions and other gatherings. Additional information may be obtained from the museum.

IN MEMORIAM

THE REV. E. J. GREGORY, San Antonio, Texas

WE PAUSE in the midst of a heavy agenda for the purpose of honoring those who have fallen in the battle since the last meeting of this body. They are more than one hundred in number, and from their hands you have received the torches which they bore and closed the ranks which they have left broken. This occasion also reminds us that we too are traveling the road to eternity "from whose bourn no traveller returns."

Monuments of stone, steel, bronze, or brick bedeck our countrysides and our silent cities of the dead. They honor the memory of those who have fallen, but today we erect a monument not of stone nor of bronze but of pleasant thoughts and memories of our departed friends.

This occasion would remind us of a question as old as man's existence upon the earth. It is not limited by time nor space, by race, language, or position. This question was asked by Job, who was the author of the first book, with respect to time, of our Bible. In one of his meditations he cries out, "If a man die, shall he live again?" (Job 14:14) Man, if it is not correct to say "all men," has come to grips with this question through the centuries, but he has not always come up with the right answer. Nor has he been willing to accept what the religious man has propounded as a reasonable answer.

There are six categories of mankind into one or more of which every rational individual may be classified. If Job's question were propounded to any group, their answers could be roughly classified as follows:

1. The crass materialist would answer with a strong negative on the ground that nothing exists which cannot be known by means of the five senses.

2. The skeptic would answer, "I doubt it on the ground of insufficient evidence."

3. The agnostic would declare, "I do not know because I have never experienced it, nor can I know until my time comes to die; neither can anyone else know for the same reasons."

4. The atheist would say, "There is no God, nor eternity for man. Death ends it all."

5. The infidel would admit the possibility of life after death, but would insist that in no way should it affect man's existence on earth. He would be simply unfaithful to all he has heard, much of which he has accepted as truth in other years.

6. The believer would give the only positive answer to Job's question when he declared with the Apostle Paul, "I know whom I have believed, and am persuaded that he is able to keep that which I have committed unto him against that day." (II Timothy 1:12)

Nor do we find alone in holy writ these noble expressions of faith, hope, and love. Poets, artists, musicians, have all left indelible impressions upon succeeding generations to the effect that "it is not all of life to live nor all of death to die." Shakespeare has Hamlet to say in one of his soliloquies:

> And makes us rather bear those ills we have
> Than fly to others that we know not of.

Could we who are left behind know the state of those noble physicians who have passed on, we could sing with the poet:

> Life is real! Life is earnest!
> And the grave is not its goal;
> Dust thou art, to dust returnest,
> Was not spoken of the soul.

In the meantime you must carry on until many more of the dread and deadly diseases known in this generation shall yield themselves to your skill. We, the people who are your patients, look to you for guidance in our health program and to bring us through the shadows when we are sick. They who have died left many tasks unfinished and many victories to be won.

> Friend after friend departs:
> Who hath not lost a friend?
> There is no union here of hearts,
> That finds not here an end:
> Were this frail world our only rest,
> Living or dying, none were blest.
>
> Beyond the flight of Time,
> Beyond this vale of death,
> There surely is some blessed clime,
> Where life is not a breath,
> Nor life's affection transient fire,
> Whose sparks fly upward to expire.
>
> There *is* a world above,
> Where parting is unknown;
> A whole eternity of love,
> Form'd for the good alone;
> And faith beholds the dying here
> Translated to that happier sphere.
>
> Thus star by star declines,
> Till all are pass'd away,
> As morning high and higher shines
> To pure and perfect day;
> Nor sink those stars in empty night—
> They hide themselves in heaven's own light.
>
> (James Montgomery.)

Read at the Memorial Services, Texas Medical Association, Annual Session, San Antonio, May 3, 1954.

Route 9, Box 351.

Let's Get Together

ROGER FLEMING,* Washington, D. C.

THE fundamental issue we face as Americans is the issue of freedom! This is true in the fields of both international and domestic policy. It is equally applicable to doctors and farmers.

Now, of course, you and I will never have a clear-cut choice, either in the political party of our choice or in a general election, as to whether or not we are *for* freedom. It is never put quite that way. The choice is, *are you prepared to take the next step that limits or jeopardizes freedom?* Furthermore, each such step away from freedom is always "dressed up" so that it appears at first blush as though it was designed to promote freedom. Any experienced socialist knows that this is by far the most effective way to get intelligent people to embrace socialism.

Therefore, if we want to analyze the issue of freedom and the real choices available to you and me as citizens, we need to recognize that the job of being a good citizen is a difficult one. The responsibility of freedom-loving citizens to understand the consequences of the choices they make is one that we cannot take lightly.

Farmers know that if we are to have prosperity under peacetime conditions, we must adopt policies which will promote efficiency and high production per man in agriculture and the rest of the economy.

We must seek to maintain full employment and a good distribution of spendable income, which means income after taxes are paid.

We must follow monetary and fiscal policies which will contribute to the maintenance of a more stable general price level.

We must correct government policies which tend to place agriculture at a disadvantage with the rest of the economy.

We must guard against the exercise of monopolistic power by any group, whether it be agriculture, labor, or industry, and prohibit practices which restrain trade.

We must follow policies which will encourage rather than strangle foreign trade.

PRICE SUPPORTS

Price supports have a place in a well-rounded program for the maintenance of farm prosperity, but they cannot do the job alone. While price supports have affected the prices of individual commodities in every recent year, we should not forget that it really was war and the fear of war that kept farm prices above parity most of the time between 1941 and 1951.

There is a lot of misunderstanding based largely on a surplus of misinformation concerning farm price policy issues. If the average citizen is confused, it is little wonder.

For example, the Agriculture Act of 1948 provided authority for the Secretary of Agriculture to use direct payments in conjunction with flexible price supports. All three general farm organizations, both political parties, and the Secretary of Agriculture approved the principal provisions of this legislation.

In a letter dated June 25, 1948, to James Webb, Director of the Bureau of the Budget, the then Secretary of Agriculture Charles Brannan forthrightly approved its flexible price support provisions but objected to the continuation for the year 1949 of rigid price support provisions for certain commodities. He said:

> There are several provisions which we consider objectionable. We object to the provision which gives special treatment to certain commodities such as those which virtually assure a mandatory price support of 90 per cent of parity for tobacco and wool for at least several years. We object, even though the provisions apply only to 1949, to the mandatory 90 per cent of parity or comparable price for hogs, chickens, eggs, and milk and its products.

During the 1948 election campaign President Truman and Candidate Dewey both campaigned for flexible price supports. Neither said a single word against this concept. Yet, a few days after the election federal appointees of some of the government agricultural agencies started the phony chant that the election was a mandate for high, fixed price supports.

In his budget message to the Eighty-First Congress in January, 1949, President Truman, restated the fundamental principles upon which the Agricultural Act of 1948 was based, by saying:

> As I said a year ago, price support should be regarded "chiefly as devices to safeguard farmers against forced selling under unfavorable conditions and economic depression." Their purpose is to bring an element of stability into agriculture. At the same time they should not place excessive burdens on the Treasury and taxpayers or inhibit shifts in production needed to meet peacetime demands and to promote adequate conservation of our soil resources.

BRANNAN PLAN

The next chapter involves the Brannan Plan. It was proposed on April 7, 1949. What was it? What is it? Congressman Albert Gore (Democrat of Tennessee), now a member of the United States Senate, discussed this during the debate on the floor of the

Address, delivered before the General Meeting Luncheon, Texas Medical Association, Annual Session, San Antonio, May 5, 1954.

**Secretary-Treasurer, American Farm Bureau Federation.*

House on July 21, 1949, the day the Brannan Plan was defeated by a vote of 239 to 170.

Speaking for his substitute proposal for the Brannan Plan, Congressman Gore made a vigorous attack on the Brannan Plan and declared that he had not heard of this plan during the 1948 campaign. "The campaign was over before I heard about it," he said. "And think of it! Somebody forgot to put it in the Democratic platform."

Reminding his colleagues that he had not heard of the Brannan Plan until April of 1949, Congressman Gore declared:

> . . . Then almost suddenly we are asked to abandon the parity price approach to a fair exchange value of farm commodities in the marketplace that has gained such wide acceptance, asked to endorse a cluster of delusionary promises of food both cheap and expensive at the same time, asked to approve a policy that would make the farmer dependent upon appropriations from the Treasury for a large part of his pay for what he produces. All of this in so short a time and with such inadequate consideration. . . .
>
> By what mandate are we called upon to endorse this fundamental departure from basic Americanism? . . . All I know is that it is Secretary Brannan's plan. The farmers claim no part of it. In fact, they do not think it is or ever will be a farm plan.

I have heard it is a plan for perishables. Who said so? The commodities to receive 100 per cent supports in H. R. 5345, the legislative version of the Brannan Plan presumably best designed to get Congressional support, were corn, cotton, wheat, tobacco, milk, hogs, butterfat, shorn wool, rice, and peanuts. At least seven out of ten are *storable* commodities.

But, someone says, payments were to be used only for perishables. Again, who said so? The only farm group supporting the plan favored the immediate substitution of direct payments for crop loans on wheat, and in response to a question put to Secretary Brannan in Des Moines, Iowa, in February, 1950, he said he would like to utilize the payment technique on cotton "immediately."

Whereupon someone inquires, if Brannan had authority in the act of 1948 to use direct payments, why all the fuss? Because the Brannan Plan was a "political dipsy doddle"—not a farm program. It presumed to promise high prices to farmers, cheap food to consumers at little cost to anybody. When the Congress found out what he and his left-wing political buddies were up to, the Congress took away the existing authority to use direct payments in conjunction with flexible, "floor type" price supports.

And did this Congressional action, in the Agriculture Act of 1949, to eliminate direct payment authority, together with the authority to draw on Commodity Credit Corporation funds and Section 32 funds to finance their use, bring an anguished wail from Secretary Brannan and those who profess such a great interest in this technique? No, indeed! In fact, President Truman signed the bill without uttering a single peep of protest concerning the loss of this authority.

Could it be that President Truman and Secretary Brannan both knew, as the American Farm Bureau has known from the start, that the proposed level of supports—and not production payments as such—was and is the key to this political panacea? Without exception, every statement we have made to the Congress on this subject has pointed out that the level of supports coupled with the Marxian concept of "equal shares" constitutes the principal distinguishing feature of the Brannan Plan. One of the main results of the Brannan Plan proposal was to eliminate the authority to use the production payment device to implement government price policy.

The fact that the facts just enumerated are so little understood—even by people who are supposed to know—provides another example to illustrate my main point, which is, it is not easy to be an understanding citizen in 1954.

But, you say, that issue is dead. It is dead just like socialized medicine is dead. Of the five congressmen chosen to speak at a party rally in Washington today, four voted for the Brannan Plan in 1949 and the other, a freshman member, recently introduced a Brannan Plan bill in the Congress.

TECHNIQUES

The favorite technique of those who favor maximum political intervention in the economic field is to try to put those of us who support the American system of private competitive enterprise on the defensive—to try to get the public to believe ours is a negative program. And, let us never forget that those who would drastically change the American system have not exhausted their supply of techniques for accomplishing their objectives.

Let us take, for example, the Farm Bureau's campaign during the Korean war period to get affirmative action on the root causes of inflation. This program included emphasis on increased production, reduced federal expenditures, pay-as-we-go taxes, strict consumer credit controls, and wise management of the public debt. To be *for* this program meant being *against* direct price and wage controls which were and are designed to submerge and conceal inflation, and thereby *divert* attention from the need for fundamental remedies that get at its basic causes—the imbalance in the supply of money in relation to the goods available for purchase.

Far too many people have been led to believe that because we opposed direct price and wage controls we were less interested than they in controlling inflation. Ours was an affirmative program—not a

negative program—yet, as I have said, you and I know that efforts were made to twist our position.

A lot of the misinformation on this issue emanated from the "controllers" in government. The biggest lobby in Washington—bar none—was and to some extent still is the federal lobby.

Federal payrollers too often have a vested political interest in maintaining and expanding, if possible, "Big government."

It is important to be against what you are not for. There is nothing unholy about this. Seven of the Ten Commandments commence "thou shalt not . . ." yet, I have not heard anybody suggest that the Ten Commandments constitute a negative program. As I have said, some of those trying hardest to create the impression that our program to protect freedom is negative are interested in the centralization of power and expansion of the activities of the federal government. These are the United States counterparts of the Fabian Socialists.

I was interested in reading the pamphlet, "One Way Only," which is a socialist analysis of the present world crisis and which contains a foreword by Aneurin Bevan written soon after he resigned from the Atlee government, presumably because he was dissatisfied that they were not completely socializing things fast enough. In this document reference is made to the "program" of the party contained in the document entitled "Let Us Win Through Together." In it are listed only two programs that relate specifically to agriculture. They are "the full use of statutory powers against inefficient farmers" and "nationalization of food-producing land which is not fully used." I ask you, what is affirmative about this program?

It seems to me that in the present setting we are about in the position of the orchardist who knows that he will not have much of an apple crop if he does not spray to control the codling moth. It is not so much that he is *against* the codling moth. It is that he is *for* apples. It seems to me that in the discussion of the public issues of the day there are quite a few political codling moths flying around and trying awfully hard to be worms. I wouldn't be surprised if some of them made it!

In addition to indicating the kind of public policy apples we are *for* and the techniques of culture which will improve our possibilities for getting a good crop, any constructive program should continue to contain a prescription for taking care of the codling moths that jeopardize the crop.

I suppose the British thought that Paul Revere was a little negative. He was doing something different than what they were for. All he did was ride through Lexington and Concord yelling, "The British are coming." Yet, today we view him as a great patriot. Why? Because we know he was *for* freedom.

If all of us recognize that today freedom is the issue, that we are *for* those things that protect and expand freedom, and that we are *against* those things which threaten freedom, it may not be too late!

On the other hand, if we are not prepared to "do battle" with the forces that threaten freedom from within, as well as without, then "we're over the hill."

The decision is up to people like you and me throughout America. Let us stand up and be counted for freedom. The choice is ours!

261 Constitution Avenue, N. W.

NEW DRUG COMBATS SHOCK

A relatively new, synthetic drug, l-arterenol, has been found to be of value in combating shock, it was reported in the January issue of *Archives of Surgery* by Dr. R. E. Fremont, Dr. N. M. Luger, Dr. S. N. Surks, and Dr. A. Kleinman.

These Brooklyn doctors report that use of the drug in conjunction with whole blood, blood plasma, and fluids helps to raise blood pressure and makes it possible for some patients in profound shock to undergo extensive surgical procedures.

The conclusions of the doctors were based on a study of 22 patients who were treated with l-arterenol. Intravenous injections of the drug resulted in an immediate, striking improvement in the majority of cases, the doctors stated. The only adverse reaction noted was a sloughing of skin. They added that l-arterenol must not be expected to abolish advanced hemorrhagic shock if the course of bleeding cannot be detected and eradicated. It is essential, they stated, that the cause of the shock state be known and definitive therapy undertaken as quickly as feasible; lost blood must be replaced and continued bleeding stopped.

Medical School Applications

The number of applicants for admission to medical schools has decreased for the fourth consecutive year although approved medical schools are now accepting their largest freshman classes, states John M. Stalnaker in the April issue of *The Journal of Medical Education.* It is pointed out that there continues to be more individuals seeking admission to medical school than can be accepted and that many of the applicants are not qualified for admission.

Mr. Stalnaker states that 23 per cent of this year's applicants had sought admission the year before and were repeating, but the number repeating application to medical school the year before was 31 per cent. Forty per cent of the applicants applying a second time were accepted, and 57 per cent of the new applicants were accepted.

Childbirth

A woman's chances of surviving childbirth today are eight times better than were her mother's, according to the American Medical Association. A woman today has better than 999 chances out of 1,000 of coming through childbirth safely.

TUBERCULOSIS IN REVIEW

I. The Changing Diagnostic Scene

J. EDWARD JOHNSON, M. D., Austin, Texas

ROENTGENOGRAMS of the chest from community surveys and periodic examinations of relatively healthy people are giving indications of pulmonary disease in such early stages that identification is often difficult. Frequently there are no symptoms and the film is not absolutely diagnostic of any one specific disease but merely suggests a half dozen or more possibilities in the differential. Although it is often possible to establish the etiology by serial films over a period of time, when tuberculosis or lung malignancy cannot be ruled out, this delay is dangerous and must not be permitted, but consultation with the pathologist, bronchoscopist, and surgeon should be sought.

The need for increased vigilance on the part of the profession for earlier and more accurate diagnosis of chest lesions is being emphasized by the reports that there are still arriving at the sanatoriums patients who do not have tuberculosis, and by the warnings from chest surgeons that pulmonary malignancy is being identified too late.

Even though many preclinical lung lesions are admittedly as difficult to diagnose positively as is the pre-eruptive stage of measles, visual dexterity and skill is growing apace with many roentgenologists so that they are able to reduce time and expense of identification by expertly narrowing the differential list to two or three conditions.

Germs exposed to effective chemotherapeutic combinations frequently lose their ability to grow in cultures or in laboratory animals.[1] These acid-fast organisms found in sputum, or in tissues removed at operation, cannot be positively identified by the usual standard laboratory methods. Trouble in diagnosis is apt to arise especially in two situations:

1. Cases treated with these drugs before bacteriologic confirmation of the diagnosis has been obtained.

2. Urgent situations in which the differential includes tuberculosis, lung abscess, and pulmonary malignancy. (In this latter instance the only recourse may be in surgical exploration and tissue biopsy.)

A third problem may well arise in the case of the child treated for a primary infection as a prophylaxis against tuberculous meningitis who later develops a lung condition that simulates tuberculosis. This may become grievous if the practice—as is now being advocated[2]—should be adopted generally and due care is not always exercised to guard against errors in diagnosis at the outset (for example, diagnosing primary infection from roentgenograms alone).

It is known that the property of germ resistance is transmitted to succeeding bacterial generations and that the new contact infections also will resist the drugs that originally provoked resistance in the germ ancestry. If the same, or similar, facts are found to be true in regard to these growth alterations, then we shall be shortly in dire need of a new laboratory method of confirmation to replace those methods we seem to be losing.

DIFFERENTIAL POINTS

Metastatic malignancy is occasionally mistaken for tuberculosis. Lung is an early target for wandering malignant cells, especially from breast, thyroid, kidney, and pigmented moles. The latter three may occur even in young subjects and—what is more important—sometimes even before any enlargement is noted in the organ of origin.

Pulmonary calcifications once considered pathognomonic of tuberculosis are now known to arise from several causes.[3] Histoplasmosis has been identified as a rather frequent cause in certain geographic areas.

Inhalants such as silica, cane pumice, and cotton lint usually cause trouble in the lungs only after long exposure and the accumulation of heavy deposits; but beryllium, because of its highly toxic reaction on lung tissue, may establish irreversible changes after short exposure and only small deposits of the element.

So-called coin lesions of lung parenchyma may be due to small localized abscess, tuberculosis, or malignancy.[4] They are potentially dangerous and should be diagnosed as early as possible. If tuberculous, they may remain quiescent for a considerable time only to undergo liquefaction and cavity formation with rapid spread of the disease.

The "hilus thickening" so often reported in chest roentgen-ray examinations may be due to lymphatic enlargement, mediastinal disease or tumor, metastatic deposits, or Hodgkin's disease, or may simply represent engorgement of pulmonary vessels due to heart disease.

Unilateral wheeze is suggestive of several serious conditions and should be investigated thoroughly.

Adapted from a panel discussion presented for the Travis County Medical Society, Austin, January 19, 1954.

When it is inspiratory in type, it may mean bronchial edema from virus pneumonitis.

It should be remembered that *abscess of the lung* may arise from bronchial obstruction by foreign body or malignancy, and also that cancer and tuberculosis may coexist and that any suspicion of the fact calls for prompt exploration.

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II. Diseases with Roentgen-Ray Shadows Simulating Tuberculosis

BEN DuBILIER, M. D., Austin, Texas

IN ADDITION to the early preclinical pulmonary lesion that is notoriously hard to diagnose positively by roentgen-ray alone, a number of diseases in various stages of advancement may produce shadows extremely difficult to differentiate from those of tuberculosis. Every doctor reading roentgenograms should be familiar with these conditions and should acquire experience in identifying them, or serious blunders may result.

With no pretense at completeness, the following list is presented as a fair sample of the simulators of tuberculosis that may present themselves for diagnosis in any modern community survey.

A. Primary complex (childhood type infection).
   1. Atypical pneumonia.
   2. Sarcoid, Hodgkin's disease, metastases.
   3. Pneumococcal pneumonia.

B. Adult tuberculosis (reinfection type).
   1. Pneumonitis—atypical pneumonia (virus, rickettsial, and other types).
   2. Nontuberculous pneumonia (upper lobe).
   3. Lung malignancy (especially upper lobe).
   4. Löffler's syndrome (eosinophilic pneumonia).
   5. Meigs' syndrome (women only).
   6. Diseases that may cause abscess, with or without cavitation.
      a. Neoplasm, especially bronchiogenic cancer.
      b. Friedländer's pneumonia.
      c. Bronchiectasis of upper lobe.
      d. Cystic disease (congenital or acquired).
   7. Mycotic infection (fungous disease).
      a. Histoplasmosis (pulmonary calcifications).
      b. Monilia, aspergillosis, and so forth.
      c. Coccidioidomycosis.
   8. Tularemia (nodular, confluent, or lobar).
   9. Inhalant reactions.
      a. Berylliosis (beryllium from neon lights).
      b. Bagassosis (sugar cane fiber).
      c. Byssinosis (cotton lint).
      d. Silicosis (hard rock dust).
   10. Pulmonary edema and congestion from shock, cardiac causes, embolism, and so forth.
   11. Miscellaneous.
      a. Diffuse interstitial fibrosis.
      b. Chronic advanced bronchial disease.
      c. Pancreatic disease.
      d. Sarcoid, Hodgkin's disease, metastases.

C. Miliary tuberculosis.
   1. Miliary carcinomatosis (especially from thyroid).
   2. Mycotic infection (especially histoplasmosis).
   3. Wheatena—probably mycotic (generalized, bilateral, miliary, cottony nodules originally thought to come from wheat field inhalations, now considered to be calcifications from histoplasmosis).

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MOTOR VEHICLE DEATH RATE

The increase in the death rate from automobile accidents in the United States since 1949 is due to accidents involving drivers and passengers rather than to those in which pedestrians were fatally injured, according to a report by Metropolitan Life Insurance Company statisticians.

Death from motor vehicle accidents in the United States claimed 32,000 in 1949 and approximately 38,000 in 1952 and in 1953.

The death rate of the company's policyholders increased by more than 40 per cent from 1949 to 1952 from accidents in which motor vehicles overturned on the road, ran off the roadway, or hit a curb, pole, or other fixed object. The death rate from accidents involving a collision of two or more motor vehicles was up 26 per cent. On the other hand, the loss of life among pedestrians injured in automobile accidents was only slightly higher in 1952 than in 1949.

More than 90 per cent of the deaths occur among drivers and passengers between the ages of 15 and 29 years. The rise in the death rate in this age group between 1949 and 1952 averaged about 40 per cent, which the statisticians see as reflecting "a growing tendency of many young people to play fast and loose with their own lives and those of their companions."

III. Bronchoscopy in Tuberculosis and Recognition and Management of Tuberculous Laryngitis

O. W. SUEHS, M. D., Austin, Texas

THE indications for bronchoscopy in a known or suspected tuberculous patient can be discussed most conveniently under three headings in that the procedure is (1) a method of obtaining an etiologic diagnosis, (2) a method of observing directly the progress of the disease in tuberculous tracheobronchitis, and (3) a method of therapy.

As an aid to diagnosis, bronchoscopy is used most often to obtain secretions from a segment of the lung suspected of being tuberculous. O'Keefe[2] has reminded that it is useful in determining the cause of bronchial obstruction in a suspected or known tuberculous patient. Only through bronchoscopy can one determine whether the obstruction and pneumonitis is due to erosion of a tuberculous lymph node into a bronchus, a tuberculoma in a bronchus, or cicatricial stenosis following healing of an ulcerated bronchus. Bronchoscopy is used to ascertain the source of hemoptysis and also to differentiate the presence of other bronchopulmonary lesions coexisting with tuberculosis, such as bronchiectasis and neoplasm.

As a method of observing the progress of the disease during the management and treatment of a tuberculous patient, bronchoscopy is indicated to ascertain the condition of the bronchial mucosa prior to collapse therapy and in anticipation of surgery for tuberculous lesions. It also is used to evaluate the response to therapy of previously diagnosed bronchial tuberculous lesions.

As a method of treatment, bronchoscopy is used to apply silver nitrate, streptomycin, and other drugs topically to ulcerogranulomatous lesions of the tracheobronchial tree, as an adjunct to parenteral and aerosol therapy. Tuberculomas and eroded lymph nodes have been removed endobronchially by various bronchologists.

TUBERCULOUS LARYNGITIS

Tuberculous laryngitis is said to occur in from 2 to 4 per cent of all cases of tuberculosis and of course is seen most frequently in the moderately advanced tuberculous patients. It is always secondary to pulmonary tuberculosis. The appearance by mirror laryngoscopy may vary from a simple erythema of a vocal cord to edema and ulcerogranulomatous changes. Edema, ulcerations, and granulations occur most frequently in the posterior portion of the larynx. Hoarseness is the most common symptom and pain is the rule when ulceration is present.

Until recent years treatment of tuberculous laryngitis consisted in vocal rest, applications of chaulmoogra oil, and cauterization with silver nitrate and the electrocautery. These methods were almost always disappointing and have been replaced by parenteral and aerosol administration of streptomycin and dihydrostreptomycin. Most observers believe that the concomitant parenteral-aerosol method of administration is the most effective for both laryngeal and endobronchial lesions.

The prognosis for cure of tuberculous laryngitis after adequate treatment with streptomycin or dihydrostreptomycin is now good. It is apparently better than the prognosis for cure of the pulmonary lesion, which is usually moderately advanced in these cases. A review of several articles on this subject indicates that one can expect complete healing of the laryngeal lesion in about 50 per cent of patients treated and marked improvement in another 25 per cent, even though the sputum remains positive in most cases and in spite of the fact that there is little change in the pulmonary lesion. Pain is quickly relieved with healing of the ulcerations, and there is little or no disability insofar as the larynx is concerned.

There is some danger of disability from the toxic effects of streptomycin and dihydrostreptomycin on the eighth cranial nerve in the labyrinth.

Streptomycin is said to have a predilection for vestibular toxicity,[1] with dysfunction appearing in approximately 15 to 20 per cent of cases soon after treatment is started, but this is reversible on stopping the drug.

Dihydrostreptomycin has a predilection for auditory toxicity in about the same percentage of cases.[1] The auditory dysfunction (hearing loss) becomes apparent only after three or four months of therapy but is progressive for several months even after the drug is discontinued.

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IV. Obstetric and Gynecologic Aspects

W. B. HAHN, M. D., Austin, Texas

ALTHOUGH childbearing still imposes an undesirable physical strain on the woman with active pulmonary tuberculosis, the disease no longer constitutes an indication for therapeutic abortion. Under modern drug therapy, management of pregnancy and delivery at term are successfully accomplished in many cases without harm to either mother or baby.

To avoid the dangers arising from undetected minimal or subclinical lesions, the prenatal schedule should require careful screening in the early months of pregnancy. This can be accomplished best by intradermal tuberculin tests and 14 by 17 inch roentgenograms of the chest for all positive reactors.

Pregnancy in a tuberculous woman can be safely advised only when definite assurance of inactivity is established; but careful supervision all through the prenatal and postnatal periods must be maintained. On the appearance of any positive indications of the reactivation of her lesions, the patient must go immediately under the indicated treatment and remain so until after delivery and until competent consultation advises release from the schedule.

I do not advise the extuberculous mother to nurse her baby. The objection is not to the strain of lactation, as was formerly taught, but to the inherent danger in the close association of the baby with a possible source of infection.

Tuberculosis of the genital tract before drug therapy frequently resulted in sterility and occasionally required mutilating excisions. Although it is now better controlled by present-day schedules, the diagnosis in early stages is still so difficult to make with certainty that surgery often must be utilized and sterility cannot always be avoided.

1506A Guadalupe.

V. Tuberculosis in Children

W. W. KELTON, JR., M. D., Austin, Texas

FOR survey purposes and routine application during infancy and childhood the Vollmer patch test for tuberculosis is accurate and practical. If certain standards are followed, it can give important information. In reading the test, one must observe both redness and induration to call it positive, and, in fact, some pediatricians require vesiculation; all other reactions should be called questionably positive and followed with the application of old tuberculin intradermally. In situations in which sharp differential is required, the use of old tuberculin in 1:10,000, 1:1,000, and 1:100 dilutions is preferable to depending on the patch test.

A positive patch or intradermal test has only one meaning—that the person has been sensitized to tuberculin. The sensitization may have occurred previously or may be the result of present activity. In either case an evaluation of the situation is warranted with any other diagnostic measures that seem practical. Certainly, chest roentgenograms should be made to find either active or healed primary lesions, and if activity is suspected, sputum or stomach contents should be examined for the tubercle bacillus.

The family should be told that this positive reaction to a routine patch test does not necessarily indicate active infection at present and should not be cause for great alarm; that a thorough study of the child is indicated to detect active disease; that all members of the family, particularly grandparents and servants, should be investigated; and that it is important to avoid further contact with tuberculosis.

TREATMENT

Active Primary Complex.—Activity of the primary complex is difficult to assess. Asymptomatic cases can safely be watched carefully with no specific therapy. Symptomatic cases in many instances should only be watched, but the early signs of hilar pressure, spread to a miliary type, or meningeal signs require the institution of chemotherapy not essentially different from adult treatment.

Tuberculous Meningitis.—Several good reports have appeared recently in regard to tuberculous meningitis, the most comprehensive of which is a controlled study in seven pediatric centers from 1948 to 1952 by the United States Public Health Service.[1]

It now seems that a formerly fatal disease has a better than 60 per cent survival rate, although the prognosis in Negroes and very young children is not good, and miliary tuberculosis complicating the men-

ingitis decreases the survival rate tremendously. Many vegetative states are sequels, and most patients have vestibular damage, but hearing returns: no deafness has persisted in streptomycin-treated miliary tuberculosis not complicated by meningitis.

The important drug in tuberculous meningitis is streptomycin, which must be used both intramuscularly (50 mg. per kilogram of body weight daily) and intrathecally (50 mg. every second day) over a prolonged period. The present method is to use repeated six week courses of streptomycin by both routes with ten day rest periods between.

Para-aminosalicylic acid, 2.5 Gm. three times a day by mouth, is necessary continuously throughout the total treatment; in addition to aiding in prevention of streptomycin resistant bacilli, para-aminosalicylic acid seems to stimulate appetite and hemoglobin formation. Isoniazid has proved very helpful in conjunction with the aforementioned therapy and is given continuously for months in doses of 4 to 8 mg. per kilogram of body weight.

Many cases need neurosurgical assistance, and streptokinase or streptodornase intrathecally has helped. Some moribund cases have been given purified protein derivative of tuberculin intrathecally with equivocal results.

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108 West Thirtieth.

VI. Renal Tuberculosis

B. CLARY BATES, M. D., Austin, Texas

THE diagnosis of renal tuberculosis can be made only by the specific identification of the acid-fast organism in the urine either by smear of the sediment, culture, or guinea pig inoculation. Specific symptoms suggestive of urinary tract infection are helpful but not diagnostic.

The treatment of renal tuberculosis is both medical and surgical. The latest drugs and dosages in the treatment of tuberculosis are also applicable to treatment of renal tuberculosis. Too much emphasis cannot be placed on the importance of early diagnosis. If more renal tuberculosis was diagnosed early, there would be much less surgical treatment involved.

Surgical treatment of renal tuberculosis is limited to the general indications for surgery in treating inflammatory disease of the urinary tract. Nephrectomy is reserved for those kidneys which show destructive changes beyond the limit of recovery, and the indication for nephrectomy should be the same indication as for any infectious process in the kidney from any organism. The degree of destruction, the presence of stones, and the degree of obstruction to drainage as a result of infection should be considered as factors in indication for surgical removal of the kidney. Unilateral involvement is also an important factor to consider. The urologist must consider renal tuberculosis in the primary stage as being bilateral. Time is the greatest factor in determining whether bilateral lesions will progress to the fulminating stage or heal as the result of medical treatment. Bladder ulceration not responding to medical treatment with unilateral renal involvement is an indication for nephrectomy.

Prognosis in the treatment of renal tuberculosis is increasingly good as it is with all forms of tuberculosis. One important fact that cannot be overlooked is that complete bed rest is as important in the treatment of renal tuberculosis as it is in the pulmonary type. Complete urologic examination of patients showing positive tuberculin reactions and early pulmonary tuberculosis should be carried out to diagnose renal lesions earlier. More vigilant diagnostic inquiry into obscure urologic ailments by the general physician on patients having history of tuberculosis will bring many of these infections under treatment in the curable stage. The danger of drug resistance, which can now generally be deferred by the proper combination of drugs, should be emphasized.

403 West Eighteenth.

Almost 68,000 light trucks owned and operated by laundries and linen services have been offered to civil defense for emergency ambulance service. Some of these trucks already have been adapted to ambulance use through the addition of emergency fittings to hold stretchers and have undergone trial runs in test exercises throughout the country.

Physicians are rated last, advertising agency executives first, in the list of spenders for entertainment for business purposes, according to a study of the 100,000 members of the Diners' Club, a credit card system covering hotels, night clubs, and florists, the Medical Society of the State of Pennsylvania reports.

VII. Tuberculosis of the Skin

EUGENE P. SCHOCH, JR., M. D., Austin, Texas

THERE is no simple formula for the diagnosis of tuberculous infections of the skin. The disease is as protean as syphilis. The cutaneous response to the tubercle bacillus depends on the existing state of allergy or immunity of the patient.

Clinically several specific types of tuberculoderms are recognized. An indolent, indurated, chancriform ulcer on the exposed skin, with a satellite lymphadenopathy, usually in a child, suggests a *primary inoculation tuberculous complex.* A verrucous, granulomatous, sometimes crusted or purulent lesion on the exposed skin surface suggests the possibility of *tuberculosis verrucosa cutis.* Dull reddish, indurated nodules with central ulceration overlying lymph nodes or bones (usually in the neck) may indicate *tuberculosis cutis colliquativa* (scrofuloderma). Painful ulcers at the mucocutaneous junction of the mouth, nose, anus, or genitals may be the *orificial type* of skin tuberculosis seen in debilitated, advanced tuberculous patients. Coalescent "apple jelly" nodules forming scarring plaques usually on the face of young adults suggest *lupus vulgaris.* A sudden onset of a postexanthematous, papulo-ulcerative eruption in children could represent an acute disseminated *miliary cutaneous tuberculosis.* Generalized, scattered lichenoid papules, crops of grouped ulcerated papules; symmetrically grouped tiny lupus-like papules, or chronic, deep, indurated nodular and ulcerated lesions on the calves could be one of the several types of *tuberculids.*

The danger of spread of skin tuberculosis to other organs is slight. Most patients with cutaneous tuberculosis already have internal tuberculosis. There is a possibility that both localized and hematogenous forms could disseminate secondarily; however, this is very remote. The type most likely to spread to other tissues is the primary complex (inoculation into virgin soil, one who has never had tuberculosis).

All forms of cutaneous tuberculosis except most tuberculids may contain viable tubercle bacilli in the lesions and are therefore potentially infectious to other persons. Probably the primary complex and the extensive ulcerative (orificial and miliary) varieties would be the most dangerous.

The prognosis of skin tuberculosis is variable with the type. The local inoculation types tend to heal spontaneously. Lupus vulgaris runs a chronic, protracted course and is often locally destructive. The orificial and miliary varieties usually eventuate in death. The tuberculids are evanescent but usually clear with improvement of the systemic tuberculosis.

Treatment of cutaneous tuberculosis has paralleled that of internal tuberculosis. *Calciferol* (vitamin D_2) has been popular during the past ten years, especially in the treatment of lupus vulgaris (dosage usually 150,000 units daily). *Streptomycin* and *dihydrostreptomycin* are recommended for those forms in which the bacilli are demonstrably numerous and may be given concomitantly or alternatingly with *para-aminosalicylic acid.* Recently *isoniazid* has been used by many groups successfully and is thought probably to be the drug of choice. The dose of this medication has been from 200 to 600 mg. per day. General tuberculosis regimens of rest, high caloric diets, vitamins, and so forth should be stressed also. Local destruction or removal of small lesions, for example, tuberculosis verrucosa cutis, sometimes also is indicated.

It must be remembered that cutaneous tuberculosis is the expression of only one of the organ systems to infection by the tubercle bacillus. The future hope for its eradication, of course, lies with control of tuberculosis as a whole.

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SUCCESSFUL USE OF PLASTIC DRESSING

Successful use of a new plastic dressing for burns and surgical wounds is described in the January issue of *Archives of Surgery* by Dr. Daniel S. J. Choy, Dayton, Ohio. The dressing is a sprayable, transparent, film-forming polyvinyl plastic called Aeroplast.

Dr. Choy based his conclusions on a study of 50 patients treated with Aeroplast who had either first degree burns, third degree burns, skin graft donor sites which were regarded as second degree burn equivalents, or other types of surgical lesions such as operative wounds and lacerations.

The chief disadvantage of the Aeroplast is the thirty to forty-five second period of sharp stinging felt when the dressing is applied to a raw area. Dr. Choy states that some of the advantages are marked savings of time over conventional pressure dressings in application, the feasibility of its use by relatively untrained personnel, applicability to parts of the body poorly adapted to pressure dressings, and transparency, allowing frequent inspection of the burned area without removal of the dressing.

Other advantages are impermeability to bacteria, the absence of tourniquet effect on limbs and of restriction of respiration when applied to the abdomen and thorax, and moderate prevention of bacterial growth.

Aeroplast's advantages in surgical wound cases, Dr. Choy believes, are ability to maintain the sterility of a clean wound, ease of application and removal, no retardation of wound healing, and transparency.

VIII. Recent Trends n Therapy

ROBERT B. MORRISON, M. D., Austin, Texas

FOR years the only effective treatment known for tuberculosis was bed rest. Climate was emphasized. In the recent past the best form of medical treatment added to bed rest such things as pneumothorax, either unilateral or bilateral, phrenic nerve interruption, and the creation of an extrapleural pneumothorax. Usually the surgeon created the latter and it was maintained by the medical man. In some instances the pneumothorax was not effective because adhesions were present and interfered with the collapse. When possible these adhesions were divided and an unsatisfactory pneumothorax was converted into a satisfactory one. On occasion a foreign substance such as oil was placed either in the pneumothorax or the extrapleural space. Pneumoperitoneum was tried and abandoned.

All of the aforementioned procedures are given credit for having accomplished a lot of good in the fight against tuberculosis. They were not, however, without their complications. Only too often such complications as empyema, persistent hydrothorax, the nonexpandable or trapped lung, and bronchopleural fistula made the phthisiotherapist wish for some safer and better means of treatment, but such methods were not at hand. The medical man more or less went in circles trying to apply already established principles in different ways. The surgeon was held in check by the threat of certain infection and faced the abyss of suffocation any time he attempted anything other than an extrapleural procedure. His main weapon was the conventional thoracoplasty. All too often patients referred to the surgeon for thoracoplasty were referred with the hope that a measure of health for the patient could be salvaged, other forms of treatment having failed.

The main argument between the medical man and the surgeon was, so to speak, pneumothorax versus thoracoplasty.

Within the past few years our concepts in the treatment of tuberculosis have changed considerably. Great strides have been made. The discovery of antimicrobial agents effective against the tubercle bacillus in vivo and the development of newer methods of anesthesia have made it possible to do things that the phthisiotherapist could only dream of a few years ago. The previously mentioned methods of treatment have not been abandoned completely but have come to fall into more well defined places. Pneumothorax has been mostly abandoned but is still considered by many to be an excellent form of treatment. Extrapleural procedures again have become popular with the use of prostheses such as lucite balls and plastic plombage to maintain the collapse once it is established. More frequent use of the bronchoscope has helped not only to explain why collapse measures in some instances failed in the past, but also to assist in the avoidance of pitfalls by indicating type of treatment. It is now known that endobronchial disease with stenosis or ulceration of the affected bronchus may produce near catastrophe if pneumothorax is attempted over this lung, and thoracoplasty may fail to bring about the desired end result. For this reason in such cases, where possible, excisional surgery is the procedure of choice. This may call for the removal of an entire lung or part of a lung.

In present times the medical chest physician and the thoracic surgeon are more inclined to work as a team in closer cooperation than in times past. Often a patient with tuberculosis is earmarked for probable ultimate surgery at the very outset of treatment, and the ultimate surgery is looked upon as the consummation of a definite achievement, rather than as a last resort measure. Pleasantly enough, the patient scheduled for ultimate surgery sometimes clears his disease sufficiently to preclude the necessity of an operation.

The revival of pneumoperitoneum has aided considerably in strengthening our present armamentarium against tuberculosis. This procedure, which is now currently popular, is used in conjunction with the antimicrobial agents.

Many patients today are placed on a routine of drugs plus pneumoperitoneum. Pneumoperitoneum has the advantages of being reversible, being relatively safe, having few complications, and attacking bilateral as well as unilateral lesions. Frequently the disease will regress and the patient make a nice recovery on this routine, which includes, of course, careful bed rest and adequate nutrition. Lesions that originally were extensive or that destroyed considerable amounts of lung tissue are observed under this regimen, and when maximum clearing has been obtained, the lesions are then resected. Cooperation with the surgeon in this respect is important, in that the timing of the operation—if it becomes necessary at all—is important. One must not be dogmatic and insist on trying to cure all types of tuberculosis with a medical routine, but *must be able to recognize the point at which medical treatment alone is of no further avail and surgery becomes necessary.* Also, the chances for successful surgery are enhanced if surgery

is performed before drug resistance is developed by the patient's tubercle bacilli.

Within the past few years much work has been done with the various antimicrobial drugs. Various combinations and dosages have been tried in an effort to do two things, (1) find dosages least apt to harm the patient yet be effective against the tubercle bacilli and (2) administer the drugs in such a way as to insure their effectiveness over the longest possible period of time. Streptomycin, dihydrostreptomycin, para-aminosalicylic acid, and isonicotinic acid constitute the backbone of drug therapy at this time. Other drugs are available but are considerably more toxic than those named. All of these drugs can be used singly but are more effective and can be used on a long-term basis when used in combination. Para-aminosalicylic acid is given orally, 10 to 12 Gm. daily. Along with this, streptomycin, 1 Gm. twice a week in the muscle, is administered. This combination is usually effective for eighteen to twenty months. The usual dose of isonicotinic acid at present is accepted as 100 mg. three times a day orally and is usually used along with streptomycin given twice a week. This combination also can be given for long periods. It has been proved that when streptomycin or one of the other drugs is used alone, the patient is apt to develop drug resistance in short order. However, the use of drugs in combination as mentioned earlier greatly delays the time of emergence of drug resistance within the tubercle bacilli.

Other combinations are under trial at present, but the dosages and combinations mentioned are those now recommended. As a rule, these dosages are well tolerated by most patients and no special precautions are necessary. However, drug sensitivity occasionally is encountered. For this reason, if one anticipates the use of these drugs, he should become thoroughly familiar with their toxic manifestations. The current literature is ample in this respect.

The treatment of tuberculosis has not yet been reduced to a simple formula of pills and hypodermic injections. Far from it! Since before Christ, mankind has sought a quick, easy and specific cure for the great white plague. As of this moment we are perhaps a little closer to success than in previous years. However, not yet has anything been found to take the place of the bed in the treatment of tuberculosis. Surely, wonderful strides have been made, but these strides merely make the bed more effective.

The specific cure remains a challenge to the medical profession.

Capital National Bank Building.

IX. Recent Advances in Surgery

RALEIGH R. ROSS, M. D., Austin, Texas

ARNOLD DE VILLANOVA in 1312 stated, "In most cases of scrofula, external applications are better than the use of the knife." In 1946, Sweet, while discussing the reasons for failure in resection for pulmonary tuberculosis, made the statement that "tuberculosis is not primarily a surgical disease." In discussing the surgical management of tuberculosis in 1949, Shaw observed that "surgery in the treatment of pulmonary tuberculosis occupies a unique position in the field of surgery, in that surgery is not definitive but is merely an adjunct in the treatment of patients having this condition."

We can see how rapidly the concept of the treatment of tuberculosis has changed—the statements just quoted were made and believed for hundreds of years. In the last four years, however, in the early era of improved surgical techniques, antimicrobial therapy, modern anesthesia, and blood banks, our ideas of the treatment of tuberculosis have changed. Now tuberculosis patients are considered for some type of collapse therapy or surgery with the exception of those in whom the disease is so minimal that such treatment is not necessary or of those in whom the disease is so far advanced that therapy of this type is impossible.

TYPES OF PROCEDURES

The types of surgical procedures used in the treatment of tuberculosis are many and varied. They range from simple needle punctures to total pneumonectomy and pleurectomy. Actually, the surgery of tuberculosis has advanced very rapidly in the last five years.

Pneumothorax, or controlled air introduced into the pleural cavity for collapse, is the simplest surgical procedure. This type of treatment is being used less and less. It has been estimated that artificial pneumothorax can be used on only 20 per cent of tuberculosis patients, but the antimicrobial drugs have cut down the number of cases within this percentage.

Pneumonolysis, or freeing of pleural adhesions, is a corollary operation to pneumothorax and so is not

used as much as it was. Pneumonolysis may be either open or closed—carried out with the thoracoscope or with an open chest at thoracotomy.

Extrapleural pneumonolysis or pneumothorax is a procedure that has a few enthusiastic advocates in this country and many on the European continent. It has fallen into disrepute with many because it is technically fairly difficult and requires close postoperative attention and care. It is believed by some that extrapleural pneumothorax brings about the most complete and the most selective collapse possible, and it is well tolerated, even in poor risk patients with a low respiratory reserve.

Lucite balls were used enthusiastically to maintain the extrapleural collapse for several years. Their use has been largely discontinued because of frequent complications following their employment. Plastic sponge has some advocates in this field, but air has remained the most foolproof medium for maintenance of collapse.

Diaphragmatic paralysis, by phrenic nerve crush, is still used occasionally. The addition of this therapy may be enough to allow a lesion to heal which would not heal without this aid. Indications for diaphragmatic paralysis are (1) minimal lesions—to augment bed rest, (2) cavities less than 3 cm. in diameter when pneumothorax has failed, (3) reexpanding pneumothorax needing supplementary treatment, (4) basal lesions beneath an upper thoracoplasty, (5) flare-up around old fibrotic lesions, and (6) resection, after which rest is needed.

Pneumoperitoneum is strongly advocated by some. It has a place in conjunction with diaphragmatic paralysis, bilateral disease, or lower lobe cavities; following lower lobe resections; or when no other procedures are immediately feasible.

Cavity drainage by the method of Monaldi or simple cavernostomy has a definite but limited place in surgery of tuberculosis. Monaldi catheter suction of large balloon cavities with fluid levels may reduce cough and toxicity and improve the general condition of the patient so as to allow definitive surgical treatment later. Rib resection with cavity drainage is a useful procedure in a few patients who have had unsuccessful thoracoplasties or in whom thoracoplasty or resection is contraindicated because of poor respiratory reserve or the position of the cavity.

Pulmonary resection in the treatment of tuberculosis has certain clearly defined and acceptable indications. These are (1) bronchial stenosis, (2) bronchiectasis, (3) lower lobe cavities, (4) thoracoplasty failure, (5) tuberculomas, (6) epithelialized cavities, (7) severe hemoptysis uncontrolled by other measures, (8) destroyed lobes or lungs, (9) tension cavities, and (10) empyema over destroyed lungs.

The type of resectional surgery used may be pneumonectomy, lobectomy, segmental resection, and subsegmental or wedge resection. The mortality rate for this type of surgery is about 3 to 5 per cent.

Resectional surgery has been used successfully in patients of all ages—even in children as young as 2 years of age. By the time a tuberculous process in the lung of a child reaches a stage requiring surgery, it is academic whether it be primary or postprimary. The principles underlying treatment of a disease which has progressed to irreparable destruction of lung tissue are basically the same.

Lung resection has been elected as a preferable procedure with increasing frequency. Concomitant partial thoracoplasty with resection in selected cases has given satisfactory results.

Segmental resection is being used more frequently and now represents one of the most commonly used surgical procedures in the treatment of pulmonary tuberculosis. Excellent results are secured with segmental resection when it is used as the primary procedure in cases with lesions well limited to the segment or segments being resected.

Wedge resection or enucleation of peripheral tuberculomas is being accepted generally. It has been proved that long-standing calcified tuberculomas often harbor live acid-fast bacilli—and so, unless otherwise contraindicated, these lesions should be excised.

Extrapleural pneumonectomy and pleurectomy for advanced tuberculous empyema has been a real step forward. This chronic condition which invalided patients for so long can now be brought under complete control. Of course, patients must have a good contralateral pulmonary reserve.

Decortication for chronic induced pneumothorax with captive lung has brought the rehabilitation of many thousands of patients who would otherwise remain pulmonary cripples. This is a satisfying procedure.

Extraperiosteal and extrapleural plombage still have some advocates, but they also have many critics. The perfect nonreactive substance to fill thoracic dead space has not yet been found.

The classical, staged thoracoplasty is still the yardstick by which resection is measured. There is no question that the clinical results of thoracoplasty are good—this has been proved by many with long-term followups. On the other hand, pulmonary resection has been shown to be a relatively safe procedure. Its use as an alternative to thoracoplasty is rapidly becoming manifest.

The availability of streptomycin, para-aminosalicylic acid, and isoniazid to "cover" the preoperative and postoperative periods has made the rapid progress in the surgical treatment of pulmonary tuberculosis possible.

It is felt by many that the ultimate treatment of pulmonary tuberculosis will be long-term intermittent antimicrobial therapy or resectional surgery.

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1309 Nueces.

X. BCG Vaccine

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THE story of BCG vaccine is that of two worlds apart. In this country, the use of this material is viewed with doubt; in Europe and most other parts of the world it has been administered to millions of persons. The fact remains that the tuberculosis mortality rate has fallen more rapidly in the areas of nonuse than in the areas where vaccine is given; therefore, it seems evident that there are other factors which are of equal or greater importance than vaccination per se.

There is disagreement on the methods of preparation, standardization, and administration of BCG. There is disagreement on the point whether tuberculin allergy means immunity, and if immunity exists, what its mechanism may be and what its duration may be. Studies have been poorly controlled. It is obvious that the value of the tuberculin test as a diagnostic and case finding method is lost when vaccination is used.

In this country, the United States Public Health Service has made a serious effort to establish studies with adequate controls. A recent note by Palmer and Shaw[1] indicates the status of these studies. Although it appears that the vaccinated groups have a slight advantage, the technical problems of mass utilization still exist.

It appears that the use of this agent in this country will be limited to those who are exposed to infection, such as doctors, nurses, and attendants, and to persons facing exceptional opportunity for exposure. In its present form, nationwide acceptance does not seem likely.

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XI. Public Health Aspects

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WITH mass community roentgen-ray surveys annually screening out the active cases, increased expansion of sanatorium bed capacity, widespread use of surgery and chemotherapy in treatment, and educational campaigns moving along at ever increasing tempo, it is easy to come up with the erroneous impression that the tuberculosis problem is about solved. The cruel truth is, however, that the tubercle bacillus still kills more people between the ages of 15 and 35 years than any other infectious disease.

Our true progress in the fight is difficult to assess, but as long as there are literally thousands of active germ-spreading cases among the population, we are yet in grave danger from the disease. Because of incomplete reporting of cases, the number that exists at any given time can only be estimated; but on the basis of such estimates, the number appears to be falling slowly.

Particularly within the past ten years, advances in the knowledge of control and of treatment have resulted in a larger and larger number of persons with advanced tuberculosis surviving into the later years of life in which heart disease, cancer, and even highway accidents account for their deaths in such manner that their tuberculosis is not recorded in the death report. This means that the disease is retreating into this older age group of the population where some of it is lost to statistics, but the germs are stored there long enough to be disseminated to many contacts in fresh infections. So, although we look with pride on our "falling death rate" in tuberculosis, we must not interpret it erroneously to mean a corresponding decrease in the prevalence of infection.

WHAT OF THE FUTURE?

The effort to control tuberculosis is supported by several independent groups. The most active units engaged in the effort are state and local tuberculosis associations; local, state, and federal public health services; and the medical profession. Perhaps the greatest need of the moment is the more efficient coordination of the members of the team. The community survey with microfilm succeeds in disseminating much information and arouses considerable interest while it is finding new cases, but as a control device it leaves much to be desired. What is needed is a steady, year round program into which all interested groups can be integrated and utilized to the fullest possible extent of their efficiency. Goals badly needed are the following:

1. Roentgen-ray examination of all hospital admissions.
2. Annual roentgen-ray examination of
   a. All hospital personnel.
   b. All food handlers.
   c. All domestics, including baby sitters.
   d. All public school personnel.
3. Annual health educational program on tuberculosis in all high schools.
4. Isolation and medical supervision of every known case of the disease in the community and follow-up of all contacts.
5. Closer cooperation of the medical profession in reporting cases to the health department.
6. Wider use of the tuberculin skin test in office examinations, especially of children and young people, and the family follow-up examinations of positive reactors.

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XII. Challenge of the Future

L. C. PAGGI, M. D., Austin, Texas

THE effective control of the tuberculosis problem depends, in essence, on three points:

1. A program of public and professional education regarding the disease, its mode of spread, its prevention, and the essentials of successful treatment.

2. A systematic and well integrated medical program that encompasses early detection, prompt adequate treatment, and follow-up rehabilitation and continuous medical supervision.

3. Research in all phases of the disease.

This certainly is not the time for us to pause and congratulate ourselves on a job well done. If a pause is made, it should be for a stock-taking to determine where we are and what we must do about this problem in the future. There is no doubt that an appreciable measure of success already has been achieved with the vastly improved methods of detection and treatment we now have at hand, and there is every reason to assume that even better methods will come along with increasing rapidity. Our immediate challenge, therefore, is to determine the best and most effective use of the tools now at our disposal and to put them to work at once to the fullest extent of our abilities.

IMMEDIATE PROBLEMS

Some of the immediate major problems in Texas yet to be solved are the following:

1. How to overcome the delay in admissions to the sanatoriums (an average of six weeks to four months). This delay results in increase in the contact infections in the community, further advance in the stage of the disease while the patients wait for admission, longer hospitalization when patients are finally admitted, and death of some patients while awaiting admission.

2. How to get nursing care and chemotherapeutic care to patients awaiting admission to the sanatoriums. Adequate treatment is often impossible because of financial difficulties in securing drugs and difficulty in getting the drugs to the patients and because of the usual unavailability of close medical supervision of those who receive the drugs and skilled care in the administering of these drugs.

3. How to effect the best use of the hospital beds available. The best use of available facilities is not always made because patients are admitted in the order that they appear on the waiting list and the waiting lists are not arranged to recognize the greater needs of some individual patients—those that are the greatest health hazards.

4. What to do about the understaffing of tuberculosis sanatoriums with regard to professional and nonprofessional nurses, doctors, and other technical personnel. These Texas hospitals have a total capacity of 2,253 beds. One has six graduate nurses, one has three, and the other has none.

5. What to do about the unavailability of needed special services at these hospitals. For instance, there are no facilities for the care of pregnant tuberculous patients and no delivery room services.

6. How to change the main factors that contribute

to the high mortality and morbidity rate from tuberculosis. These include lack of education, large families with insufficient incomes and low living standards, and other environmental factors.

7. How to coordinate better all services to the tuberculosis patient. This problem includes:

a. Better cooperation of physicians with community case finding programs and more complete processing of referred cases. There are still many people dying with tuberculosis that is diagnosed only at death.

b. Efforts of all concerned to get every case under medical supervision and in isolation.

c. Better cooperation of physicians with sanatorium staffs in loaning roentgenograms on referred patients and in forwarding case summaries when requested.

d. More careful diagnosis of cases prior to requests for admission to the sanatoriums. Patients are still being admitted who do not have tuberculosis. The result is delay in admission of more needy patients and unnecessary waste, financial and otherwise.

e. Better cooperation between physicians and others in arranging medical supervision of patients allowed to go home.

f. Lack of proper care in reporting of cases by physicians to the proper authorities. Texas law requires this reporting, a fact not generally remembered. As a general rule, the cases reported now are in an earlier stage of the disease than were those in past years.

CHALLENGES FOR FUTURE

In addition to these problems, there are many other challenges that must be met." These include:

1. Choosing between communitywide case detection methods and case finding programs in selected groups, the latter of which gives higher yields. However, the cases so found account for only a fraction of the total unknown infectious cases in the community.

2. Choosing between the hospitalizing of patients throughout the entire period of chemotherapy, thus giving greater assurance of complete and permanent recovery and maximum protection to the public, and reducing the period of dislocation of family and community life.

3. Choosing between compulsory hospitalization of all "uncooperative" infectious patients and a sympathetic determination of the reasons for such behavior, this to be done by social workers skilled in psychiatric techniques and followed by attempts to remove the underlying causes. One wonders what would be done to care for these patients if compulsory hospitalization is made a law. Our facilities are already very strained.

Some of the remarks Dr. James Perkins, managing director of the National Tuberculosis Association, made recently[1] seem apropos. In his article, he gives his views on some of the more long range challenges as follows:

1. "Is it possible to prepare a vaccine which will be cheap and which will give a high degree of immunity, be absolutely safe, devoid of toxic reactions, and which can be given to everyone regardless of his reaction to tuberculin?"

2. "Will treatment drugs, better than those now available, be devised? Is it possible that a drug will be developed, so effective and non-toxic that it can be used essentially like a vaccine, a drug which will eliminate infection in the infected and produce resistance to the disease in the uninfected?"

3. "Even in the absence of a super vaccine or a super drug, can the factors involved in resistance to tuberculosis be determined precisely and applied practically as a shortcut in the attempt to eradicate tuberculosis? For example, could those nutritional elements which enhance resistance be isolated and developed to the point where they could, perhaps, be administered widespread in concentrated form to prevent the development of infection or active disease?"

In the absence of such theoretical advances in the future, are we going to be able to maintain the progress already made, forge ahead, and complete the job so nobly begun, or are we to allow a resurgence of the tuberculosis problem by disinterest and neglect of these patients? Recently "Searchlight on TB," a statewide study by the Texas Tuberculosis Association, has gotten under way to bring to light the tuberculosis problem in every community in our state. County committees will be searching for information that only the physician can give. It is important that each of us does his part to help bring out the facts surrounding tuberculosis and its victims in our own communities. We now stand at the crossroads of opportunity. Are we ready and willing to do our part?

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In the period from the end of World War II to early 1950, an average of approximately 400,000 persons per year earned Red Cross First Aid Certificates. From early 1950 (when Civil Defense began operations) to mid-1952, an average of about 1,000,000 persons per year were earning such certificates. The number of instructors in First Aid tripled in that time.

Physicians per Persons

On the basis of an estimated United States population of 160,000,000 in 1953, there is one physician actually engaged in the practice of medicine for every 1,000 persons. There are 220,104 physicians in the United States today, 156,433 of whom are in active practice, the American Medical Association reports.

LIPID PNEUMONIA

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IN SPITE of the fact that it has been known for twenty-five years that mineral oil when aspirated may cause serious lesions in the lungs, it is still prescribed by physicians more or less indiscriminately and is perhaps the substance most commonly used by the layman in self medication.

As evidence that this man-made disease, as Cannon[1] calls it, is not unimportant, one might mention the reports of more than 500 cases in the literature. I have observed 107 cases in less than 2,000 autopsies performed on my service in a county hospital in the past fifteen years.

It is not the purpose of this paper to describe these cases but to review briefly the subject of oil aspiration pneumonia, to point out the potential danger in the use of oil, and to emphasize the necessity for keeping in mind the lesion in differential diagnosis in order to avoid errors which have all too often caused much harm to the patient.

The first description of the baleful effects of the aspiration of mineral oil was by Laughlen in 1925.[6] He found a peculiar exudate of macrophages filled with oil droplets in the lungs of infants who died of pneumonia and who, as part of their treatment, had had nose drops in which mineral oil was used as a base. He followed this observation by the experimental production of the lesion in rabbits by instilling the oil into their tracheas.

It was in the same year that I observed my first case,[15] that of a young man who entered the hospital suffering from cardiospasm. He was in a state of starvation from his inability to swallow anything except liquids and these in small quantity. His physician prescribed cream as a food with a high caloric value and in liquid form. The patient developed a mediastinitis following an esophagoscopy. Morphine was given for the relief of pain, and while asleep, the patient evidently aspirated a large amount of the cream from the much dilated esophagus, for at autopsy both lungs showed large areas of consolidation with the exudate of macrophages filled with oil droplets as in Laughlen's cases instead of the polymorphonuclear leukocytes usually seen in pneumonia.

DANGERS

It not infrequently happens that some keen observer publishes a description of a lesion of a type which has been in existence for a long time but has been overlooked. Such was the case in this disease, and when pathologists reviewed autopsy material, they found a considerable number of previously overlooked lesions.

There is now a voluminous literature on the subject, and many warnings[3, 7, 8, 10, 13] have been published on the dangers of promiscuous use of oil. The Council on Pharmacy and Chemistry of the American Medical Association voted to omit mineral oil nose drops from the list of new and nonofficial remedies.[11]

It appears that some good has been accomplished since the number of papers on the subject has decreased in the past few years. Physicians for the most part have ceased writing prescriptions for nose drops with an oil base, but I am told by a pharmacist friend that one of the most popular nose drops sold to laymen contains the oil.

The condition has a variety of names, the most common being lipid pneumonia, lipoid pneumonia, oil pneumonia, oil aspiration pneumonia, and pneumolipoidosis. Lipid pneumonia is accepted by *The Journal of the American Medical Association,* but I prefer the term oil aspiration pneumonia.

While emphasis is placed on mineral oil, the animal oils and fats must not be ignored. No less than 23 per cent of the cases described have been produced by cod liver oil and 5 per cent by butterfat (milk and cream). Only 4 per cent are due to the vegetable oils, these with a few exceptions being harmless.

The vast majority of the cases have occurred in infants of 1 to 3 years of age and in adults of 50 years or older, for it is in these age groups that oils are given most often. Nose drops with a mineral oil base and cod liver oil are given in cases of the infant, and mineral oil generally is used as a laxative in the adult.

It has been emphasized in the many publications that mineral oil is particularly dangerous when given to the debilitated patient and to the person with difficulty in swallowing. This undoubtedly is true, but recently a paper by Schneider[16] brought to attention a number of healthy adults who because of the absence of the gag reflex have inhaled the oil with serious lesions resulting. He reported 7 cases with severe lesions demonstrated by roentgen ray in otherwise healthy adults who had been in the habit of taking mineral oil as a laxative.

Schneider found in all of these patients the gag reflex either absent or greatly subdued. He believed

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that either many such cases were overlooked altogether or, when lesions were found by roentgen ray, the cause was not recognized and therefore erroneous diagnoses were made.

Mineral oil is a bland substance and can trickle down the trachea without producing the violent coughing reflex generally seen when a foreign substance gains entrance to the lower respiratory tract.

Following the publication of Schneider's case my interest waned, but it was renewed on my coming to the county hospital, where I found characteristic lesions in more than 5 per cent of the patients coming to autopsy.

Upon inquiry I learned that mineral oil was the drug of choice as a laxative and furthermore was told by the chief resident that a county hospital could not be run without mineral oil. He was shown to be wrong, for at the present time oil rarely is used and never in nose drops or as a laxative. We still encounter the disease at the county hospital, though less often, but the patients have had oil before coming to us.

TYPES OF LESION

Ikeda[4] has shown that there are two distinct types of lesions which he called the infantile and adult but which I prefer to call the acute and chronic. In the acute or infantile type there is only the exudative reaction in which the lesion is characterized by an exudate of monocytes or macrophages filled with oil droplets. In this stage the lesion is reversible; in other words, if the administration of the oil is stopped, the lungs will return to normal. In the adult or chronic type there is a foreign body or granulomatous reaction in which there is marked connective tissue proliferation causing the formation of a solid tumor-like mass, a paraffinoma to use Ikeda's[4] terminology. The mass shows up readily on examination of the chest by roentgen ray and so closely resembles a tumor that several instances have been reported in which lobectomies have been performed following a diagnosis of carcinoma.[5, 14, 17] There have been 2 such happenings in my own community within the past year, and I am sure there have been others which have not been nor will be reported.

That such things happen is sufficient reason, it seems to me, to have the lesion in mind in order to avoid such mistakes or, as Schneider[16] pointed out, if we are suspicious enough, we will recognize these lesions for what they are.

Symptoms of the lesion are variable, none characteristic; indeed they are protean and may simulate almost any lung disease. In infants symptoms are those usually seen in bronchopneumonia, perhaps with less fever. Where there is a history of protracted bronchopneumonia or repeated attacks in a child stunted in growth with failure to gain weight, oil pneumonia should be suspected.

In adults, in whom the chronic type occurs as a rule, the onset is insidious. One may find a persistent hacking cough, rapid respiration with some dyspnea, and perhaps occasional cyanosis. There is no fever unless the condition is complicated by infection, which sometimes occurs; indeed, formation of abscesses has been observed. There may be loss of weight or failure to gain weight. There may be congestive heart failure if the fibrosis is marked.

DIAGNOSIS

The diagnosis is not easy and may be extremely difficult. The roentgen ray is of the greatest help; the roentgenographic shadow, however, as in the case of the symptoms, is not characteristic and may be mistaken for a variety of conditions, including cancer, as has been mentioned.

With the ever increasing search for tuberculosis by means of the roentgen ray, more and more of these shadows are being found, and it is imperative that we use every means at our disposal to differentiate the paraffinoma from cancer.

Generally, the shadow is bilateral and most often in the lower lobes, in which case there is less likelihood of its being mistaken for a malignancy. Where it is unilateral and there is a history of the mineral oil habit, the physician should examine the sputum for oil and/or resort to aspiration of the consolidated area.

Examination of the sputum may be of much value, but it must be done with care. Losner[9] and his coworkers recommended that the patient be placed on a fat free diet from four days to a week and that twenty-four hour specimens of the sputum be collected for three to five days. To examine the sputum they place a drop of it on a slide, dry it in the incubator, and stain it with Sudan IV. In some instances the oil is found in such quantities that it may be recognized as a top layer in the twenty-four hour specimen.

Aspiration of the lung by needle is more serious but is recommended by some[2, 12] who claim that it is not a difficult procedure. I have had no experience with the method, but I think it should be tried before an exploratory thoracotomy is done.

There is no satisfactory treatment for the lung lesion. In some cases in which the fibrosis is not too extensive, the process is reversible to some extent if the use of oil is discontinued. There are few cases in which lobectomy is justified. The treatment is chiefly prophylactic.

Rather than discard mineral oil altogether as a

drug (which is not a bad idea), the following rules which have been taken from various sources can be followed with benefit: (1) do not use nose drops having an oil base, (2) do not give oils to patients with dysphagia, (3) do not give oils to anyone just before he retires, (4) use oils with caution on all bedridden patients, (5) use oils with caution on patients with subdued reflexes, (6) use oils with caution on all debilitated persons, and (7) use oils with caution in infants.

SUMMARY

Oil aspiration pneumonia is an insidious disease and seldom diagnosed clinically.

Every care must be used in the patient in whom a unilateral shadow in the lung is shown by roentgen ray so as not to mistake the lesion for a carcinoma and advise lobectomy. On the other hand the physician must be careful not to bypass a carcinoma by making the diagnosis of oil aspiration pneumonia and deprive the patient of his chance of survival.

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15. Thomas, W. S., and Jewett, C. H.: Pneumonia Following Aspiration of Fats from Esophagus Dilated as Result of Cardiospasm, Clifton M. Bull. *12:*130-138 (Dec.) 1926.

16. Schneider, L.: Pulmonary Hazard of Ingestion of Mineral Oil in Apparently Healthy Adult, New England J. Med. *240:*284-291 (Feb. 24) 1949.

17. Stokes, A. M.: Lipid Pneumonia, Am. Rev. Tuberc. *47:*348-350 (March) 1943.

435 East Henrietta Road.

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, Fort Worth, April 25-27, 1955. Dr. F. J. L. Blasingame, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, San Francisco, June 21-25, 1954. Dr. Edward J. McCormick, Toledo, Ohio, Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice, Los Angeles, March 28-31, 1955. Dr. W. B. Hildebrand, Menasha, Wis., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. Bayard Carter, Durham, N. C., Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery. Dr. Emile F. Holman, San Francisco, Pres.; Dr. Paul C. Samson, 2938 McClure St., Oakland 9, Calif., Secy.

American Association of Genito-Urinary Surgeons. Dr. Vincent J. O'Conor, Chicago, Pres.; Dr. John A. Taylor, 2 E. 45th St., New York 22, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 9-11, 1954. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Chicago, April 25-30, 1955. Dr. Homer Prince, Houston, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, Philadelphia, April 25-29, 1955. Dr. C. C. Sturgis, Ann Arbor, Mich., Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Philadelphia, April 25-29, 1955. Dr. C. C. Sturgis, Ann Arbor, Mich., Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 4, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-18, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress on Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chairman.

American Congress of Physical Medicine and Rehabilitation, Washington, D. C., Sept. 6-11, 1954. Dr. William B. Snow, New York, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Belleair, Fla., April 17-21, 1955. Dr. Richard S. Weiss, St. Louis, Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, San Francisco, June 18-19, 1954. Dr. J. M. Ruffin, Durham, N. C., Pres.; Dr. H. Marvin Pollard, 1313 E. Ann St., Ann Arbor, Mich., Secy.

American Gynecological Society. Dr. Richard W. TeLinde, Baltimore, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association. Dr. E. Cowles Andrus, Baltimore, Pres.; Dr. William H. Bunn, 44 E. 23d St., New York 10, Secy.

American Hospital Association, Chicago, Sept. 13-16, 1954. Mr. Ritz E. Heerman, Los Angeles, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society. Dr. LeRoy A. Schall, Boston, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Atlantic City, N. J., June 14-16, 1954. Dr. Roland P. Mackay, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, Glacier Park, Mont., June 16-18, 1954. Dr. William L. Benedict, Rochester, Minn., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, Bretton Woods, N. H., June 6-9, 1954. Dr. A. R. Shands, Jr., Wilmington, Del., Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society. Dr. Rustin McIntosh, New York, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, Los Angeles, June 2-5, 1954. Dr. Wendell Green, Toledo, Ohio, Pres.; Dr. Stuart T. Ross, 131 Fulton Ave., Hempstead, N. Y., Secy.

American Psychiatric Association. Dr. Kenneth E. Appel, Philadelphia, Pres.; Dr. R. Finley Gayle, 6300 Three Chopt Rd., Richmond 21, Va., Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Cincinnati, Oct. 25-30, 1954. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Washington, D. C., Sept. 6, 1954. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Cleveland. Dr. Howard C. Naffziger, San Francisco, Pres.; Dr. R Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, New York, May 31-June 3, 1954. Dr. J. A. Campbell Colston, Baltimore, Md., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Delegates Interim Meeting, Chicago, Oct. 1-2, 1954. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1954. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association. Mr. Mark H. Harrington, Denver, Pres.; Mr. Kemp D. Battle, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nasbville, Pres.; Dr. George G. Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, Oct. 21, 1954. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Oklahoma City, Sept. 27-29, 1954. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secy.

Tri-State Medical Assembly, Fall, 1954. Dr. Joe D. Nichols, Atlanta, Pres.; Dr. Broox C. Garrett, 940 Margaret Pl., Shreveport, La., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice, Galveston, Sept. 9-11, 1954. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris. 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 11-12, 1954. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association. Dr. J. S. Minnett, Dallas, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians. Dr. Howard E. Smith, Austin, Pres.; Dr. John Wiggins, 1707 Medical Arts Bldg., Fort Worth, Secy.

Texas Club of Internists. Victor E. Schulze, San Angelo, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, Fort Worth, April 24-25, 1955. Dr. Paul H. Power, Pres.; Dr. Thomas L. Sbields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, Fort Worth, April, 1955. Dr. George M. Jones, Dallas, Pres.; Dr. Hugo Engelhardt, P. O. Box 2180, Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas, Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Geriatric Society, Fall, 1954. Dr. Henry H. Niehuss, Longview, Pres.; Dr. Frank V. Mondrik, 214 Bramlette Bldg., Longview, Secy.

Texas Heart Association. Dr. George R. Herrmann, Galveston, Pres.; Mr. Edgar M. Brown, 412 Fidelity Union Life Bldg., 1511 Bryan St., Dallas, Executive Director.

Texas Hospital Association. Mr. W. U Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, Galveston, Fall, 1955. Dr. Edgar S. Ezell, Fort Worth, Pres.; Dr. Bruce H. Beard, 1519 Pennsylvania, Fort Worth, Secy.

Texas Orthopedic Association. Dr. Brandon Carrell, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, Oct. 22-23, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society. Dr. Jack Kerr, Dallas, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 13-16, 1955. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Houston. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, Fort Worth, April, 1955. Dr. Raleigb White, Temple, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred W. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Mineral Wells, 1955. Dr. Charles N. Burrows, San Antonio, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 3, Executive Secy.

Texas Society of Anesthesiologists. Dr. Frank O. Barrett, El Paso, Pres.; Dr. Milton R. Rosensweig, 200 Wildwood Drive East, San Antonio, Secy.

Texas Society of Gastroenterologists and Proctologists. Dr. Charles Hardwicke, Austin, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, Dallas, Jan. 30, 1955. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Galveston, April 15-16, 1955. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Corpus Christi, 1954. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg., Corpus Christi, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society. Dr. John R. Mast, Midland, Pres.; Dr. M. J. Loring, 304 North N St., Temple, Secy.

Third District Society, Borger, April, 1955. Dr. M. C. Overton, Jr., Pampa, Pres.; Dr. William Klingensmith, 215 Fisk Bldg., Amarillo, Secy.

Fourth District Society, San Angelo, Oct. 14, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 8-18, 1954. Dr. Y. C. Smith, Sr., Corpus Christi, Pres.; Dr. E. Jackson Giles, 705 Medical-Professional Bldg., Corpus Christi, Secy.

Seventh District Society, Austin, June 18, 1954. Dr. Benjamin Clary Bates, Austin, Pres.; Dr. William McLean, 4618 Burnet Road, Austin, Secy.

Eighth District Society, Victoria, September, 1954. Dr. Howard Z. Fretz, Wharton, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society. Dr. Thomas H. Giddings, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. John M. White, Port Arthur, Pres.; Dr. Rider Stockdale, Jasper, Secy.

Eleventh District Society, Jacksonville, Fall, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society, Corsicana, July 13, 1954. Dr. Neil Buie, Marlin, Pres.; Dr. Paul H. Mitchell, Corsicana, Secy.
Thirteenth District Society. Dr. Mal Rumph, Fort Worth, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.
Fourteenth District Society, Denton, June 1, 1954. Dr. J. W. Atchison, Gainesville, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.
Fifteenth District Society, Mount Pleasant, 1955. Dr. R. L. Johnson, Mount Pleasant, Pres.; Dr. R. L. Hardman, Mount Pleasant, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas. Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.
Central Texas Spring Clinic, Waco. Dr. Walter B. King, 2320 Columbus Ave., Waco, Secy.
International Medical Assembly of Southwest Texas, San Antonio, Feb. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.
New Orleans Graduate Medical Assembly, New Orleans, March 7-10, 1955. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.
North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Sept. 22, 1954. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.
Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.
Postgraduate Medical Assembly of South Texas, Houston, July 19-21, 1954. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.
State Tumor Conference, Wichita Falls, April, 1955. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.
Texas State Board of Medical Examiners, Fort Worth, June 21-23, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Sec'y.

TEXAS AIR-MEDICS ASSOCIATION

Dr. John S. Minnett, Dallas, assumed the presidency of the Texas Air-Medics Association at the group's meeting May 2-3 in San Antonio. Other officers are Dr. W. A. Ostendorf, Fort Worth, president-elect; Dr. C. F. Miller, Waco, secretary-treasurer; and Dr. W. D. Marrs, Fort Worth, new director.

The program was presented as announced in the March *Journal*. Approximately twenty-five members attended. Dr. T. H. Sutherland, Marion, Ohio, secretary of the Aero Medical Association, reported on the activities of that organization.

The meeting concluded with guided tours of the Bacteriology, Pharmacology, and Physiology Departments of the School of Aviation Medicine, Randolph Field. In each department a lecture regarding problems of aviation medicine was given.

TEXAS SOCIETY OF PATHOLOGISTS

A new scholarship at the University of Texas Law Science Institute was created by the Texas Society of Pathologists at its May 3 meeting in San Antonio. To begin in September, 1954, the project is limited strictly to investigation of the present coroner-justice of the peace system, with plans and procedures to be proposed for establishment of a modern medical examiner system.

A unanimous directive to the officers called for proceeding with incorporation by seeking a charter from the Secretary of State of Texas at an early date.

The members individually contributed nearly $1,000 to assist in the expenses of the approaching third International Congress of Clinical Pathology to be held in Washington, D. C., September 6-10.

Dr. Harold D. Palmer, Denver, guest of the Texas Medical Association and pathologist, addressed the society on both scientific and general subjects. The program was presented as outlined in the March *Journal*, and fifty-two physicians attended. The group will meet at the Southwestern Medical School of the University of Texas, Dallas, on January 30, at which time new officers will be elected.

Texas Chapter, American College of Chest Physicians

Dr. William A. Hudson, Detroit, president-elect of the American College of Chest Physicians, delivered the first Charles M. Hendricks Memorial Address at the May 2 meeting in San Antonio of the Texas Chapter of the national group. The remainder of the program, including a luncheon address by Dr. Alvis E. Greer, Houston, national president, was presented as printed in the March *Journal*.

Dr. Howard E. Smith, Austin, was elected president; Dr. Samuel Topperman, Tyler, first vice-president; Dr. Walter C. Brown, Corpus Christi, second vice-president; and Dr. John Wiggins, Fort Worth, secretary-treasurer.

The group adopted resolutions to the memory of Dr. Charles M. Hendricks of El Paso and Dr. R. G. McCorkle of San Antonio, both of whom died within the past year.

Dr. Henry R. Hoskins, San Antonio, president for 1953-1954, presented a certificate from the Texas Chapter to Dr. Hudson in commemoration of the first Charles M. Hendricks Memorial Address.

Approximately fifty members registered for the meeting, and a number of guests were present.

Texas Neuropsychiatric Association

Dr. Edgar S. Ezell, Fort Worth, was elected president of the Texas Neuropsychiatric Association at the group's May 2 meeting in San Antonio, and other officers were elected as follows: Dr. Howard Burkett, Dallas, first vice-president; Dr. William B. Cline, Jr., Corpus Christi, second vice-president; and Dr. Bruce H. Beard, Fort Worth, secretary-treasurer.

As a part of the scientific program, which was presented as outlined in the March *Journal*, Dr. Tracy J. Putnam, Beverly Hills, Calif., delivered two talks.

Business transacted at the meeting included the appointment of a committee, headed by Dr. Ezell, to draw up a resolution directed to Dr. James Bethea and Governor Allan Shivers stating that the association favors an increase in the budget to allow for a minimum expenditure of $3 per day per patient in the state mental hospitals; the appointment of Dr. Hamilton Ford of Galveston, Dr. Stephen Weisz of Dallas, and Dr. David Wade of Austin to organize teams for in-service training in state hospitals; a discussion of the mental health fund-raising drive; and the decision to invite the Mexican Neuropsychiatric Association to meet with the Texas group in Galveston in the fall, with Dr. M. L. Towler of Galveston to be in charge of negotiations and arrangements.

Conference of City and County Health Officers

Forty-five local health officers attended the annual Conference of City and County Health Officers May 3 in San Antonio. Dr. Gordon W. Grace, Los Angeles, and others named in the March *Journal* presented the program.

Dr. Henry A. Holle, new State Health Officer for Texas, was introduced by Dr. George W. Cox and commented on the past and future public health programs in Texas. Dr. Holle is the new chairman of the conference.

Texas Railway and Traumatic Surgeons

Sixty members of the Texas Railway and Traumatic Surgical Association attended the group's meeting May 3 in San Antonio and took part in the scientific program printed in the March *Journal*. Dr. Raleigh R. White, Temple, was elected president; Dr. Albert O. Singleton, Jr., Galveston, first vice-president; Dr. J. H. Dorman, Dallas, second vice-president; and Dr. W. D. Marrs, Fort Worth, secretary-treasurer.

TEXAS DIABETES ASSOCIATION

In conjunction with the annual session of the Texas Medical Association, the Texas Diabetes Association met May 2 in San Antonio and heard the scientific program outlined in the March *Journal*. More than 100 members and guests attended.

New officers elected are Dr. George M. Jones, Dallas, president; Dr. Lawrence B. Reppert, San Antonio, first vice-president; Dr. W. S. Barcus, Fort Worth, second vice-president; Dr. Hugo Engelhardt, Houston, secretary-treasurer; and Dr. David W. Carter, Jr., of Dallas, Dr. Merton M. Minter of San Antonio, and Dr. Ivan G. Mayfield of Lubbock, councilors.

TEXAS SOCIETY OF ANESTHESIOLOGISTS

Approximately eighty members of the Texas Society of Anesthesiologists attended the group's May 2 meeting in San Antonio. The new slate of officers includes Dr. Frank O. Barrett, El Paso, president; Dr. Joe B. Wood, Dallas, president-elect; Dr. Charles R. Allen, Galveston, vice-president; and Dr. Milton Rosenzweig, San Antonio, secretary-treasurer.

Dr. James Robinett, Houston, and Dr. Rosenzweig, were elected delegates to the American Society of Anesthesiologists; Dr. Eugene Slataper, Houston, and Dr. M. D. Thomas, El Paso, were elected alternates.

The program printed in the March *Journal* was presented. Dr. Digby Leigh, Vancouver, B. C., Canada, was a special guest.

TEXAS ORTHOPEDIC ASSOCIATION

The Texas Orthopedic Association met in San Antonio May 3 and elected Dr. Brandon Carrell, Dallas, president; Dr. Duncan C. McKeever, Houston, vice-president; and Dr. Margaret Watkins, Dallas, secretary-treasurer.

The program was presented as outlined in the March *Journal*. Special guest was Dr. William T. Green, Boston. Approximately forty members attended.

New members of the group follow: Lt. Col. Herbert E. Block, Lackland Air Force Base, San Antonio; Col. R. S. Brau, Lackland Air Force Base, San Antonio; Dr. G. V. Carroll, Houston; Dr. Richard DeYoung, Houston; Dr. Richard Leong, Houston; Dr. Alfred E. Luckett, El Paso; Dr. William T. Payne, Dallas; Dr. Thomas Shindler, Houston; and Dr. Richard L. Shorkey, Beaumont.

UNIVERSITY OF TEXAS ALUMNI ASSOCIATION

Alumni of the University of Texas Medical Branch held a dinner meeting May 3 in San Antonio, with Dr. Kleberg Eckhardt, Corpus Christi, vice-president, presiding in the absence of Dr. Tom M. Oliver, Waco, president.

Dr. Howard O. Smith, Marlin, became president for 1954-1955, and other officers were elected as follows: Dr. Eckhardt, president-elect, Dr. L. Bonham Jones, San Antonio, vice-president; and Miss Mildred M. Robertson, Galveston, secretary-treasurer.

Guest speaker of the evening was Dr. Titus H. Harris, professor of neuropsychiatry. Colored slides of the new buildings and of other campus views were shown.

Dr. G. G. Passmore, San Antonio, was in charge of arrangements.

Texas Dermatological Society

Dr. Paul H. Power, Waco, was elected president; Dr. William F. Spiller, Galveston, vice-president; and Dr. Thomas L. Shields, Fort Worth, secretary, when the Texas Dermatological Society met May 3 in San Antonio. The program printed in the March *Journal* was presented. Eighty-five members and guests attended.

Texas Geriatrics Society

The organizational meeting of the Texas Geriatrics Society was held in San Antonio May 3, with Dr. Henry H. Niehuss of Longview serving as temporary president.

The sixteen doctors present heard Dr. Niehuss discuss what had been done to date regarding the organization of the society, Dr. F. J. L. Blasingame of Wharton express a favorable opinion of beginning such an organization in Teaxs, and Dr. Charles R. Gowen of Shreveport state that he intended to see that a geriatrics society was organized in his state.

Those who joined the society before July 10, Dr. Niehuss explained, would be charter members. He expected the membership to reach a hundred.

Officers were elected as follows: Dr. Niehuss, president; Dr. Gowen, vice-president; and Dr. Frank V. Mondrik, Longview, secretary-treasurer.

The group voted for the present to meet twice a year, once in conjunction with the Texas Medical Association's annual meeting and the other time in the fall, the date and place to be determined later. Other business carried out at the meeting included the appointment of Dr. Hugh P. Revely of San Antonio as chairman of the membership committee.

FIFTY YEAR CLUB

Twenty-five members of the Fifty Year Club attended the group's May 4 breakfast meeting in San Antonio. Dr. George Turner, El Paso, President of the Texas Medical Association; Dr. R. G. Baker, Fort Worth, chairman of the Board of Councilors; and Dr. William Crawford, Fort Worth, were guests.

With Dr. L. H. Reeves, Fort Worth, secretary, presiding in the absence of Dr. W. M. Brumby, Houston, founder and president, new officers were elected. Dr. Brumby became life president, and Dr. Felix Miller of El Paso was elected vice president and Dr. Reeves, secretary.

The presentation of slides picturing some deceased physicians of Texas concluded the program.

PAST PRESIDENTS' ASSOCIATION

The Past Presidents' Association held a luncheon meeting on May 3 in San Antonio with eleven members and two honorary members present.

Guests included Dr. J. M. Travis, Jacksonville, secretary of the Texas Medical Association; Dr. R. G. Baker, Fort Worth, chairman of the Board of Councilors; Dr. F. J. L. Blasingame, Wharton, incoming President; Dr. George Turner, El Paso, outgoing President; Dr. and Mrs. H. O. Deaton, Fort Worth, who presented a musical program; Mr. Philip Overton, Austin general counsel of the association; and Mr. N. C. Forrester, Austin, executive secretary.

Dr. Felix Miller, El Paso, was elected president, and Dr. T. C. Terrell, Fort Worth, was elected vice-president. Dr. L. H. Reeves, Fort Worth, is permanent secretary of the Association.

University of Arkansas Alumni

The dean of the University of Arkansas School of Medicine, Dr. Hayden C. Nicholson, Little Rock, was principal speaker at the organizational meeting of the Texas alumni of the school May 3 in San Antonio. Twenty-four persons attended the cocktail party and dinner.

Officers were elected as follows: Dr. William M. Center, San Antonio, president; Dr. Mark L. Welch, Dallas, vice-president; and Dr. Grace A. Beasley, Fort Worth, secretary-treasurer.

PAST PRESIDENTS' ASSOCIATION

THIS page is dedicated to the physicians who as past presidents of the Texas Medical Association or as practitioners for fifty years or more have done so much to make Texas medicine what it is today. It is also dedicated to their friends, Dr. Holman Taylor and Dr. R. B. Anderson, Jr., who, as secretary-editor from 1910 to 1947 and assistant secretary-editor from 1927 to 1947, respectively, helped the Association to serve its members effectively.

TAYLOR-ANDERSON TREE

The Past Presidents' Association with guests at its May 3 meeting in San Antonio is pictured above.

The Spanish oak planted at the entrance to the Texas Medical Association building in Austin by Dr. L. H. Reeves of Fort Worth in memory of Dr. Taylor and Dr. Anderson is in the center.

The Fifty Year Club with guests convening May 4 in San Antonio appears below.

FIFTY YEAR CLUB

Texas Heart Association

Membership in the Texas Heart Association has more than doubled in the past year and now numbers 563. Approximately 175 attended the group's meeting May 3 in San Antonio and were presented with the scientific program as printed in the March issue of the *Journal.* Special guest speaker was Dr. Myron Prinzmetal, Los Angeles, who appeared on the program twice.

The new slate of officers follows: Dr. George R. Herrmann, Galveston, president; Dr. Kleberg Eckhardt, Corpus Christi, president-elect; Dr. George E. Clark, Jr., Austin, vice-president; Douglas B. Marshall, Houston, chairman of the board; and R. L. Thomas, Dallas, secretary-treasurer.

State headquarters of the association will move to the Jesse H. Jones Library Building, 1133 M. D. Anderson Boulevard, Houston, as soon as the building is completed, probably by July 1.

At the awards dinner May 2, certificates were presented to the past presidents and others who had given outstanding service during the nineteen years of the association's existence. The following past presidents were awardees: Dr. C. M. Grigsby (deceased); Dr. Edward H. Schwab, Galveston; Dr. David W. Carter, Jr., Dallas; Dr. Joe Kopecky, San Antonio; Dr. H. K. Beall (deceased); Dr. Charles T. Stone, Sr., Galveston; Dr. Marvin L. Graves (deceased); Dr. Victor E. Schulze, San Angelo; Dr. Robert M. Barton, Dallas; Dr. DeWitt Neighbors, Fort Worth; Dr. Walter B. Whiting, Wichita Falls; Dr. Merritt B. Whitten, Dallas; Dr. George W. Parson, Texarkana; Dr. Paul V. Ledbetter, Houston; Dr. J. C. Crager, Beaumont; and Dr. Joseph F. McVeigh, Fort Worth.

Other awardees were Douglas B. Marshall, Houston; S. E. McCreless, San Antonio; Ben H. Wooten, Dallas; R. L. Thomas, Dallas, DeWitt T. Ray, Dallas; W. R. White, Th.D., Waco; C. F. Carter, Houston; John Ben Sheppard, Austin; and Governor Allan Shivers, Austin.

Receipts of $385,527 in the 1954 Heart Fund campaign were reported at the time of the meeting.

POSTGRADUATE MEDICAL ASSEMBLY OF SOUTH TEXAS

The twentieth annual meeting of the Postgraduate Medical Assembly of South Texas will be at the Shamrock Hotel, Houston, July 19-21. Included in the three-day meeting will be scientific programs, luncheons, scientific and technical exhibits, and special entertainment for the ladies.

Out-of-state speakers include Drs. Edgar Burns, New Orleans; Frederick B. Campbell, Kansas City; Ramon Castroviejo, John J. Conley, Franklin M. Hanger, and Gordon McNeer, New York City; Matthew S. Ersner and John C. Ullery, Philadelphia; L. E. Harris, Rochester; William K. Keller, Louisville; Clarence S. Livingood, Detroit; A. E. Maumenee, San Francisco; Lester M. Morrison and Myron Prinzmetal, Los Angeles; Duncan E. Reid, Boston; Danely P. Slaughter, Chicago; Donald H. Stubbs, Alexandria, Va.; and I. Snapper, Brooklyn.

Physicians who are members of their county medical societies are invited to participate in the meeting.

College of Surgeons in District Meeting

The American College of Surgeons, fifth district chapter of Texas, will hold a scientific session in the auditorium of the new Houston Academy of Medicine Library Building on July 17. This meeting will be prior to the Postgraduate Medical Assembly of South Texas, which meets July 19-21.

PERSONALS

Dr. Charles T. Stone, Sr., Galveston, spoke on "Cardiac and Renal Reserve in the Aged as Related to Operability" at the eleventh annual meeting of the American Geriatrics Society, San Francisco, June 17-19.

Dr. Michael E. DeBakey, Baylor University College of Medicine, Houston, was one of two surgeons to receive the Rudolph Matas Award in Vascular Surgery.

Dr. Arthur Grollman, Dallas, was a guest speaker at the seventy-third annual meeting of the South Dakota State Medical Association in Huron, May 16-18.

Dr. G. W. N. Eggers, Galveston, is spending six to eight weeks in the Far East as a consultant in orthopedic surgery at the invitation of the surgeon general of the Army.

Dr. T. H. Thomason, Fort Worth, and *Dr. H. O. Deaton,* Fort Worth, were appointed honorary Texas generals by State Senator Gus Strauss, Hallettsville, who was Acting Governor on April 4. *Dr. F. J. L. Blasingame,* Wharton, was appointed an honorary Texas admiral by the Senator.

Dr. and Mrs. William Smith and their four children have been chosen one of the two Texas Presbyterian "Families of the Year." A write-up about the Smiths appears in the May 1 *Texas Presbyterian.*

Dr. W. G. Maddox, Denton, spoke recently to the School Health Services section meeting of the District Five State Teachers Association convention at Texas State College for Women.

Dr. John S. Bagwell, Dallas, has been named to fill a vacancy on the Highland Park Board of Education.

Dr. Joe D. Nichols, Atlanta, was the main speaker at a dinner in honor of the Mississippi legislature in Jackson.

Dr. Frank J. Altick, Dallas, was recently named to the board of directors of Mid-Texas Trust and Insurance Securities Corporation, Dallas.

According to the *Alumni Bulletin* of the University of Texas Medical Branch, parents of new girls are *Dr. and Mrs. Paul de Mesquita,* Galveston, whose daughter was born in February; *Dr. and Mrs. George V. Miller,* Houston, April 4; *Dr. and Mrs. Rider Stockdale,* Jasper, March 12; and *Dr. and Mrs. D. M. Carnes,* Ysleta, November 23, 1953.

The Tarrant County Medical Auxiliary *Stethoscope* announces the birth of girls to the following Fort Worth couples; *Dr. and Mrs. John Jernigan,* April; *Dr. and Mrs. Melvin Johnson,* April 12; and *Dr. and Mrs. Robert Holmgren,* April 7.

UNIVERSITY OF TENNESSEE ALUMNI

Dr. L. H. Reeves, Fort Worth, will again serve as president of the Texas alumni of the University of Tennessee. He first held the office in 1914 and was elected this year at the May 3 meeting in San Antonio. Dr. Robert D. Moreton, Fort Worth, was elected vice-president and Dr. S. W. Thorn, Houston, secretary.

Dr. J. B. Cummins, 95 year old Fort Worth practicing physician, was among the twenty-eight members present, as were Dr. J. E. Robinson of Temple and Dr. H. A. White of Corpus Christi.

Many wives also attended the banquet-meeting.

Rocky Mountain Cancer Conference

The eighth annual Rocky Mountain Cancer Conference will be in Denver, July 14 and 15, with eight guest speakers bringing the scientific programs. This meeting is sponsored jointly by the Colorado Division of the American Cancer Society and the Colorado State Medical Society. A program and additional information can be obtained from Rocky Mountain Cancer Conference, 835 Republic Building, Denver 2.

CORRECTION: ASTEROL ENCEPHALOPATHY

Some of the laboratory data in the case report appearing with the article entitled "Asterol Encephalopathy" by Drs. Morris William Rosenthal and Robert J. Goodall on page 303 of the May, 1954, JOURNAL were incorrectly stated.

The first portion of the third paragraph of the case report should read: "Laboratory work revealed a normal hemogram and normal urinalysis. Analysis of fluid from a lumbar puncture was reported as yielding 4 cells, 3 lymphocytes and 1 polymorphonuclear leukocyte; 65 mg. of sugar per 100 cc.; 186 milliequivalents of chloride per liter; and 125 mg. of total protein. On June 27 the serum calcium level was reported as 5.75 milliequivalents per liter."

The last paragraph of the case report should begin: "A repeat lumbar puncture on July 1 was reported as revealing 1 cell (lymphocyte); sugar 59 mg. per 100 cc.; chloride 120 milliequivalents per liter; protein 40 mg. per 100 cc."

Baylor Medical Alumni

The Baylor Medical Alumni Association met in San Antonio on May 3 with Dr. Frank Kidd presiding at the meeting of 165 members and wives. Officers elected were Dr. C. C. Shotts, San Antonio, president-elect; Dr. Russell Deter, El Paso, first vice-president; Dr. J. C. Holsomback, Baytown, second vice-president; Dr. J. C. Haley, Houston, secretary-treasurer; and Dr. H. H. Harris, Houston, faculty representative. Dr. C. M. Bielstein, Oklahoma City; Dr. L. E. Shirley, Jennings, La.; and Dr. Steve Marshall, Roswell, N. Mex., were elected representatives at large. Dr. R. H. Harrison, Bryan, is now president of the group.

Gastroenterologists and Proctologists

The Texas Society of Gastroenterologists and Proctologists met in San Antonio and elected Dr. Charles Hardwicke, Austin, president. Other officers elected were Dr. Edward J. Lefeber, Galveston, first vice-president; Dr. Robert J. Rowe, Dallas, second vice-president; and Dr. William T. Arnold, Houston, secretary-treasurer.

The program was held as outlined in the March Journal, with 175 physicians attending.

Life Insurance Medical Directors

The Society of Life Insurance Medical Directors of Texas met in San Antonio and had 15 members present at the meeting in which Dr. Ghent Graves, medical director of the American General Life Insurance Company of Houston, was elected president.

The fall meeting will be in Dallas during November.

Tulane University Alumni

The Cos House in San Antonio was the scene on May 3 of the alumni party of Tulane University. Miss Beatrice Fields discussed and presented slides of the new buildings on the Tulane campus. Approximately fifty alumni and guests attended the cocktail hour and dinner. Dr. A. Fletcher Clark, Sr., San Antonio, was elected president.

LIBRARY SECTION

RECENT PUBLICATIONS BY TEXAS PHYSICIANS

Following is a list of recent articles published by Texas physicians and available at the Memorial Library of the Texas Medical Association. Articles appearing in the TEXAS STATE JOURNAL OF MEDICINE are not included. If a physician who has had a paper printed in the past six months is not named below, the Library would appreciate being notified. Also, the Library would like to have two reprints of each article.

Axelrod, Harold: Nipple Discharge, Am. J. Surg. *87:*247-250 (Feb.) 1954.

Bernard, Jack A.: Hypothyroidism; Often Forgotten, Southwestern Med. *35:*113-115 (March) 1954.

Block, J. Harvey: Do You Need to Know About Allergy, Illinois M. J. *105:*5-10 (Jan.) 1954.

Bowen, Ralph: Achilles Heel in Allergy, South. M. J. *47:*163-169 (Feb.) 1954.

Bozzell, James D., and Powell, N. B.: Splenectomy Associated with Surgery of Left Kidney, J. Urol. *71:*183-191 (Feb.) 1954.

Butler, D. B.: Rectal Cancer; Questions and Answers, Am. J. Proctology *5:*47-51 (March) 1954.

Carter, Norman W.: Mechanisms of Formation of Ammonia in Urine, Dallas M. J. *40:*5-7 (Jan.) 1954.

Carter, Rexford G.: Ureterovaginal Fistula, J. Urol. *71:*200-207 (Feb.) 1954.

Chapman, John S.: Application of Physical Therapeutic Principles to Pulmonary Disease, South. M. J. *47:*249-253 (March) 1954.

Clark, Helen; Graham, P.; and Muirhead, E. E.: Effects of Diets on Anemia, Azotemia and Survival of Bilaterally Nephrectomized Rabbits, J. Lab. & Clin. Med. *43:*113-118 (Jan.) 1954.

DeBakey, Michael E.: Critical Evaluation of Problem of Thromboembolism, Surg. Gynec. & Obst. *98:*1-27 (Jan.) 1954.

DeBakey, Michael E.; Cooley, Denton A.; and Creech, Oscar, Jr.: Surgical Treatment of Aneurysms and Occlusive Diseases of Aorta, Post-Grad. M. J. *15:*120-127 (Feb.) 1954.

Dernehl, C. U.: Recent Challenges in Industrial Medical Practice, South. M. J. *47:*170-174 (Feb.) 1954.

Doss, A. Keller: Management of Ureteral Calculi, J. Louisiana M. Soc. *106:*47-51 (Feb.) 1954.

Earle, K. M.: Primary Carcinoma of Lung in Male Veteran, Arch. Path. *57:*106-114 (Feb.) 1954.

Foraker, Alvan G.; Denham, Sam Wesley; and Johnston, M. Harlan: Histochemical Changes in Irradiated Ovaries, Arch. Path. *57:*30-35 (Jan.) 1954.

Golding, F. C.: Case Report, Illustrating Effect of Oxygen Inhalation Upon Electrocardiogram, Southwestern Med. *35:*29-31 (Jan.) 1954.

Goode, John V.: Dangerous Silent Gallstones, South. M. J. *47:*137-141 (Feb.) 1954.

Haines, Richard D.: Practical Application of Liver Function Tests in Management of Jaundiced Patients, J. Oklahoma M. A. *47:*3-8 (Jan.) 1954.

Haines, Richard D., and Powell, W. N.: Multiple Myeloma; Report of 51 Cases; Some Observations with Urethane Therapy, J. Louisiana M. Soc. *106:*1-7 (Jan.) 1954.

Harris, J. B.; Hoff, H. E.; and Wise, R. A.: Diaphragmatic Flutter as Manifestation of Hysteria, Psychosom. Med. *16:*56-66 (Jan.) 1954.

Hay, Elliott B., and Cronin, Thomas D.: Factors Influencing Morbidity and Mortality in Burns, Am. J. Surg. *87:*84-87 (Jan.) 1954.

Hooks, Charles A.: Consideration of Bilateral Cryptorchism, J. Louisiana M. Soc. *106:*51-54 (Feb.) 1954.

Howard, Ben K., and Goodson, James H.: Experimental Placental Abruption, Obst. & Gynec. *2:*442-453 (Nov.) 1953.

Hsu, T. C.; Hooks, C. A.; and Pomerat, C. M.: Opportunities for Determining Sex in Human Tissue, Texas Rep. Biol. & Med. *11:*585-587 (Winter) 1954.

Jawarski, H. L.: Waco Tornado Disaster, Am J. Surg. *87:*484-486 (March) 1954.

Karnaky, Karl John: Pruritus Vulvae, Am. J. Surg. *87:* 188-194 (Feb.) 1954.

Kent, Bartis; Knight, Ralph; Morris, George; Dezon, Miguel; and Mayer, John H.: Clinical Observations on Use of Chlorpromazine (SKF-2601A) as Antiemetic Agent, Med. Rec. & Ann. *48:*758-761 (Jan.) 1954.

Lorimer, W. S.: Giant Gastric Leiomyoma, Am. J. Surg. *87:*278-285 (Feb.) 1954.

Luckett, A. E.: Operative Management of Torn Medial Meniscus, Southwestern Med. *35:*27-29 (Jan.) 1954.

Marcuse, Peter M.: Pulmonary Syncytial Giant Cell Embolism, Obst. & Gynec. *3:*210-213 (Feb.) 1954.

Martin, Charles L.: Treatment of Cancer of Tongue and Its Cervical Metastases with Irradiation, South. M. J. *47:* 1-9 (Jan.) 1954.

Meltzer, Leonard, and Torfel, Bernard: Unilateral Hairy Tongue, Arch. Dermat. & Syph. *69:*497-498 (April) 1954.

Muirhead, E. E.: Experimental Hypertension Following Bilateral Nephrectomy, South. M. J. *47:*110-116 (Feb.) 1954.

Mullins, J. Fred: Trichophyton Tonsurans Infection in Tinea Capitis Survey, Arch. Dermat. & Syph. *69:*438-440 (April) 1954.

Norman, W. B.: Tuberous Sclerosis, Case Report, Laryngoscope *64:*113-115 (Feb.) 1954.

Paulson, D. L.: Injuries of Chest Wall, J. A. M. A. *154:* 901-902 (March 13) 1954.

Petet, Paul T.: Smoking and Its Influence on Respiratory Allergy, South. M. J. *47:*242-246 (March) 1954.

Prince, Homer E.; Etter, Richard L.; and Jackson, Richard H.: Aerosol Trypsin Therapy in Treatment of Asthma, Ann. Allergy *12:*25-29 (Jan.) 1954.

Rigdon, R. H., and Kerchoff, Helen: Smoking and Cancer of Lung; Let's Review Facts, Texas Rep. Biol. & Med. *11:*715-727 (Winter) 1954.

Schuleman, I. H.: Electroencephalogram in Post-Traumatic Headache Syndrome, Dis. Nerv. System *14:*335-337 (Nov.) 1953.

Schultz, Jacob F.: Complications Following Cataract Extraction, M. Rec. & Ann. *48:*769-772 (Jan.) 1954.

Sellers, Lyle M.: Modern Applications of Hearing Tests; Hand Tools of Today's Otologist, South. M. J. *47:*154-163 (Feb.) 1954.

Shoemaker, Emett H., and Yow, Ellard M.: Clinical Evaluation of Erythromycin, Arch. Int. Med. *93:*397-406 (March) 1954.

Small, A. B.: Education for Life, Dallas M. J. *40:*8-11 (Jan.) 1954.

Spence, Harry M.: Anomalies and Complications of Urogenital Tract Associated with Congenital Imperforate Anus, J. Urol. *71:*453-463 (April) 1954.

Spence, Harry M.: Nephro-Ureterectomy and Hemine-phro-Ureterectomy in Infancy and Childhood, J. Urol. *71:* 171-182 (Feb.) 1954.

Thompson, Robert F.: Rupture (Fracture) of Penis, J. Urol. *71:*226-229 (Feb.) 1954.

Wall, John A.; Fletcher, Gilbert H.; and MacDonald, Eleanore J.: Endometrial Biopsy as Standard Diagnostic Technique, Am. J. Roentgenol. *71:*95-101 (Jan.) 1954.

Walser, Mackenzie; Seldon, D. W.; and Grollman, Arthur: Radiosulfate Space of Muscle, Am. J. Physiol. *176:* 322-324 (Feb.) 1954.

Whitson, R. O.: Relation of Radial Nerve to Shaft of Humerus, J. Bone & Joint Surg. *36A:*85-88 (Jan.) 1954.

Winston, John R.: Emotionally Handicapped in Industry, South. M. J. *47:*59-62 (Jan.) 1954.

Wolf, A. Ford: Allergy of Eyelids, South. M. J. *47:*238-242 (March) 1954.

BOOKS RECEIVED IN MAY

Bickers, William: Menorrhalgia Menstrual Distress, Springfield, Charles C Thomas, 1954.

Dimon, E. Gray: Electrocardiography, St. Louis, C. V. Mosby, 1954.

Douthwaite, Arthur H.: French's Index of Differential Diagnosis, ed. 7, Baltimore, Williams and Wilkins, 1954.

Edwards, Jesse E.: Atlas of Congenital Anomalies of Heart and Great Vessels, Springfield, Charles C Thomas, 1954.

Farber, Seymour M.: Lung Cancer, Springfield, Charles C Thomas, 1954.

Friedberg, Felix: Thoughts About Life, New York, Philosophical Library, 1954.

National Conference on Care of Long-Term Patient: Care of Long-Term Patient, Washington, U. S. Government Printing Office, 1954.

Shirley, Hale F.: Child, His Parents and Physician, Springfield, Charles C Thomas, 1954.

Young, Carl B.: First Aid and Resuscitation, Springfield, Charles C Thomas, 1954.

CONTRIBUTIONS TO LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library for the following recent gifts:

Dr. T. J. Archer, Austin, 52 journals.

Austin Anesthesiologists Group, Austin, 87 journals, 16 reprints.

Mrs. A. J. Black, Kerrville, 2 books.

Dr. Clyde H. Crawford, Bartlett, 308 journals, 119 books, 62 pamphlets.

Mrs. Harry J. Leon, Austin, 1 book.

Mrs. J. R. Nichols, Austin, 52 books.

Dr. W. D. Roberts, Austin, 41 journals.

Dr. N. L. Schiller, Austin, 29 journals, 20 reprints.

Dr. John F. Thomas, Austin, 9 journals, 11 books.

Mrs. G. F. Thornhill, Austin, 83 books.

MOTION PICTURES FOR LOAN

Transthoracic Esophageal Diverticulectomy

16 mm., silent, color, 23 minutes.

The patient in this film has a large diverticulum immediately above the diaphragm. A one-stage diverticulectomy with immediate repair of esophagus is presented. The procedure is accomplished transthoracically, with various anatomic landmarks demonstrated. This is an excellent film for county medical societies.

Breast Self Examination

16 mm., sound, color, 15 minutes.

In a concise and sensible manner this film stresses the importance of alertness on the part of the patient. A physician introduces the subject, teaches the woman the method

of examination of her own breasts, and emphasizes repeatedly the importance of periodic check-ups. It is impressed on the patient that should she note any abnormality during the monthly self examination, her physician is the person to pass final judgment. The approach used in the film is excellent, with the material presented in a manner to avoid "cancerphobia." It is made plain that not all lumps are carcinoma but that diagnosis should be left to the physician, not the patient.

BOOK NOTICES

[1]Textbook of Medical Treatment

Edited by D. M. DUNLOP, M. D., F.R.C.P. (Ed.), *Professor of Therapeutics and Clinical Medicine, University of Edinburgh;* L. S. P. DAVIDSON, M. D., F.R.C.P. (Ed.), *Physician to Her Majesty the Queen of Scotland, and Professor of Medicine and Clinical Medicine, University of Edinburgh;* JOHN MCNEE, D.S.O., M. D., D.Sc. (Glas.), *Physician to Her Majesty the Queen of Scotland, and Regius Professor of Practice of Medicine, University of Glasgow. Sixth edition. 1,023 pages. $9.50. Edinburgh and London, E. & S. Livingstone, 1953. Distributed by Williams and Wilkins, Baltimore.*

The object of this book is to present to the student and general practitioner the subject of medical therapeutics in a simple and rational form. This goal is accomplished admirably.

In some diseases in which several methods of treatment are successful the authors have chosen one method and have been explicit in giving the details in such a manner that the student or practitioner without great experience is able to carry out the measures successfully.

Many controversial methods of treatment have been omitted. The various contributors to the writing of the book have been chosen because of their rank as authorities in their respective fields of medicine and surgery in Great Britain.

The discussion of "General Management of the Patient" which includes diet, rest, handling of the relatives, and so forth received more attention than in other textbooks of medicine. This is to be commended because too much emphasis often is put on the administration of pharmaceuticals and little is discussed in regard to the handling of the patient's morale.

This volume will be useful in the library of the student or young practitioner.

Bailey's Textbook of Histology

Revised by PHILIP E. SMITH, Ph. D., Sc. D., *Professor Emeritus of Anatomy, College of Physicians and Surgeons, Columbia University, and* WILFRED M. COPENHAVER, Ph. D., *Professor of Anatomy, College of Physicians and Surgeons, Columbia University. With the Assistance of* DOROTHY D. JOHNSON, Ph. D., *Assistant Professor of Anatomy, College of Physicians and Surgeons, Columbia University. Thirteenth Edition. 776 pages. $9. Baltimore, Williams and Wilkins, 1953.*

The thirteenth edition of this classic has been revised and brought up to date. Changes have been made throughout the text to include new information of nucleic acids, enzymes, histochemistry, physiology, and electromicrography. The references at the end of each chapter have been revised and new material included.

Six new colored plates and eighty-eight halftone and live figures have been added.

The book is primarily for the use of medical and dental students and does not pretend to be a source book.

Its excellent coverage of the field makes it one of the best histology texts available in the field.

[2]Practical Methods in Biochemistry

FREDERICK C. KOCH, *Late Frank P. Hixon, Distinguished Service Professor Emeritus of Biochemistry, University of Chicago, and Late Director of Biochemical Research, Armour and Company, Chicago; and* MARTIN E. HANKE, *Associate Professor of Biochemistry, University of Chicago. Sixth edition. 537 pages. $5. Baltimore, Williams and Wilkins, 1953.*

This is distinctly a laboratory manual in elementary biochemistry. It covers experiments on the different foods, the digestive tract, blood, and urine; and also it covers the more complicated chemistry of different enzymes, vitamins, and hormones. The experiments are well written and well chosen to help in a growing appreciation of elementary biochemistry.

[3]Respiratory Diseases and Allergy; New Method of Approach

JOSEF S. SMUL, M. D., *Formerly Associate Gastroenterologist, Beth David Hospital, and Clinical Assistant Physician, Beth Israel Hospital, New York. 80 pages. $2.75. New York, Medical Library Company, 1953.*

This book of eighty numbered pages is, in the several meanings of the adjective, thin. The allergic bias is obvious and the exposition is superficial. The primary purpose seems to be directed toward validation of the author's coined term "respirallergy" to supplant some "twenty-odd so called 'diseases'." The sections concerned with infectious and neoplastic diseases of the respiratory system contain little of merit. Perhaps the most remarkable thing in this book is the concluding paragraph of the section on respirallergy in which the author states that no criticism can be valid unless based on repetition of the work described.

[4]Practice of Psychiatry

WILLIAM S. SADLER, M. D., F.A.P.A., *Consulting Psychiatrist to Columbus Hospital and Pinel Sanitarium, Chicago. 1,183 pages. $15. St. Louis, C. V. Mosby, 1953.*

This text is divided into seven parts. In the author's terms, "It is the purpose of this book to serve as a ready and compact reference for diagnosis and immediate treatment."

One part, which deals with general psychiatric considerations, will probably cause much discussion of the author's classification, with particular reference to the pathoses, though there is much "common sense" in such a classification. These disorders are described as being "pre-neurotic." Here the author classifies cultists, pessimists, nonconformists, malingers, and so forth. He has found the classification serviceable in clinical practice. The part on "The Psychoses" contains easily readable discussions of the diagnosis and treatment of psychotic disorders, which alone make the volume of value to the general practitioner.

The discussion on general psychotherapeutics earns this text a sure place as a reference book. Most readers will enjoy the section on philosophy and religion. The general practitioner can and should assist many families and relatives by being able to discuss the various shock therapies and psychosurgery; these are well described.

The schools of psychiatry are discussed in the appendix. This reviewer enjoyed the approach to the "American School of Psychiatry." Dr. Sadler is a master at coining expressive phrases.

[1]*Otis Taylor, Jr., M. D., Lubbock.*

[2]*Marvin D. Bell, M. D., Dallas.*
[3]*E. P. McKinney, M. D., Nacogdoches.*
[4]*Albert D. Pattillo, M. D., Austin.*

ORGANIZATION SECTION

TRANSACTIONS

EIGHTY-SEVENTH ANNUAL SESSION of the Texas Medical Association

SAN ANTONIO, TEXAS, MAY 2, 3, 4, AND 5, 1954

Sunday, May 2, 1954

MINUTES OF THE HOUSE OF DELEGATES

FIRST MEETING

(The House of Delegates of the Texas Medical Association convened at 9 a. m., Sunday, May 2, 1954, in the North Terrace of the Gunter Hotel, San Antonio.)

Dr. Hobart O. Deaton, Fort Worth, Speaker of the House: Will the House of Delegates please be in order. Does the Credentials Committee have a report? Dr. Raleigh Ross of the Credentials Committee reports that a quorum is present, so the House of Delegates will now be in order for the transaction of business.

MEMBERSHIP OF THE HOUSE OF DELEGATES

(The membership of the House of Delegates established by the Reference Committee on Credentials at this and subsequent meetings included 123 elected delegates and 45 ex-officio members with 7 of these 45 serving in two ex-officio positions. One ex-officio member also was an elected delegate, making the total 160 persons. The membership was as follows:)

Elected Delegates*

Anderson-Houston-Leon.—R. H. Bell.
Andrews-Ector-Midland.—William A. Wiesner.
Angelina.—L. H. Denman.
Armstrong-Donley-Childress-Collingsworth-Hall.—E. W. Jones.
Atascosa.—W. H. Joyce.
Bastrop-Lee.—James W. Thomas.
Baylor-Knox-Haskell.—E. H. Balch.
Bee-Live Oak-McMullen.—D. W. Davis.
Bell.—Robert A. Murray, J. C. Walker.
Bexar.—William H. Heck, J. Lewis Pipkin, John L. Matthews, J. J. Hinchey, W. W. Bondurant, Jr.
Bosque.—V. D. Goodall.
Bowie.—C. A. Smith.
Brazoria.—Ralph E. Gray.
Brazos-Robertson.—J. G. Sanders.
Brown-Comanche-Mills-San Saba.—S. Braswell Locker.
Cameron-Willacy.—H. L. Scales, Jr.
Cass-Marion.—William S. Terry.
Cherokee.—George M. Hilliard.
Clay-Montague-Wise.—J. T. Darwin.
Colorado-Fayette.—L. E. Ihle.
Comal.—William W. Sullivan.
Cooke.—James Atchison.
Coryell.—E. E. Lowrey.
Crane-Upton-Reagan.—B. J. Maynard.
Dallas.—Guy T. Denton, Jr., Ridings E. Lee, D. W. Carter, Jr., Jack G. Kerr, George M. Jones, Barton E. Park, Fred W. Horn, R. A. Trumbull, Arnott DeLange, Frank H. Kidd, Jr.
Denton.—Dickson K. Boyd.
DeWitt.—F. A. Prather.
Eastland-Callahan-Stephens-Shackelford-Throckmorton.—P. M. Kuykendall.
Ellis.—Herbert Donnell.
El Paso.—H. D. Garrett, C. C. Boehler.
Erath-Hood-Somervell.—T. F. Bryan.
Falls.—Roy B. Giles.
Galveston.—John Otto, W. T. Anderson.
Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson.—Joe R. Donaldson.
Grayson.—Robert W. Duncan.
Gregg.—Frank V. Mondrik.
Grimes.—S. D. Coleman.
Guadalupe.—J. B. Williams.
Hale-Floyd-Briscoe-Swisher.—M. C. Schlecte.
Hardeman-Cottle-Foard-Motley.—A. C. Traweek, Sr.
Harris.—S. W. Thorn, Thomas J. Vanzant, T. P. Kennerly, B. P. York, Homer E. Prince, John H. Wootters, Alvis E. Greer, C. Forrest Jorns, George W. Waldron, H. L. Alexander, J. Stanley Oliver (W. H. Hamrick).
Harrison.—James H. Harris.
Hidalgo-Starr.—Marvin R. Lawler.
Hill.—Dick Cason.
Howard-Martin-Glasscock.—E. V. Swift.
Hunt-Rockwall-Rains-Delta.—S. D. Whitten.
Jefferson.—W. Pierre Robert, L. C. Carter, L. C. Powell.
Johnson.—Tolbert F. Yater.
Karnes-Wilson.—J. W. Oxford.
Kerr-Kendall-Gillespie-Bandera.—D. R. Knapp.
Kimble-Mason-Menard-McCulloch.—J. S. Anderson.
Lamar.—T. E. Hunt, Jr.
Lamb-Bailey-Hockley-Cochran.—G. V. Edgar.
Lampasas-Burnet-Llano.—R. L. Shepperd.
LaSalle-Frio-Dimmit.—B. E. Pickett, Sr.

EDITOR'S NOTE: *Throughout the Transactions parentheses indicate explanatory material not included in the verbatim report.*

**Names in parentheses in the list of delegates are of alternate delegates who served during part of the session.*

Lavaca.—C. T. Dufner.
Liberty-Chambers.—C. W. Castle.
Lubbock-Crosby.—William H. Gordon, A. G. Barsh.
McLennan.—Howard R. Dudgeon, Jr.
Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala.—J. D. Williamson.
Montgomery.—M. G. Hutchins.
Nacogdoches.—Stephen B. Tucker.
Nolan-Fisher-Mitchell.—Chester U. Callan.
Nueces.—C. P. Yeager, John F. Pilcher.
Palo Pinto-Parker-Young-Jack-Archer.—H. E. Griffin.
Pecos-Jeff Davis-Presidio-Brewster.—Charles E. Oswalt, Jr.
Potter.—A. E. Winsett, August J. Streit.
Reeves-Ward-Winkler-Loving-Culberson-Hudspeth.—C. A. Robinson.
Rusk.—Loyd Deason.
San Patricio-Aransas-Refugio.—Claude A. Selby.
Smith.—Madison J. Lee.
Tarrant.—Joseph F. McVeigh, Mal Rumph, J. D. Murphy, E. P. Hall, Jr., Holland T. Jackson (W. F. Armstrong, L. H. Reeves).
Taylor-Jones.—R. W. Varner.
Tom Green-Coke-Crockett-Concho-Irion-Sterling-Sutton-Schleicher.—Carl A. Kunath.
Travis.—Raleigh R. Ross, S. N. Key, Jr., B. M. Primer, Sr.
Van Zandt.—H. A. Baker.
Victoria-Calhoun-Goliad.—Joseph V. Hopkins.
Washington-Burleson.—G. V. Pazdral.
Webb-Zapata-Jim Hogg.—Albert C. King.
Wharton-Jackson-Matagorda-Fort Bend.—L. B. Johnson.
Wichita.—Robert L. Daily, E. Aubrey Cox.
Williamson.—Albert J. Rice.

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President-Elect.—F. J. L. Blasingame, Wharton.
Vice-President.—Andrew S. Tomb, Victoria.
Secretary.—J. M. Travis, Jacksonville.
Speaker of the House of Delegates.—Hobart O. Deaton, Fort Worth.
Vice-Speaker of the House of Delegates.—Charles P. Hardwicke, Austin.
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Council on Medical Defense.—Charles L. McGehee, San Antonio, Chairman.
Council on Scientific Work.—May Owen, Fort Worth, Chairman.
Council on Medical Economics.—Harvey Renger, Hallettsville, Chairman.
Council on Medical Education and Hospitals.—Milford O. Rouse, Dallas, Chairman.
Committee on Public Relations.—Troy Shafer, Harlingen, Chairman.
Delegates to the American Medical Association.—T. C. Terrell, Fort Worth; Milford O. Rouse, Dallas; J. B. Copeland, San Antonio; A. C. Scott, Jr., Temple; John K. Glen, Houston.
Alternate Delegates to the American Medical Association.—J. C. Terrell, Stephenville; Troy Shafer, Harlingen, George Turner, El Paso; John L. Otto, Galveston; Robert W. Kimbro, Cleburne; L. C. Heare, Port Arthur.

Speaker Deaton: There are a few preliminaries that we wish to get out of the way. We have some student representatives from the Student AMA chapters. I have the name of only one so far, Mr. L. E. Chapman, Jr., from Galveston. Stand up and take a bow.

Those of you who are intending to present resolutions, if you will have six copies, it will facilitate matters and help to keep the records straight.

The first item in the order of business is the reading of the minutes of the previous meeting.

Dr. R. G. Baker, Fort Worth: Mr. Speaker, the minutes have been published, and I move the adoption of the minutes as published in the STATE JOURNAL OF MEDICINE in the June issue.

Dr. J. T. Billups, Houston: I second the motion. (Thereupon said motion being put to a vote, the same was duly carried.)

Speaker Deaton: Gentlemen of the House of Delegates, it gives me a great deal of pleasure to present the President of the Texas Medical Association, Dr. George Turner of El Paso.

ADDRESS OF PRESIDENT

Dr. Turner: I would like to make some remarks on the progress of the year 1953.

Our new headquarters office and Memorial Library building has now been open for more than a year, and I am sure that all of us feel we are getting our money's worth in the improvement that has resulted in the operation of Texas Medical Association activities. The difference in efficiency is accounted for by having adequate physical equipment with which to work and not being crowded into insufficient and poorly arranged space. Much better and more work is being accomplished easier because of facilities designed and built for the particular purpose needed. These working conditions coupled with the able direction of our Executive Secretary in coordinating and unifying the efforts of our central office personnel make the operation of our headquarters of the highest type. Recently an expert accountant has been added to the staff, which service, I am sure, will reflect itself in our financial management. In other words, we will know what is becoming of our dues money in a precise fashion. A visiting secretary from the central office will help materially to bridge the communications gap between this "information center," as it were, and the county medical societies. Your President and other officers work at this job, but this effort is not sufficient within itself. At least one traveling secretary, continuously on the road, will no doubt serve to cement better internal relations in our Association, and more than one might be better.

The Memorial Library has far extended its services and sphere of usefulness under the direction and unceasing efforts of our highly competent medical librarian. She has developed the Library practically from its beginning and is substantially responsible for all advancement and a highly commendable service. We can now say that the extensive facilities of our Library are becoming a practical working tool for more and more doctors across the state each day, and should again remind you that you can get all needed

reference material on any medical subject in which you may be interested with the simple use of one post card, and this will be sent to you by your Library. I like the term "your Library" because it belongs to the 6,400 doctors, more or less, who pay dues and are members of the Texas Medical Association. Our state membership picture this year is good: 270 new members have been added to the rolls and dues have been paid promptly at the state and AMA levels.

The Washington office of the AMA has been improved this year as our number one observation post concerning the progress of pending medical legislation. This office now maintains a most efficient, flexible, and complete set of files on every piece of medical legislation passing through the national Congress. Immediate information on the exact status, content, and possibilities of any pending medical legislation can be furnished instantly from this office.

Our Council on Medical Jurisprudence and our general counsel report that at the state level no legislation which would affect detrimentally the health care of the people of Texas has been enacted into law this year.

Our activities in the field of rural health have developed stronger relationships and better understanding with other groups concerned in the same problem. We have completed and learned much from an extensive survey of our own profession to determine actual facts on alleged "doctor shortage." We have been contacting lay officials and chambers of commerce of many communities to demonstrate our sincere desire to effect the most efficient doctor distribution possible. These efforts give promise of meeting with considerable success. We have been host this year to the National Rural Health Conference, recently completed in Dallas. At this conference, Texas doctors and our Texas program received much favorable comment.

Our Council on Medical Defense has prepared and distributed an excellent booklet dealing with the increasingly complicated legal aspects of medical practice.

We have begun a sound program to encourage more and more secretary training at the county society level. We have prepared an outline guide for secretary training and have augmented that with a detailed series of lectures. These are available to individual doctors or to societies that wish to encourage secretary training in night schools, business schools, or in the formation of local clubs for doctors' secretaries.

The meeting this year of county medical society presidents and secretaries is believed the most successful to date. The lines of communication between our Association headquarters and these local medical leaders is greatly strengthened.

It has long been felt that a closer liaison should be kept between our medical students—the doctors of tomorrow—and organized medicine. The Texas Medical Association made this project a reality this year in a "Medical Students' Day" program carried out in cooperation with the Dallas, Harris, and Galveston County Medical Societies. The speakers were officers of the Texas Medical Association who have had long experience in the practice of medicine and who deeply feel that these indocrination talks to students serve a useful purpose to them. The subject of medical organization was covered in detail at the county, district, state, national, and world levels. Other subjects covered were the salient aspects of internal and external public relations, the business side of medical practice, legal aspects of medicine, and professional and community responsibilities of doctors. Such subjects as the importance of membership and active participation in the affairs of organized medicine, the importance of having a clear understanding with the patient concerning the cost of medical or surgical service before it is performed, and the terms of payment for said services were emphasized. The talks were well received at each of the three medical schools and such remarks as ". . . these meetings held at the various medical schools in Texas comprise a very needed basic concept in the training of the doctors of the future" serve as encouraging stimuli for the continuance of this project.

Much time and thought have been given this year to the type and arrangement of our annual program, with a view of providing more for the greatest number and thereby increasing the attendance. You will be a better judge than I of our success in this respect, but I believe that our Council on Scientific Work has done a splendid job, and that this year's annual session will be one of the best. Our program this year is a departure from the usual section meetings; we have only two major groups, one pertaining to medicine and the other pertaining to surgery, and I am sure the larger attendance at the larger groups will be more stimulating to the speakers..

All boards, councils, and committees have functioned to a full measure of efficiency, and all accomplishments of the year stem from the untiring effort of each individual member. I wish to thank each member of the councils and committees and Board of Trustees and everyone who worked so diligently to make this year what it was and to make it a success. Our Board of Trustees has been tireless in its efforts for organized medicine. Our Board of Councilors has done much to develop stronger coordination throughout the councilor districts and serve as a policy-making body for Texas medicine. The grand total of the substantial progress in medicine accomplished during the year is due to the work and effort of all men and women who have served in the many projects of medical activity in your behalf.

Recommendations

In conclusion, I wish to make several recommendations for consideration by this House of Delegates. All of these recommendations concern some particular phase of medical practice. It does not necessarily mean they have to be included in the By-Laws or any definite rules made concerning any of these recommendations, but as a matter of policy to be followed in Texas medicine, I do wish to make these suggestions.

In several references to health insurance through the year, I stated that in my judgment, the minor costs of medical care such as an illness requiring only a few home visits by the doctor or a few visits to his office are no more than a part of the normal cost of living and should be optionally included in his health insurance protection. I, therefore, suggest that this House go on record as approving a $50 or more deductible clause in health insurance policies.

The utilization of television by county medical societies has come to rank along with the press in importance as a modality of presenting the picture of American medicine and furthering health education. I would like to recommend in this connection that a policy outlining regulations regarding physicians' appearances on TV be formulated for the guidance of county medical societies.

Our work in furnishing information for the guidance of student nurses and receptionists is proving of great value. I recommend that this effort be expanded to make this same type of information available for all medical associates and that a booklet be published containing a description of courses and mentioning accredited schools where such courses are given. I refer to pharmacists, medical technologists, physical therapists, x-ray technicians, mental health associates, ophthalmic associates, dieticians, occupational therapists, medical artists, dental associates, public health associates, public health educators, health inspectors, hos-

pital administrators, medical social workers, medical secretaries, medical librarians, vital statisticians, and industrial and skin hygienists. The purpose of that is to have information available so prospective students can have information available and be trained in the proper way, believing that the work of these associates is most valuable and the training of them is necessary for our best health.

We not infrequently hear the statement that hospitals are actively engaged in the practice of medicine and that there is apt to be more and more medicine practiced by corporative institutions. An expression of policy by the Medical Association on this important question of infringement on the practice of medicine by hospitals seems timely.

Our state and county public health units and activities have long had the support of organized medicine, but in recent years our attitude has become more of a disinterested toleration than of active support. Reaffirmation of our support and sincere effort to assist in seeing that public health coverage is extended to every area of the state lacking it is a gesture worthy of our consideration at this time.

Our Medical Students' Day program was well received and many requests have been made to make the project a permanent yearly activity. I suggest that this policy be established.

In view of the obvious success and value to the Association of our county medical society presidents and secretaries meeting, I recommend that this meeting be made a permanent adjunct to our January Executive Council meeting each year.

Because of important matters coming before our councils and committees that should not lay over for a full year or even until the next Executive Council meeting, I recommend that the last meeting of the House of Delegates be left on the last day of a convention.

Speaker Deaton: Thank you, Dr. Turner. The address of the President will be referred to the Reference Committee on Report of Officers and Committees, except that portion dealing with health insurance and the policy on TV, which will be referred to the Reference Committee on Medical Service and Public Relations. The recommendation as to the last meeting on the last day will be referred to the Reference Committee on Amendments to the Constitution and By-Laws.

Someone has suggested that the reference committees be announced and I might give you that briefly:

REFERENCE COMMITTEES

Reference Committee on Credentials.—Raleigh R. Ross, Austin, Chairman; J. C. Walker, Temple; J. R. Donaldson, Pampa; R. W. Duncan, Denison; John H. Wootters, Houston; James D. Murphy, Fort Worth.

Reference Committee on Reports of Officers and Committees.—E. P. Hall, Jr., Fort Worth, Chairman; John F. Pilcher, Corpus Christi, Vice-Chairman; R. H. Bell, Palestine; R. W. Varner, Abilene; Thomas J. Vanzant, Houston; A. G. Barsh, Lubbock; D. K. Boyd, Denton.

Reference Committee on Resolutions and Memorials.—S. D. Coleman, Navasota, Chairman; S. Braswell Locker, Brownwood, Vice-Chairman; Howard Dudgeon, Jr., Waco; C. P. Yeager, Corpus Christi; Guy T. Denton, Jr., Dallas; H. E. Griffin, Graham; Charles E. Oswalt, Jr., Fort Stockton.

Reference Committee on Finance.—E. W. Jones, Wellington, Chairman; Stephen B. Tucker, Nacogdoches, Vice-Chairman; H. A. Baker, Wills Point; G. V. Pazdral, Somerville; J. C. Terrell, Stephenville; C. A. Robinson, Kermit; Byron P. York, Houston.

Reference Committee on Amendments to the Constitution and By-Laws.—Jack G. Kerr, Dallas, Chairman; J. J. Hinchey, San Antonio, Vice-Chairman; Chester U. Callan, Rotan; J. B. Williams, Seguin; E. V. Swift, Big Spring; R. L. Daily, Wichita Falls; Charles Adna Smith, Texarkana.

Reference Committee on Scientific Work.—A. C. Scott, Jr., Temple, Chairman; C. Forrest Jorns, Houston, Vice-Chairman; John L. Otto, Galveston; G. V. Edgar, Levelland; C. C. Boehler, El Paso; Dick Cason, Hillsboro.

Reference Committee on Medical Service and Public Relations.—Van D. Goodall, Clifton, Chairman; Ridings E. Lee, Dallas, Vice-Chairman; W. W. Bondurant, Jr., San Antonio; Ralph E. Gray, Lake Jackson; Joseph F. McVeigh, Fort Worth; Dwight R. Knapp, Kerrville; H. D. Garrett, El Paso.

Speaker Deaton: The various work that comes before the House of Delegates will be referred to these committees. The times and places of their meetings will be announced; if you wish to appear before any of those committees, you are certainly privileged and urged to do so. I will turn the microphone back to Dr. Turner, for some further announcements that he wishes to make.

Dr. George Turner, El Paso: Some three weeks ago in Salina, Kan., Dr. Leo J. Schaefer, who was presenting a paper before his county medical society, suffered a heart attack and was carried to the hospital, where he still is. The way that affects us, Mrs. Schaefer is President of the Woman's Auxiliary to the American Medical Association. Since Dr. Schaefer's illness, the President-Elect of the Woman's Auxiliary to the American Medical Association has been filling appointments for Mrs. Schaefer. This person is Mrs. George Turner, who is here for Mrs. Schaefer and will make a few remarks to you at this time.

GREETINGS FROM WOMAN'S AUXILIARY TO AMA

Mrs. George Turner, El Paso: It is a great privilege to be here this morning, and as you have been told, I am a substitute for the President of our Auxiliary at this meeting. I am pleased to bring you greetings from our 65,350 members who belong to 1,130 county auxiliaries in the 48 states, the territories of Hawaii and Alaska, and the District of Columbia.

We know that health is a primary consideration of people. Our programs for the Auxiliary meetings are planned to inform our members of the problems of the Medical Association and the ways in which the doctors are attempting to solve and in many instances are solving them. Therefore, as Auxiliary members, we have a twofold service to render: educating ourselves and bringing proper information to our home communities through the organizations in which we hold membership.

Not too many years ago the life of a doctor's wife was rather calm and placid. Today she must be informed concerning problems which affect health or else offer no comment in the discussions to which she must listen in any group in which she may find herself.

We need your help. It was recently announced that there are now 146,723 members of the American Medical Association while our own membership is only 65,350. Our ultimate goal is to match your membership. We want every eligible doctor's wife as a member. We are working this year toward a 10 per cent increase in our membership.

Outstanding is our work in nurse recruitment, which we further in various ways, by scholarships, by loan funds, and by establishing or sponsoring future nurses' clubs in high schools.

Another thing of which we are very proud is our contribution to the American Medical Education Foundation.

For three years the National Auxiliary has donated $10,000 from what we call our accrued balance. Of course, that is coming to an end because our money does not accrue that fast. However, that is being supplemented now by donations from the state and county auxiliaries. Last year $22,630 was contributed and we feel sure that through June of 1954 this amount will be doubled. Of course, our only source of income is from our $1 per member annual dues. With a membership more closely approximating your membership, we could increase our potential value in our philanthropies. We do prefer to increase our membership rather than to increase our dues.

Today's Health magazine, published by the American Medical Association, is an excellent medium for disseminating authentic health information. People eagerly read medical articles in other magazines, so why should we not make authentic information available to them? We sell subscriptions to *Today's Health,* and our goal this year is 64,000 subscriptions, one for each member, which will about double the subscription list of last year. Here again, we need your help. Only 15 per cent of the doctors subscribe to *Today's Health.* We know you do not want to read it or do not need to read it, but your patients do need to read it, so won't you please make it available to them in your reception rooms? Then I might add that the county auxiliary gets $1.50 for selling these subscriptions, so the local organization gets something out of it.

We keep ourselves informed on medical legislation, mental health problems, and voluntary health insurance. We help however we may to promote community health forums, local community health days, and rural health programs. We assist with the civil defense program at the local level. We participate in other health organization projects such as cancer, polio and so forth, on both the community, state, and national levels. Many of our members hold responsible offices in these organizations.

In 1954-1955, we are asked to put special emphasis on assisting the county medical societies with health forums and to join actively and work with the county and state mental health societies, and further to work with the safety program and the juvenile delinquency program in our respective communities. We believe that saving healthy lives is perhaps more important than saving diseased lives.

Each November a conference of state presidents and presidents-elect and National Auxiliary committee chairmen is held in Chicago, with representatives from our 51 state and territorial auxiliaries attending. Here are exchanged ideas and ideals, and valuable assistance and inspiration are given by speakers from the American Medical Association and other speakers of note. Each member attending this conference goes home more enlightened and more eager to assist her state and county medical societies in any work which they may assign.

The achievements of American medicine are unparalleled, and we, your wives, are justifiably proud of you, our husbands. However, we must realize that the appreciation of the public is not based on excellent medical care alone, but is in ratio to our devotion to the welfare of the community through community health education and community health service. Through the daily relationship between doctor and patient and the doctor's wife and her contacts, confidence in our ability and sincerity as leaders in community health is established.

I know that a good speech must have a good beginning and a good ending, both of which are kept close together. In closing, may I quote an old proverb: "He who would leave footprints on the sands of time must wear work shoes." May I add that the Auxiliary does wear work shoes.

Dr. George Turner, El Paso: Now we have the very charming President of the Woman's Auxiliary to the Southern Medical Association, whom I am happy to present at this time, Mrs. George D. Feldner from New Orleans. (Greetings were extended by Mrs. Feldner.)

Dr. Turner: Next to the total affairs of the Texas Medical Association is my deep interest in the State Health Department. As I have said before, through the years and in the present, we should see to it that the public health service is extended to every part of the state which is now not getting it and which does lack it. We have a state health officer who, I am sure, will most ably direct the activities of that great department and give Texas the type of health service and coverage to which the tax payers are entitled. It gives me great pleasure to introduce to you Dr. Henry A. Holle, state health officer of Texas (introducing Dr. Holle). Thank you, Mr. Speaker.

Election of General Practitioner of Year

Speaker Deaton: The next item of business is the election of General Practitioner of the Year. Do we have some nominations for General Practitioner of the Year?

Dr. R. G. Baker, Fort Worth: Some of you may be new in the House of Delegates. This particular item is processed in this way: these nominations are submitted and they are referred to the Board of Councilors; the Board of Councilors selects from the names submitted two, which are then submitted to the House of Delegates for action.

The Board of Councilors considered four proposed members for the award of General Practitioner of the Year, and herewith nominates Dr. Thomas P. Ware of Poteet and Dr. A. L. Thomas of Ennis as candidates for this award.

Dr. Thomas P. Ware

Dr. J. J. Hinchey, San Antonio: Dr. W. B. Russ of San Antonio, past president of the Texas Medical Association, addressed the Poteet Strawberry Festival in 1953 with these words: "The Golden Rule represents the wisdom of the ages and all religions. This man represents the Golden Rule." This statement was made in an address to those who had gathered to honor their doctor on the completion of his fiftieth year of practice.

Thomas Ware was born near D'lo, Miss., August 6, 1881, the youngest of five children of Thomas and Tabitha Dye Ware. The parents were pioneers in the deepest sense of the word, for they had come to Mississippi in ox wagons in 1855 to wrest a living from the soil and to rear their children. This same spirit was instilled into their sons and daughters to the extent that the youngest was to pioneer as a "country doctor" in a new and unfamiliar environment.

Tom Ware attended the common schools of Mississippi, and at the age of 17 was granted a first grade teacher's license. To finance his childhood dream of becoming a doctor, he taught in the common schools for one term. Entry into medical school was delayed by typhoid fever in 1899, but in the fall of 1900, he entered Memphis Hospital Medical College. He was awarded the degree of doctor of medicine on April 30, 1903. Memphis Hospital Medical College was later to become the official medical school of the University of Tennessee.

The young Dr. Ware set up his first practice in New Hebron, Miss. One of his first professional calls was into the country home of Will Hutchins. There he met Myra Hutchins, and on October 19, 1904, she became his wife. They reared four children: Mrs. Lee Ricks, Sr., wife of a Pleasanton merchant; Mrs. J. B. Copeland, wife of a San Antonio doctor; Mrs. E. O. Threlkeld, wife of a Seguin

attorney; and T. P. Ware, Jr., petroleum engineer in Corpus Christi.

After eight years of practice in New Hebron, Dr. Ware moved to South Texas, and on November 11, 1911, he opened his first Texas office in Dilley.

According to Dr. Ware, medical practice in South Texas, at that time, was more difficult than practice had been in Mississippi. Mississippi roads were far superior, in those days, to the cattle trails of Texas; so he had to give up the horse and buggy that he had used for transportation in favor of a horse and saddle. His saddlebags replaced the Mississippi drug store, and from them he compounded medicines with which to treat his patients.

In 1913, Dr. Ware moved to Lytle and became associated with Dr. R. B. Touchstone, a former classmate. In 1917, the disastrous flu epidemic struck the nation, and after many long days and nights of faithful service, Dr. Ware himself became a victim of the disease. The damage wrought by the flu and overwork led to a general debility, then pellagra, and forced him to sell his practice to Dr. W. M. Gipson in 1920.

In 1921, he set up practice in Floresville, and after one year moved to Kyle, where he remained until 1924. Dr. Gipson in Lytle became ill, and being unable to care for the entire practice, prevailed upon Dr. Ware to return to the area. This he did, and began practice in Somerset. Shortly thereafter, Dr. Gipson died, leaving the entire area of Somerset, Lytle, Poteet, Jourdanton, Rossville, Leming, Pleasanton, and Charlotte to be cared for by Dr. Ware and Dr. C. C. Shotts, Sr., of Poteet.

In 1937, Dr. Shotts died, leaving the Poteet Hospital without a doctor. Since the center of population was in Poteet, Dr. Ware moved his office to the hospital so that he could care more adequately for the large practice area.

He has served as county health officer for Atascosa County at various times and on so many occasions that he doesn't "rightly remember" which years they were. He knows that for ten years he served as president of the Atascosa County Medical Society, and one year served as its representative to the House of Delegates of the State Medical Association. He has been a member of the Texas Medical Association since he began practicing in Texas and in 1954 refused to be made an honorary member of that Association, preferring to remain an active member. He is also a member of the Academy of General Practice in Texas.

During World War II, his office made all Selective Service examinations for Atascosa County. At times, the load became so heavy that a colleague from Lytle was called on to help. Dr. Ware holds a presidential citation for his services during that time.

He has served as local surgeon for the Missouri-Pacific Railroad since 1914. He has made thousands of examinations for life insurance and oil companies. For thirty years Dr. Ware served as team doctor for the football squads of the towns where he has lived, and he has never made a charge for these services.

In Clear Creek, Miss., on his twenty-first birthday, Dr. Ware made application to become a Mason. On September 6, 1902, he took his first degree; the second degree in October, 1902; and the master's degree in January, 1903. He has been affiliated with the Royal Arch, Knights Templar, and the Shrine. When he received his 50 year pin in Masonry, he was believed to be the youngest 50 year Mason in Texas. The Somerset Masonic Lodge presented him with a life membership in 1953.

A member of the Baptist Church since childhood, Dr. Ware has actively participated in church functions since that time. He has long advocated the furthering of the social position and living conditions of the Latin-American people and in 1949 was most instrumental in the formation and building of the Baptist Spanish-American Mission in Poteet.

Dr. Ware served as a member of the Poteet School Board and has been a member of the Rotary Club and other service organizations in the cities in which he has lived. He has refused to accept officer appointments in any of these organizations, feeling that his medical practice comes first.

Dr. Ware's influence in Poteet community life is graphically illustrated by his efforts, several years ago, to raise the final funds necessary to build a new community hall and fire station. The civic leaders were stalled until "Doc" was persuaded to take over at a mass meeting. It took him about ten minutes to raise the $1,500 additional that was needed.

In 1906 Dr. Ware took a postgraduate course in general medicine at the College of Physicians and Surgeons in Chicago, and in 1918 he did further postgraduate work at Tulane University.

In May, 1947, Dr. Ware, tired by his near single-handed efforts to give this section of South Texas medical service during World War II, announced that he would take a rest. (It was briefer than he had anticipated.)

However, this announcement moved the Pleasanton *Express* to comment in its June 5, 1947, edition: "During the last world war, when practically every doctor in the county was called to military duty, Dr. Ware took over their duties and was on call night and day all over the county and also operated the Shotts Memorial Hospital. The clock never pointed to the end of his day's work. How he managed to keep on going and going to answer the call of the sick and injured, no one will ever know. We only know that when we called, he came and administered. . . .

"The love and respect held by thousands and thousands of Atascosans for this fine citizen truly is immeasurable. Evidence of this fact was demonstrated when many, many of his patients, upon being told he was retiring from practice for awhile, broke down and wept like children; for they trusted in him beyond measure and loved him as much."

It is the opinion of many persons that Dr. Ware's unselfish work during World War II, with supreme disregard for his own health and well-being, reflects great credit not only upon himself, but the medical profession as well. It is a matter of record that during the war, he once delivered five babies in one twelve hour period at widely scattered locations in the county.

On September 28, 1953, along with the remaining living graduates of the class of 1903 of the University of Tennessee, he was presented with a Golden "T" certificate at special commencement exercises which honored those graduates who have practiced for fifty years.

Probably the greatest day of Dr. Ware's medical life occurred April 30, 1953, when the people of Atascosa County paid tribute to their doctor on "Doc Ware Day." A parade of "Doc's babies" marched behind him through the streets of Poteet. The army of "babies," trailing in formation behind the doctor's car, was somehow reminiscent of the Pied Piper. Their ages ranged from 2 months to 39 years. More than 500 registered, but many more marched. Doc estimates that he has made more than 5,000 home deliveries since beginning practice.

Later, he heard himself eulogized by Dr. W. B. Russ of San Antonio, who praised the "country doctor" in general, and Dr. Ware in particular, saying, "The Golden Rule represents the wisdom of the ages and all religions. This man you're honoring today represents the Golden Rule."

Said the Pleasanton *Express* editorially, in writing on the

celebration: "It is doubtful if any man in South Texas ever received a more spontaneous demonstration of affection and respect than was accorded Dr. Thomas Preston Ware at Poteet last Saturday. . . . Regardless of their circumstances, their fame, their discoveries, no doctor could be richer than Doc Ware. He's given a lifetime of service to people who appreciate his efforts."

After the celebration, Dr. Ware asserted, "After all this, about all I can do now is either quit or die." But thousands of South Texans would protest his doing either.

Dr. A. L. Thomas

Dr. Mayo Tenery, Waxahachie: For many years the cities of Waxahachie and Ennis have been great rivals, but this is one time when a Waxahachian feels it is a great honor to say something in behalf of a citizen of Ennis.

Dr. A. L. Thomas is 78 years of age. He was born in Augusta, Ga., and came to Texas at the age of 11. He taught school for awhile and then went to medical school in Louisville, Ky. After that he came back to Ellis County and began the practice of medicine in 1903. Except for one year when he stopped for an internship, he has been continuously in general practice in Ellis County since that time.

Last year the citizens of Ellis County likewise held a reception in honor of Dr. Thomas for his fifty years in service to the people of Ellis County, and hundreds attended. He is very close to the hearts of his people and he is still in active practice. In fact, he can do more work in one day than I possibly can, and he plans to continue to do so.

Dr. Thomas was the first in Ellis County to have a microscope and did the microscopic work for doctors all over the county for several years. He was the first one in Ellis County to have an x-ray machine. He started out, of course, like many of you, in the horse and buggy days and did his first operation on the kitchen table out in the country.

Not only is Dr. Thomas a great physician, a surgeon and obstetrician, and family counsellor, but he is also a citizen of Ellis County. He has been health officer for the city of Ennis for many, many years. He was chairman of the first library board in the founding of a library for Ennis. He is chairman of the trustees of Ennis High School and has been for several years. Any of you who know the work of the school board, know how much time that takes. He has been president of the Kiwanis Club. In 1951 the Lions Club, when inaugurating the idea of the first citizen of the year, picked Dr. Thomas as the first one it would claim as the citizen of Ennis. He is now chairman of the committee to revise the charter of the city of Ennis.

Dr. Thomas is a devoted Christian. He is a member of the Methodist Church, a member of the board of stewards and chairman a number of times. He is at this time chairman of the building committee for the new church. He has been teacher of the men's Bible class for many, many years. He is the lay delegate from his Methodist Church to various congresses.

He has been a member of the Texas Medical Association continuously since 1908, a total of forty-seven years of continuous service in organized medicine. He has been president of the Ellis County Medical Society many times and president of the doctors' weekly luncheon club in Ennis, and he is constantly working for organized medicine.

Dr. Thomas is still very interested in the education of young people and many, many young people go to him for advice and help. Many such young people are carrying on their education with his help, financially and otherwise, of which he says nothing—just goes ahead about his daily routine of carrying on the practice of medicine as he has done now for fifty-one years.

Speaker Deaton: Are there any other speakers in behalf of these candidates?

Dr. J. Wilson David, Corsicana: I want to second the nomination of Dr. Thomas of Ennis. I know Dr. Thomas as he lives only about 25 miles from me and have known him for many years not only personally but by reputation. It would be futile for me to try to repeat the many things that Dr. Thomas has done as outlined by Dr. Tenery. I do want to say, however, that I know Dr. Thomas fulfills all the requirements of what we expect of a general practitioner.

Dr. H. E. Griffin, Graham: July 15, 1907, I started the practice of medicine in Ennis. Across the hall from me was Dr. Thomas' office. I remained in that town six or seven years and moved out into the west. There is no man in Texas who deserves this honor better than Dr. Thomas.

Speaker Deaton: Gentlemen, are you ready to take a vote? I will ask the tellers to collect the ballots and Dr. Jack Kerr of Dallas will act as chairman of the canvassing committee.

(The tellers subsequently reported 117 voting, with Dr. Ware receiving 47 votes and Dr. Thomas receiving 70. Dr. Thomas was declared General Practitioner of the Year.)

Speaker Deaton: The next business at hand is the report of the Executive Secretary, Mr. Forrester.

(Mr. N. C. Forrester, Austin, then presented a published report and supplementary report as follows:)

REPORT OF EXECUTIVE SECRETARY

The volume of work at the central office continues to increase with the growth of the Association. With the exception of the actual printing of the JOURNAL, all of the material is processed in the headquarters building. New machines have been installed in the business office to facilitate the handling of membership records and bookkeeping procedures.

The number of doctors requesting material and information from the Memorial Library has almost tripled, and the volume of the material requested has increased four-fold. The Physicians Placement Service continues to assist many doctors to find suitable locations and communities in their efforts to make medical care available.

Changes have been made in the physical appearance and format of the TEXAS STATE JOURNAL OF MEDICINE. We believe it to be one of the outstanding journals now published by a state medical association.

The activity of the State Advisory Committee to the Selective Service System has decreased since the cease fire order, but Public Law 84 (83rd Congress) is still in effect.

The addition (April 1, 1954) of Mr. C. Lincoln Williston to work directly with the Councilors and county medical societies should prove beneficial to the progress of organized medicine in our state.

With the addition of modern equipment and simplified procedures we have been able to reduce the central office staff by two full time employees. We deeply appreciate the advice and cooperation of the members of the Association.

Changes in Official Family

The following changes in the official family of the Texas Medical Association have occurred since the last meeting:

Vice-Councilors appointed were Dr. Howard Smith, Marlin, Twelfth District, and Dr. L. J. Webster, Abilene, Thirteenth District.

Dr. A. B. Cooper, El Paso, was appointed to the Committee on Mental Health.

Dr. Hugh Welsh, Houston, was appointed chairman of the Committee on Public Health to replace Dr. John F. Pilcher of Corpus Christi who resigned as chairman but remained a member of the Committee.

Dr. George D. Bruce, Baytown, was appointed to serve on the Committee on Rural Health.

Three new special committees were appointed as follows:

Committee for Coordination of Insurance Claims—Dr. M. C. Overton, Jr., Pampa, chairman; Dr. Tom B. Bond, Fort Worth; Dr. John H. Wootters, Houston; Dr. James W. Rainer, Odessa; and Dr. J. B. Copeland, San Antonio.

Committee for Liaison with Workmen's Compensation Insurance Companies—Dr. Sam N. Key, Jr., Austin, chairman; Dr. Frederick C. Rehfeldt, Fort Worth; Dr. R. G. Carpenter, Dallas; Dr. M. H. Morris, San Antonio; and Dr. Wendell H. Hamrick, Houston.

Committee to Study Infringements on Private Practice of Medicine—Dr. T. C. Terrell, Fort Worth, chairman; Dr. Laried S. Oates, Center; Dr. C. F. Crain, Corpus Christi; Dr. Neil D. Buie, Marlin; Dr. Robert A. Johnston, Houston; and Dr. Joe Nichols, Atlanta.

Appointed on the Advisory Board to the Texas Society of Medical Technologists was Dr. M. S. Hart, El Paso.

To the Texas Joint Commission for the Improvement of the Care of the Patient were appointed Dr. A. C. Scott, Jr., Temple; Dr. Truman G. Blocker, Jr., Galveston; Dr. G. E. Brereton, Dallas; and Dr. Joseph F. McVeigh, Fort Worth.

Respectfully submitted,
N. C. FORRESTER.

SUPPLEMENTARY REPORT OF EXECUTIVE SECRETARY

Honorary, Inactive, and Emeritus Membership

The list of nominations of the various county medical societies for honorary, inactive, and emeritus memberships has been printed, and a copy is available on the desk where you register as you come into this hall. That will eliminate reading this entire list each time. (The list of nominees follows:)

HONORARY MEMBERSHIP

District 1:

El Paso County Medical Society—

Dr. James W. Laws, El Paso; born 1873; member 1918-1954, 37 years.

Dr. Will P. Rogers, El Paso; born 1875; member 1906-1954, 49 years.

Dr. B. F. Stevens, El Paso; born 1874; member 1904-1954, 51 years.

Dr. James Vance, El Paso; born 1875; member 1906-1954, 49 years.

District 2:

None reported.

District 3:

Armstrong-Donley-Childress-Collingsworth-Hall Counties Medical Society—

Dr. Perry R. Jeter, Childress; no date of birth recorded; member 1929-1954, 26 years.

Lubbock-Crosby Counties Medical Society—

Dr. W. E. Payne, Slaton; born 1887; member 1915; 1917; 1920-1924; 1930-1954, 32 years.

Dr. A. C. Surman, Post; born 1887; member 1915-1917; 1923-1929; 1931-1932; 1935-1954, 32 years.

Dr. D. C. Williams, Post; born 1885; member 1915-1917; 1924; 1927-1928; 1930; 1934-1935; 1937-1954, 27 years.

Potter County Medical Society—

Dr. Robert P. Gallagher, Amarillo; born 1914; member 1953-1954, 2 years.

District 4:

Kimble-Mason-Menard-McCulloch Counties Medical Society—

Dr. John Gordon McCall, Brady; born 1876; member 1906-1954, 49 years.

District 5:

Atascosa County Medical Society—

Dr. Jeremiah Ward, Jr., Poteet; born 1879; member 1915-1918; 1944-1952; 1954, 14 years.

Bexar County Medical Society—

Dr. John B. Herff, San Antonio; born 1878; member 1904-1912; 1914; 1916-1954, 49 years.

District 6:

Cameron-Willacy Counties Medical Society—

Dr. Clarence M. Cash, San Benito; born 1864; member 1905-1954, 50 years.

Hidalgo-Starr Counties Medical Society—

Dr. Thomas W. Glass, Weslaco; born 1888; member 1923; 1929-1954, 26 years.

Dr. L. J. Montague, Edinburg; born 1894; member 1927-1928; 1930-1934; 1936-1954, 26 years.

District 7:

Travis County Medical Society—

Dr. Sam N. Key, Sr., Austin; born 1886; member 1912; 1914-1954, 42 years.

Williamson County Medical Society—

Dr. Edmond Doak, Taylor; born 1878; member 1906-1932; 1935-1950; 1952-1954, 46 years.

District 8:

None reported.

District 9:

None reported.

District 10:

Angelina County Medical Society—

Dr. L. T. Tinkle, Lufkin; born 1893; member 1919-1951; 1954, 34 years.

Jefferson County Medical Society—

Dr. D. A. Mann, Beaumont; born 1876; member 1909; 1913-1916; 1918-1954, 42 years.

Dr. J. D. Martin, Beaumont; born 1883; member 1924-1941; 1943-1954, 30 years.

District 11:

None reported.

District 12:

None reported.

District 13:

Tarrant County Medical Society—

Dr. Bertha S. McDavitt, Fort Worth; born 1877; member 1915-1954, 40 years.

Wichita County Medical Society—

Dr. Fred R. Landon, Wichita Falls; born 1902; member 1933-1954, 21 years.

Dr. Tim H. Parmley, Electra; born 1883; member 1915-1954, 40 years.

District 14:

Cooke County Medical Society—

Dr. Silas M. Yarbrough, Gainesville; born 1898; member 1926-1954, 28 years.

Dallas County Medical Society—

Dr. Guy B. Fain, DeSoto; born 1873; member 1922-1937; 1939; 1941-1952; 1954, 30 years.

Dr. W. W. Fowler, Dallas; born 1871; member 1905-1906; 1908-1954, 49 years.

Dr. Edward G. Lyon, Dallas; born 1884; member 1930; 1939-1954, 16 years.

Dr. James Madison Potts, Dallas; born 1873; member 1920-1954, 35 years.
Dr. Price M. Walker, Houston; born 1896; member 1923-1954, 32 years.
Denton County Medical Society—
Dr. Joseph H. Allen, Justin; born 1877; member 1904-1952; 1954, 50 years.
Ellis County Medical Society—
Dr. J. H. Curby, Maypearl; born 1878; member 1908; 1911; 1914; 1927-1929; 1931-1954, 30 years.
Dr. E. F. Gough, Waxahachie; born 1878; member 1908-1954, 47 years.
Dr. A. L. Thomas, Ennis; born 1875; member 1908-1954, 47 years.
Hunt-Rockwall-Rains-Delta Counties Medical Society—
Dr. Samuel D. Whitten, Greenville; born 1883; member 1915-1916; 1918-1954, 38 years.
Kaufman County Medical Society—
Dr. Percy C. Shands, Mesquite; born 1878; member 1904; 1906-1954, 50 years.
District 15:
Gregg County Medical Society—
Dr. Henry H. Niehuss, Longview; born 1876; member 1933-1952; 1954, 21 years.

Inactive Membership

District 1:
None reported.
District 2:
None reported.
District 3:
None reported.
District 4:
None reported.
District 5:
Bexar County Medical Society—
Dr. R. E. Bowen, Sr., San Antonio; born 1879; member 1908-1910; 1915; 1918-1954, 41 years.
Dr. A. O. Hull, San Antonio; born 1891; member 1917-1929; 1936-1937; 1949-1954, 20 years.
Dr. Thad Shaw, New York, N. Y.; born 1884; member 1919-1954, 35 years.
District 6:
None reported.
District 7:
None reported.
District 8:
Lavaca County Medical Society—
Dr. J. W. Boyle, Jr., Temple; born 1888; member 1920-1954, 35 years.
District 9:
None reported.
District 10:
Jefferson County Medical Society—
Dr. C. W. Fulbright, Altheimer, Ark.; born 1895; member 1925-1954, 30 years.
District 11:
None reported.
District 12:
None reported.
District 13:
None reported.
District 14:
Denton County Medical Society—
Dr. Bobby Jewell Short, Denton; born 1917; member 1946-1951; 1954, 7 years.
District 15:
None reported.

Emeritus Membership

District 14:
Dallas County Medical Society—
Dr. Oscar M. Marchman, Sr., Dallas; born 1872; member 1906-1954, 49 years.

Membership

As of today, the membership of the Texas Medical Association is as follows: regular, 5,824; intern, 184; honorary, 231; inactive, 14; military, 193; emeritus, 8; a total of 6,454, an increase of exactly 300 over this date last year. The final paid membership for 1953 was 6,721 and in that, of course, we include the honorary and inactive. It is our belief that the membership this year will exceed 7,000. The AMA membership as of this date is 5,332.

We would like to call your attention to one thing: many of you have not as yet received the new membership directory of the Texas Medical Association for 1953. This is being mailed without cost to each member whose name is in this book. The directories are being mailed alphabetically, but be patient for a few days and you will receive your copy.

Appreciation

I should like to express the appreciation of the entire staff of the Texas Medical Association and myself for the wonderful cooperation of you doctors. We realize and know that we are employees. We have nothing whatsoever to do with determining the policies of the Texas Medical Association. That is your job. But we do want to do a good job for you and we can only do that when you help us and give us constructive criticism. If something is wrong, you tell us and we will do our best to correct those errors. It is a pleasure to make this report to you and to assure you that it is our sincere desire to serve you to the best of our ability.

Respectfully submitted,
N. C. Forrester.

Speaker Deaton: The report of the Executive Secretary and the supplementary report will be referred to the Reference Committee on Reports of Officers and Committees, except that the nominations for honorary, inactive, and emeritus membership will be referred to the Board of Councilors.

The next item of business is the report of the Treasurer, Dr. Herbert Thomason of Fort Worth. I understand that Dr. Thomason is on his way to Europe to attend a meeting of the College of Surgeons. The report will be found printed, and this report also will be referred to the Reference Committee on Finance.

(The report follows:)

REPORT OF TREASURER

The facts and figures pertaining to the accounts of the Treasurer of the Texas Medical Association are reflected in the auditor's report, which will be submitted by the Board of Trustees, and to which I refer.

There is cash on hand and in the bank as of December 31, 1953, as follows:

Austin National Bank—Regular	$38,739.49
Austin National Bank—Payroll	3,859.50
American National Bank	4,809.08
Petty Cash	80.00
Total	$47,488.07

The total cash received from all sources during the calendar year, 1953, amounted to $365,541.42, and the total cash disbursed for the same period totaled $373,434.84.

Texas Memorial Medical Library Association

As Treasurer of this Association, I report the following investments of said Association as of December 31, 1953:

STOCKS AND DEBENTURES		
Building & Loan Association Stock		$ 6,000.00
American Telephone & Telegraph Stock		4.471.25
American Telephone & Telegraph Debentures		400.00
TOTAL STOCKS & DEBENTURES		$10,871.25
U. S. SAVINGS BONDS		
Series "G"	$7,000.00	
Series "F"	1,480.00	$ 8,480.00
TOTAL INVESTMENTS		$19,351.25

Summary of cash transactions of the Library Association for the calendar year, 1953, is as follows:

CASH ON DEPOSIT—January 1, 1953		$2,240.37
RECEIPTS		
Income from Investments	$ 617.73	
Donations	1,405.50	2,023.23
TOTAL CASH TO BE ACCOUNTED FOR		$4,263.60
DISBURSEMENTS		
Investors Mutual, Inc. Stock	$3,000.00	
American Telephone & Telegraph Debentures	400.00	$3,400.00
CASH ON DEPOSIT—December 31, 1953		$ 863.60

Respectfully submitted,
T. H. THOMASON, Treasurer.

We certify the above to be correct as disclosed by audits.
HOWARD T. COX & COMPANY
By Fred J. Sublette,
Certified Public Accountant.

Speaker Deaton: The next item of business is the report of the Board of Trustees, Dr. R. W. Kimbro of Cleburne, chairman.

Dr. Kimbro: Before presenting our report I would like to call to your attention two facts which are in the report. I want to make known to you Mr. E. Maxwell Jones, who is a certified public accountant and is serving as business manager of the Association. Mr. Jones is the man you saw at the registration desk. I would like all of you to know him because he is doing a splendid job.

The next new addition to the staff is Mr. Lincoln Williston. His title is assistant executive secretary, and he is the gentleman referred to as our traveling field man. Mr. Williston came to us from Chicago, where he was the manager of public relations for the University of Illinois Medical Center. His education was received in the University of Illinois, and he received the Sigma Delta Chi award as the most outstanding graduate of the university's school of journalism in 1942. He has had newspaper experience, served as a captain in the Air Force for four years, and has been chairman of the Medical Schools Section, American College Public Relations Association. I think you will find Mr. Williston most capable, and I hope you will meet him while you are here.

(Dr. Kimbro then presented the following reports:)

REPORT OF BOARD OF TRUSTEES

The Board of Trustees, since the completion of the new home, has concerned itself not only with a continuation of services that have been rendered, but also with expansion and addition of new services. The loan against the building has been reduced substantially, and the financial status of the Association is satisfactory. The membership of the Association has grown steadily for the past six years, and the actual membership for 1953 approached the 7,000 mark.

The Board, in cooperation with the Board of Councilors, is in full accord with the constitutional amendment whereby dues for honorary, inactive, and military members will be completely eliminated. It is the Board's considered opinion that the finances of the Association are now in such shape as to permit this to be done without curtailing the necessary activities of the Association.

Through the generous cooperation of Blue Cross and Blue Shield the Association has assisted in the publication of a new directory of the members. This directory is to be distributed free prior to the 1954 annual session to the members of the Association whose names appear in it.

For the past two years the Board has allocated funds to a student delegate from one of the medical schools in Texas to the annual session of the American Medical Association. Believing this to be of great importance, the Board now is allocating funds to a student from each of the three medical schools in Texas each year to attend the annual session of the American Medical Association.

In cooperation with the Committee on Public Relations the Board sponsored financially in each of the three medical schools last year a Medical Students' Day. This was received enthusiastically by the students and the faculties of the schools, and accordingly they will be sponsored again this year and enlarged upon.

Financial contributions have been made the past two years to the national essay contest sponsored by the Association of American Physicians and Surgeons. During 1953 the first and second place winners in Texas won second and third place respectively in the national contest. We believe this to be a fine gesture on the part of the medical profession in the public schools of this state, and therefore the amount of money allocated for state winners has been increased materially.

Realizing that a large percentage of the graduates of the medical schools of this state will practice medicine in Texas and in order to acquaint them with the Association and its activities as much as possible, the Board authorized and is now sending the TEXAS STATE JOURNAL OF MEDICINE to all seniors in the three medical schools.

The Board has given its cooperation and wholehearted support to the efforts of the Committees on Rural Health, Doctor Distribution, and Public Relations in their studies and surveys of rural health conditions in Texas. To show further the Association's interest in rural health problems, the Board is cooperating financially with the Council on Rural Health of the American Medical Association which met in Texas March 4-6 this year.

Personnel Changes

Miss Anna Keith, who had been with the Association for thirty years, was retired and Mr. E. Maxwell Jones, a certified public accountant, was employed as business manager of the Association. It is believed that with the tremendous increase in activities of the Association which calls for the purchase of considerable equipment and supplies, economies may be effected by the employment of a C. P. A. as business manager.

The Board has been concerned for some time with the problem of a closer liaison between the central office and the county medical societies. Texas is a large place geographically, and there are a large number of county medical societies. To resolve this problem and bring the central office and societies closer together, the Board has employed a field man, Mr. C. Lincoln Williston, who will report for duty April 1, 1954. The Board spent considerable time in interviewing candidates for this position and feels that Mr. Williston, because of his background and training, will be able to render a much needed service to the Association. It is anticipated that he will work closely with the Councilors in the various districts in their efforts to resolve problems

of the county medical societies and also to carry information regarding the activities of the central office to the membership throughout the state.

Budget for 1954

Considerable time was spent in a detailed study and analysis of the budget for 1954. This budget is available for study to any council, committee, or member of the Association. It is believed that the funds have been allocated where the greatest amount of good will inure to the members of the Association. The lists of the assets and liabilities of the Association follow in printed form. The complete audit of the Association's activities for 1953 is available upon request to the Executive Secretary of the Association.

Report of Auditor to Texas Medical Association

January 18, 1954.

Board of Trustees
Texas Medical Association
Austin, Texas
Gentlemen:

We have completed our examination of the books of account and record of the Texas Medical Association, Austin, Texas, for the calendar year 1953, and present our report.

FINANCIAL CONDITION

In our opinion, the Balance Sheet presents fairly the financial condition of the Association at December 31, 1953.

SCOPE OF EXAMINATION

Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedure as we considered necessary in the circumstances.

Should further information be desired, kindly advise us.

Very truly yours,
HOWARD T. COX & COMPANY
Fred J. Sublette,
Certified Public Accountant.

BALANCE SHEET
December 31, 1953
ASSETS

CURRENT			
CASH			
Petty Cash	$ 80.00		
Austin National Bank: Regular $38,739.49			
Austin National Bank: Payroll 3,859.50	42,598.99		
American National Bank	4,809.08	$ 47,488.07	
ACCOUNTS RECEIVABLE			
Advertising		2,189.09	$ 49,677.16
PERMANENT			
Land		$ 32,500.00	
Building	$706,107.00		
Less: Reserve for Depreciation	18,822.84	687,284.16	
Furniture and Fixtures	$101,347.95		
Less: Allowance for Depreciation	22,514.65	78,833.30	
Automobile	$ 2,120.00		
Less: Allowance for Depreciation	555.00	1,565.00	800,182.46
OTHER			
Meter Deposits		$ 23.40	
Prepaid Insurance Expense		2,679.18	
Prepaid Annual Meeting Expense, 1954		115.04	2,817.62
			$852,677.24

LIABILITIES

CURRENT			
ACCRUED			
Social Security Taxes—Title VIII	$ 315.77		
Social Security Taxes—Title IX—Texas	37.14		
Social Security Taxes—Title IX—Federal	185.57		
Withholding Tax	684.90		
Hospitalization Insurance—Employees	61.85	$ 1,285.23	
DEFERRED INCOME			
1954 Annual Meeting	$ 2,902.50		
1954 Non-Membership Subscriptions	127.50		
1954 Membership Dues	18,300.00		
1954 Advertising	2,337.00	23,667.00	
MORTGAGE PAYABLE			
Equitable Life Assurance Society of the United States		262,953.03	
NET WORTH		564,771.98	
		$852,677.24	

Report of Auditor to Texas Memorial Medical Library Association

January 16, 1954

Dr. R. W. Kimbro, President
Texas Memorial Medical Library Association
Cleburne, Texas
Dear Sir:

We have completed our examination of the books of account and record of the Texas Memorial Medical Library Association, Austin, Texas, for the calendar year, 1953, and present our report.

BALANCE SHEET

The Balance Sheet, in our opinion, correctly presents the financial position of your Association at December 31, 1953.

The income from the funds appearing on the Balance Sheet shall be for the use and benefit of libraries maintained and operated by the Texas Medical Association. The income from the Texas Pediatric Society Library Endowment Fund is restricted to use in connection with the Pediatric Service only. The proceeds of the Dr. Karl John Karnaky Fund is limited to the buying of film for the library.

The Undistributed Income includes the unexpended balance of funds as follows:

Texas Pediatric Society Library Endowment Fund	$ 92.69
Unrestricted Investment Funds	602.06
	$694.75

Should further information be desired, kindly advise us.

Very truly yours,
HOWARD T. COX & COMPANY
Fred J. Sublette,
Certified Public Accountant.

BALANCE SHEET
December 31, 1953
ASSETS

CURRENT		
Cash		
On Deposit—Austin National Bank		$ 863.60
Investments		
Equitable Building & Loan Association Stock	$ 1,000.00	
Mutual Building & Loan Association Stock	1,000.00	
Tarrant County Building & Loan Association Stock	1,000.00	
Investors Mutual, Inc. Stock	3,000.00	
American Telephone & Telegraph Stock	4,471.25	

American Telephone & Telegraph Debentures		400.00	
Total Stocks		$10,871.25	
U. S. Savings Bonds:			
Series "G"	$7,000.00		
Series "F"	1,480.00	8,480.00	19,351.25
			$20,214.85

SURPLUS

FUNDS		
Dr. and Mrs. N. D. Buie		$ 1,000.00
Dr. Martin Junius Taylor		1,000.00
Dr. and Mrs. William Thomas Carter Memorial		1,000.00
Woman's Auxiliary to the Texas Medical Association:		
G. A. Ray Memorial Fund	$1,000.00	
Romayne Ray Memorial Fund	1,000.00	
The President's Library Endowment Fund	1,000.00	
Woman's Auxiliary Library Endowment	3,005.00	6,005.00
County Medical Society Library Endowment		1,688.00
Mary Carter Owen and Mattie Hanes Brindley Memorial		1,000.00
Dr. and Mrs. V. R. Hurst		1,000.00
Dr. J. C. Terrell		1,000.00
Dr. Karl John Karnaky		209.00
Anonymous Donor		125.00
Dr. W. B. Weary		13.10
Texas Pediatric Society Library Endowment		1,000.00
Dr. and Mrs. Sam E. Thompson Memorial		1,000.00
Warner E. Williams Memorial		1,000.00
Hattie Hunt Memorial		1,000.00
Dr. D. H. Hudgins Memorial		740.00
Dr. Sterling E. Russ Memorial		740.00
Undistributed Income		694.75
		$20,214.85

Respectfully submitted,
R. W. KIMBRO, Chairman,
G. V. BRINDLEY, Vice-Chairman,
DENTON KERR, Secretary,
E. A. ROWLEY,
SAM N. KEY, SR.

SUPPLEMENTARY REPORT OF BOARD OF TRUSTEES

The Board of Trustees desires to make a supplemental report along with certain recommendations, especially in regard to the financial structure of the Association, taking into consideration the duties and obligations of the Board of Trustees in regard to the allocation of dues.

Although the Board of Trustees, under Articles IV and XI of the Constitution, is charged with the duties of handling the business affairs of the Association, and the distribution of the funds as set forth under Article IV of the Constitution and also under Chapter II, Section 6 and Chapter XIII, Section 8 of the By-Laws, it is the desire of the Board at all times to keep the House of Delegates informed of its actions, especially in regard to finances.

In this connection, the Board would like to call to the attention of the House of Delegates that in 1950 the House of Delegates provided for an increase in the dues of the Association from $35 to $50. The additional $15 dues provision was set forth under Chapter XIII, Section 2 and reads as follows: "Additional dues of $15 per capita on the membership of component county medical societies, making a total of $50 per capita per annum, shall be collected and added to the General Fund until the mortgage on the new Association headquarters and library building is retired."

In Section 8 of Chapter XIII, we find the following provision: "The Trustees may divide the General Fund, herein provided for, into such funds as may be for the best interests of the Association, and may make appropriations therefrom to meet the requirements of the Association."

It is the desire of the Board of Trustees at all times to comply with all provisions of the Constitution and By-Laws. However, there are times when the Board of Trustees, in carrying out its duties, finds it necessary to reallocate monies from one fund to another in order to act in the best interest of the Association.

The Board would like to point out that in 1948 under Chapter VIII of the By-Laws, Section 5, the powers and duties of the Council on Medical Defense were set forth. In the second paragraph of Section 5 was this provision: "The Medical Defense Fund shall be a special fund entrusted to the Board of Trustees for investment and re-investment. The annual income of the fund shall be allocated to the payment of benefits to the members in good standing of the Association, and the balance remaining shall revert either to the corpus of the Medical Defense Fund or to the General Fund. *No loan shall be made from the corpus of this fund to any other activity of the Association*" (emphasis added).

Since the House of Delegates instructed the Board of Trustees to build a headquarters and Library building, it was therefore dependent on the Board of Trustees to utilize such funds as were available in the different accounts of the Association to make payments for the building as they became due.

On December 31, 1949, there was $44,444.11 in the Medical Defense Fund, and in 1950 the House of Delegates amended this Section 5, Chapter VIII so that it now reads as follows: "The Medical Defense Fund shall be a special fund entrusted to the Board of Trustees for investment and re-investment, *and such other purposes as the Board shall determine.* The annual income of the fund shall be allocated to the payment of benefits to the members in good standing of the Association, and the balance remaining shall revert either to the corpus of the Medical Defense Fund or to the General Fund."

Therefore, after this change was made by the House of Delegates, the Board of Trustees utilized the monies then in the Medical Defense Fund for the purpose of making payments on the amounts due for the construction of the building. At this time, there is a balance owed by the General Fund to the Medical Defense Fund of $61,198.90.

It is the understanding of the present Board of Trustees that there was an understanding between the Council on Medical Defense and the Board of Trustees that the funds borrowed from the Medical Defense Fund by the General Fund would be repaid as soon as possible.

It is the feeling of the Board of Trustees at this time that after meeting the payments due to Equitable Life Assurance Society of the United States, whatever portion of the $15 as set up under Chapter XIII, Section 2 remains should be utilized to repay the monies borrowed from the Medical Defense Fund since that money was used for payments on construction of the building. Also, in view of the increase in malpractice suits that are being filed against physician members in Texas and the increase in malpractice insurance rates, the Council on Medical Defense should have adequate funds to render assistance to any member of the Association against whom a malpractice suit is filed.

The Board of Trustees would like to call to your attention that all of the surplus monies of the Association on hand at the time the contract for construction of our Library building was made were utilized in paying for the construction of the building. This included, among other things, money from the sale of United States savings bonds and certain stocks that belonged to the Association. It is the

feeling of the Board of Trustees that these funds also should be repaid so that in case of any emergency the Association would have at least some monies in reserve so that the best interest of the Association and its members could be protected and that an additional assessment would not have to be levied by the House of Delegates.

While it is the opinion of members of the Board of Trustees that they have the authority under the Constitution and By-Laws to carry out the policies as set forth above, it was felt in this case it would be in order to present the matter to the House of Delegates with the following recommendations:

1. That after making payments due under the note and mortgage to the Equitable Life Assurance Society of the United States, any part of the monies remaining from the $15 allocated to pay off the loan on the building be utilized to repay the monies borrowed from the Medical Defense Fund.

2. That the reserve funds of the Association which were utilized by the Board of Trustees in making payments on the construction of the building be repaid also from any unused portion of the $15 allocated for the construction of the building.

For the information of the House of Delegates, under the note and mortgage with the Equitable Life Assurance Society, the Association is required to pay $2,514.90 per month or a total of $30,178.80 per year. The note bears 4 per cent interest. The Association has made the following advance payments, over and above that required by the note, as follows: November 28, 1952, $30,000; March 10, 1953, $30,000; May 21, 1953, $40,000; September 15, 1953, $30,000; or a total of $130,000.00 that has been prepaid on our note, leaving at this time an unpaid balance of $255,506.56.

It is the intention of the Board of Trustees, if the above recommendations meet with the approval of the House of Delegates, to repay the monies borrowed from other funds of the Association and, when they are repaid, make advance payments on our loan as often as possible.

Respectfully submitted,
R. W. KIMBRO, Chairman,
G. V. BRINDLEY, Vice-Chairman,
DENTON KERR, Secretary,
E. A. ROWLEY,
SAM N. KEY.

Speaker Deaton: You have heard the report and the supplemental report of the Board of Trustees. This is referred to the Reference Committee on Finance. The next item of business is the report of the Board of Councilors, Dr. R. G. Baker of Fort Worth, chairman.

Dr. Baker: The report is submitted as printed:

REPORT OF BOARD OF COUNCILORS

The usual meetings of the Board of Councilors have been held, with complete attendance at almost every meeting. Disposition has been made of all matters before the Board at each of its meetings.

Several other meetings have been attended by individual Councilors, or committees from the Board of Councilors, furnishing and receiving information and advice on matters not the sole concern of the Board.

Cooperation and help have been given to and received from various officers, councils, and committees with benefit to all concerned.

An interlocking liaison has been established with the Texas Pharmaceutical Association to handle possible interprofessional disputes and to promote a better relationship between doctors and druggists. This was accomplished by a committee from the Board of Councilors and a committee from the Pharmaceutical Association.

The Board is participating in certain contemplated and current action to effect closer cooperation between various agencies of the Texas Medical Association, seeking to eliminate some overlapping and at times conflicting activities.

Several intradistrict changes have been made by rearranging county society jurisdictions to meet population changes of local nature.

A good many questions, which are answered clearly in either the State Association's Constitution and By-Laws or the Principles of Medical Ethics of the American Medical Association, are submitted to the Board of Councilors for rulings. Copies of these documents are, or should be, in the possession of each county medical society. They explain, among other things, individual conduct and obligations of members and the responsibilities and actions of county medical societies.

For the first time in several years a disciplinary action of a county medical society has been appealed to the Board of Councilors, where it was upheld. An appeal then was carried to the Judicial Council of the American Medical Association, which sustained the original county society action and the appeal action of the Board of Councilors.

It is expected that a supplementary report from the Board of Councilors will be submitted to the House of Delegates.

Recommendation

The Board strongly recommends that county society members, especially officers, familiarize themselves with those portions of the Association's Constitution and By-Laws and of the Principles of Medical Ethics of the American Medical Association dealing with the individual conduct and obligations of members and the responsibilities and action of county medical societies.

Respectfully submitted,
R. G. BAKER, Chairman,
J. T. BILLUPS, Secretary.

Speaker Deaton: The report of the Board of Councilors is referred to the Reference Committee on Reports of Officers and Committees.

The next item of business is the report of the Delegates to the American Medical Association; Dr. Copeland will present that report.

Dr. J. B. Copeland, San Antonio: At the request of Dr. Robert B. Homan of El Paso, who is chairman of the delegation, I make this report:

REPORT OF DELEGATES TO AMERICAN MEDICAL ASSOCIATION

There were three mandated resolutions from the House of Delegates last year requesting the delegation from Texas to submit the resolutions to the House of Delgates of the American Medical Association.

Extension of Social Security

The first resolution was as follows:

"*Whereas*, among the few remaining groups of self-employed individuals in this nation not now included in Social Security coverage are many who prefer to exercise their God-Given right to provide for themselves in their own old age; and

"*Whereas*, the extension of Social Security was a campaign promise of President Eisenhower; and

"*Whereas*, legislation now proposed and pending com-

mittee action is intended to accomplish this campaign promise; and

"*Whereas,* legislation now proposed further attempts to increase vastly the scope of federal medical and hospitalization care; and

"*Whereas,* the Board of Trustees and the House of Delegates of the American Medical Association have shown no inclination to oppose the present administration; therefore be it

"RESOLVED, by the House of Delegates of the Texas Medical Association in regular session assembled this twenty-sixth day of April, 1953: That the delegates from the Texas Medical Association be instructed to present a resolution to the American Medical Association through the House of Delegates of the American Medical Association demanding unequivocal opposition to any extension of Social Security; and be it further

"RESOLVED: That a copy of this resolution be spread upon the minutes of this meeting, and that copies be sent to:

1. All delegates to the American Medical Association;
2. Officers and chairmen of committees of the American Medical Association;
3. Officers of the Association of American Physicians and Surgeons;
4. The president of each state medical association with a letter suggesting that the medical association of his respective state take similar action at the earliest possible moment."

This resolution was introduced in the House of Delegates of the American Medical Association by Dr. Robert B. Homan, Jr., and the policy as set forth in the resolution was adopted as the policy of the American Medical Association. Only recently, Dr. F. J. L. Blasingame of Wharton appeared before the House Ways and Means Committee of Congress testifying in opposition to the extension of social security.

Public Condemnation of Physicians

The second resolution was as follows:

"*Whereas,* the President of the Texas Medical Association stressed the necessity of harmony within the profession; and

"*Whereas,* certain spokesmen for an allied medical organization, and certain physicians who have written articles, have in recent months made statements for publication that would tend to divide the doctors into warring groups and undermine the confidence of the public in the physician of their choice; and

"*Whereas,* the support of newspapers and magazines has been openly sought by these groups in fighting an alleged evil, instead of the usual courses open to them through the offices of the parent organization, namely, the American Medical Association; and

"*Whereas,* many of the statements of these spokesmen for some of the allied medical organization are (1) beneath the dignity that doctors strive to attain for their profession, and (2) inclined or intended to cast aspersions upon, arouse suspicions against, or undermine the public confidence in any particular group within the medical profession; therefore be it

"RESOLVED: That the House of Delegates of the Texas Medical Association call attention to its delegates to the AMA to this serious breach of etiquette and of ethics; and be it further

"RESOLVED: That the delegates be instructed to support a reasonable measure which will discipline the offenders or prevent the recurrence of unwarranted attack on one group of physicians by another, and be it further

"RESOLVED: That the Texas delegation to the AMA endorse and support any reasonable regulation that would severely discipline any individual or group of doctors or spokesmen for them that would enlist the aid of the newspapers or magazines to condemn any group of physicians until they have been duly charged and convicted by our own regulatory bodies; and be it further

"RESOLVED: That the Texas delegation to the AMA, in order to implement a reasonable regulatory procedure which would prevent recurrence of these unfortunate articles in the lay press, introduce a resolution at the June session of the AMA House of Delegates which would incorporate a press, radio, and television code at the national level with authority to regulate and pass on medical press, radio, and television releases by members of the American Medical Association."

The above resolution, generally referred to as the Hawley resolution, was introduced in the House of Delegates of AMA by Dr. J. B. Copeland of Texas, and there were ten other resolutions covering the like subject from the following nine states: California, Florida, Illinois, Minnesota, New York, Oklahoma, Pennsylvania, West Virginia, and Wisconsin.

As you know, these resolutions were stimulated by recent newspaper and magazine articles reporting statements attributed to an official spokesman of an allied medical organization, Dr. Paul R. Hawley of the American College of Surgeons. The members of this organization are also members of the American Medical Association, and recognizing the importance of the general problem involved and the interest of the public, as well as that of the profession, the reference committee of the AMA held open hearings on the matters contained in these resolutions. All of the resolutions were carefully studied, including the one from Texas, and the reference committee took no action on these resolutions but instead requested the House of Delegates to give careful objective consideration to the ethical problem involved. It was felt that the Principles of Medical Ethics as formulated, interpreted and applied by the American Medical Association, must be considered the only fundamental and controlling application of ethics for the entire profession and that any statement relating to ethical matters by other organizations, within the general profession of medicine, advances views of only a particular group and is without official sanction of the entire profession as represented by the American Medical Association.

It was the feeling of the reference committee of AMA, in considering the resolutions, that the harm done to the profession by the current articles in the national publications, which lower the confidence of patients in their doctors, cannot be objectively evaluated. This highlights the fact that when individuals or groups without official status in the AMA or its component county societies utter or publish ill-considered statements, the result is too often that the confidence of the public in the medical profession is placed in jeopardy.

Federal Medical Services

The third resolution was as follows:

"*Whereas,* a great many of the patients being treated at taxpayer's expense in Veterans Administration hospitals are being treated for nonservice-connected disabilities; and

"*Whereas,* undoubtedly many of these patients are able to pay for their medical care, or, if indigent, can be provided such care at less cost by local communities; and

"*Whereas,* the Special Committee on Federal Medical Services, appointed by the Board of Trustees of the American Medical Association, recommended to the American Medical Association House of Delegates in Denver, December 2, 1952, that it go on record as opposing the care of nonservice-connected disabilities in Veterans Administration hospitals; and

"*Whereas,* the Booz, Allen, and Hamilton survey recommends that Congress look into this problem of federal care, via the Veterans Administration of nonservice-connected disabilities; and

"*Whereas,* the Hoover Commission and other independent agencies have called attention to the extravagant building program of the Veterans Administration, the careless expenditure of funds in government hospitals, and the wasteful use of medical and nursing talent in these institutions; and

"*Whereas,* an elected representative of the American Legion, speaking before the American Medical Association House of Delegates in Denver in December, 1952, denounced those 'chiselers' who are bringing the medical services of the Veterans Administration into disrepute with the taxpayers—both lay and physician; and also

"*Whereas,* the House of Delegates of the American Medical Association has resolved, with admirable restraint, to await the outcome of a proposed conference of the appropriate committees of (1) Congress, (2) the Veterans Administration, (3) the American Legion, and (4) the American Medical Association, before adopting the recommendations of the Special Committee on Federal Medical Services; therefore be it

"RESOLVED by the House of Delegates of the Texas Medical Association in regular session on this twenty-ninth day of April, 1953: That the delegates of the Texas Medical Association be instructed to present a resolution to the American Medical Association through the House of Delegates of the American Medical Association requesting the continuation of the efforts of the American Medical Association to bring about changes in legislation which will correct the existing evils which are permissible by the present existing laws."

This resolution was introduced in the House of Delegates of the AMA by Dr. Robert B. Homan, Jr., and was referred to the Reference Committee on Insurance and Medical Service, and was one of many like resolutions from other states.

After several hours of open hearings and lengthy executive sessions of the reference committee, the following report was made:

"Your Committee recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

"(a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated; and

"(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of nonservice-connected origin, who are unable to defray the expenses of necessary hospitalization.

"Your Committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with nonservice-connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs.

"The recommendation of the Committee with respect to the treatment of veterans with tuberculosis and neuropsychiatric disorders of nonservice origin in federal hospitals is believed necessary at this time because of the inadequacy of local facilities designed to provide treatment for all such cases. It is the feeling of the Committee, however, that the entire question of whether the care of these patients is a local or a federal responsibility must be reanalyzed by the Congress. The rapidly expanding veteran population and the need for facilities for the remainder of our citizens afflicted with these diseases suggests that community facilities must be developed under state or local administration for the benefit of all. Preferential treatment for veterans with these nonservice-connected disabilities cannot be continued indefinitely, in view of its detrimental effect on the health and the economy of the entire nation.

"In conclusion, your committee would like to stress the fact that these recommendations do not suggest any limitation or impairment of the hospitalization or medical care now available to veterans who have become physically handicapped as a result of military service. Your committee is in complete accord with that program.

"Your committee also recommends most earnestly that all of the facilities of the American Medical Association and of its constituent state and component county societies be employed immediately to disseminate background information and accurate statistical data in this regard. Every effort should be made to inform the profession and the public concerning the nature of the problem, the position of the American Medical Association and the reasons on which that position is predicated."

Federal Legislation

It is the recommendation of the delegates of the American Medical Association that all members of the House of Delegates carefully read the report of the Council on Medical Jurisprudence as it sets forth many important pieces of federal legislation that are now being considered by the national Congress and also presents the views of the AMA and the action and recommendations of the Council on Medical Jurisprudence of the Texas Medical Association.

We respectfully request that each member of this House of Delegates contact his Congressmen and Senators concerning matters pending in the national Congress as set forth in the report of the Council on Medical Jurisprudence and make his views known to them and find out what their views are on these subjects.

Relations Between Osteopathy and Medicine

Also presented to the House of Delegates of the American Medical Association was the report of the Committee for the Study of Relations Between Osteopathy and Medicine.

The House of Delegates of AMA recommended that this be passed over by the House of Delegates and referred to the component state associations for their consideration before final action is taken by the House of Delegates of the AMA.

In this connection, we have a resolution to offer:

Whereas, the House of Delegates of the American Medical Association has referred to each state medical association the thought-provoking report of the special Committee for the Study of Relations Between Osteopathy and Medicine, headed by Dr. J. L. Cline as chairman; and

Whereas, the officials of the American Osteopathic Association apparently have not yet made known any desire for a comprehensive collaboration with the medical profession on any of their problems; and

Whereas, there is no apparent tendency by the existing colleges of osteopathy to abandon or abrogate the original concepts which made the practice of osteopathy a cult; and

Whereas, there is some overlapping of interests and responsibilities in the matter of public health between the medical profession and the practitioners of osteopathy, therefore be it

RESOLVED by the House of Delegates of the Texas Medical Association:

1. That we express our sincere appreciation to Dr. Cline and his committee members for a thorough and interesting review of the matter of the relationship of the medical profession to osteopathy.

2. That it is our opinion that further progress on the possible solution of any mutual problems of medicine and osteopathy can come only when responsible officials of the American Osteopathic Association shall manifest a sincere desire to discuss mutual problems, and when the colleges of osteopathy shall give evidence of abandoning or abrogating the original concepts which classify the practice of osteopathy as a cult.

3. That we suggest that the present special committee of the Board of Trustees, headed by Dr. Cline, be continued, to stand ready at any time, upon the proper expressed desire of responsible officials of the American Osteopathic Association, to study further any problems of mutual concern to the medical profession and osteopathy, with further reports back to the House of Delegates of the American Medical Association as worth-while mutual studies are requested and carried out.

4. That a copy of these resolutions be presented to the House of Delegates of the American Medical Association at the forthcoming session in San Francisco.

Respectfully submitted,

ROBERT B. HOMAN, JR., Chairman,
T. C. TERRELL,
M. O. ROUSE,
J. B. COPELAND,
A. C. SCOTT, JR.,
JOHN K. GLEN.

Speaker Deaton: This report will be referred to the Reference Committee on Reports of Officers and Committees except the resolution, which will be referred to the Reference Committee on Medical Service and Public Relations.

This brings us to the reports of the several councils of the Association. The first is the report of the Executive Council; Dr. George Turner of El Paso will make the report.

Dr. Turner: That report is published:

REPORT OF EXECUTIVE COUNCIL

The Executive Council met in the Sam Thompson Room of the Association headquarters building on September 13, 1953, and again on January 24, 1954.

Dr. George Turner, President, Texas Medical Association, presided at both sessions. The question of nonservice-connected medical care for war veterans in Veterans Administration hospitals was discussed at length. President Turner summed up the situation as follows: "The Association's position is that medical care and treatment for nonservice-connected disabilities should be paid for by the veteran himself or be made the responsibility of his respective community."

Dr. C. M. Cash of San Benito was presented the General Practitioner's Plaque for 1953.

Reports of the councils and committees were presented at each session of the Executive Council. These reports appear under individual listing and should be given careful attention. The Council on Medical Jurisprudence stressed the importance of the members of the Association being informed of the membership of the following state boards:

State Board of Health—Dr. J. B. Copeland, San Antonio, chairman; Dr. George Turner, El Paso, vice-chairman; J. P. Burden, San Angelo; Dr. O. B. Kiel, Wichita Falls; A. C. Sloan, D.D.S., Dallas; Dr. F. W. Yeager, Corpus Christi; Dr. Hampton C. Robinson, Houston; Elmer C. Baum, D. O., Austin; and J. T. Stryker, Woodville.

Board for Texas State Hospitals and Special Schools—James Marvin Windham, Livingston, chairman; J. R. Hill, Dallas, vice-chairman; Mrs. Lawrence Tarlton, Fort Worth; Dr. James Wooten, Columbus; Rufus Higgs, Stephenville; Durwood Manford, Smiley; Claud Gilmer, Rocksprings; Dr. Raleigh R. Ross, Austin; and John Dudley, Houston.

State Board of Medical Examiners—Dr. H. L. Klotz, Austin, president; Everett W. Wilson, D. O., San Antonio, vice-president; Dr. M. H. Crabb, Fort Worth, secretary; Dr. L. H. Denman, Lufkin; Dr. Howard O. Smith, Marlin; Dr. Chester B. Gardner, Merkel; Dr. Cecil Greer, Houston; R. L. Martin, D. O., Mt. Pleasant; R. H. Peterson, D. O., Wichita Falls; Dr. J. G. Rodarte, Temple; Dr. Wendel A. Stiles, Dallas; and Dr. Denton Kerr, Houston.

The January meeting was preceded one day by the third annual meeting of the presidents and secretaries of county medical societies. Featured on this program were Dr. Frank Wilson, director of the American Medical Association Washington office; Dr. Everett C. Fox of Dallas; and Dr. F. J. L. Blasingame, Wharton, President-Elect of the Texas Medical Association.

Dr. M. O. Rouse, Dallas, chairman, Council on Medical Education and Hospitals, asked the members to contact Governor Allan Shivers and urge that he present to the proposed special session of the Legislature the need of funds for the medical schools of Texas.

Members of the Woman's Auxiliary to the Texas Medical Association were in attendance at each meeting of the Council.

The Executive Secretary reported a membership in the Association of 6,713 at the close of the fiscal year on December 31, 1953. His report showed 5,751 Texas doctors belonging to the American Medical Association; 250 more members would increase the delegates from Texas to the AMA to seven.

Respectfully submitted,
GEORGE TURNER, President,
N. C. FORRESTER,
Executive Secretary.

Speaker Deaton: The report of the Executive Council will be referred to the Reference Committee on Reports of Officers and Committees. The next report is that of the Council on Medical Defense, Dr. McGehee, chairman.

Dr. Charles L. McGehee, San Antonio: In addition to the printed report we have a supplemental report which we would like to submit. (The reports follow:)

REPORT OF COUNCIL ON MEDICAL DEFENSE

The Council on Medical Defense has been active this year in working with the medical schools in order that an adequate program covering medical jurisprudence could be taught in the three medical schools in Texas.

It has been the feeling of this Council that many modern-day questions should be added to the teaching of a course in medical jurisprudence in order that the young physician will have a working knowledge of present-day medical jurisprudence when he starts to practice medicine. The Council has received splendid cooperation from the medical schools, and it is the intention of the Council to continue its work along these lines.

Malpractice Coverage

Also, it is the intention of the Council to make a study of malpractice conditions in Texas at a very early date. Among the questions that have confronted the Council is one pending at the present time in which the National Bureau of Casualty Underwriters has filed an application

with the Board of Insurance Commissioners for increased rates for malpractice coverage. The Council has made a study of this matter and will appear before the Board of Insurance Commissioners in opposition to the filing for rate increase as made by the National Bureau of Casualty Underwriters.

Based on the information the Council has been able to obtain from the Medical Protective Company, which covers approximately 80 per cent of the physicians in Texas, the Council does not feel that the request made by the National Bureau of Casualty Underwriters is sound. The Council has had occasion to obtain the actuarial experience, premium income, and loss ratio from the Medical Protective Company, and based on this information, if any increase at all is justified, it should not exceed over 10 per cent of the present premium. In the request filed by the National Bureau of Casualty Underwriters, an organization composed of quite a number of the casualty companies which write approximately 20 per cent of the malpractice business in Texas, the premium would increase for example, from $25 to $40 on $5,000 to $15,000 coverage for physicians not doing major surgery and from $25 to $60 for the $5,000 to $15,000 coverage on those doing major surgery.

The Council will cover this matter more thoroughly in a supplemental report to be presented to the House of Delegates at the annual meeting.

The Council wishes to thank the membership of the Council on Medical Economics, the Board of Trustees, and the officers of the Association, in joining in opposition to the rate increase as requested by the National Bureau of Casualty Underwriters. The Council would like to commend the Medical Protective Company of Fort Wayne, Ind., for its cooperation in furnishing the information giving the experience of the company which does cover approximately 80 per cent of those carrying malpractice insurance in the state.

Respectfully submitted,
CHARLES L. MCGEHEE, Chairman,
JOE NICHOLS,
P. M. KUYKENDALL,
HAROLD M. WILLIAMS,
JOHN H. WOOTTERS,
GEORGE TURNER (ex-officio),
N. C. FORRESTER (ex-officio).

SUPPLEMENTARY REPORT OF COUNCIL ON MEDICAL DEFENSE

The Council on Medical Defense files this supplemental report concerning the action of the Board of Insurance Commissioners in granting an increase for malpractice insurance.

As will be found in the original report of the Council, an application for increased rates for malpractice insurance was filed by the National Bureau of Casualty Underwriters with the Board of Insurance Commissioners under date of February 26, 1954.

The National Bureau of Casualty Underwriters is an organization which represents numerous casualty companies writing multiple lines of insurance, which includes fire, casualty, and other types, of which malpractice insurance for physicians is one phase.

This Council has made a diligent effort to obtain a list of the companies that are members of the National Bureau of Casualty Underwriters which write malpractice insurance in Texas, and based on the information received from a representative of the Casualty Division of the Board of Insurance Commissioners, the following companies do write malpractice insurance in Texas. The Council is endeavoring to give not only the name, but to the best of its ability the number of physicians that they cover with insurance.

Company	*Texas Physicians Covered*
MEMBERS OF NATIONAL BUREAU OF CASUALTY UNDERWRITERS	
Aetna Casualty and Surety Company	806.5
American Surety Company of New York	?
Fidelity and Casualty Company of New York	36.0
Glens Falls Indemnity Company	8.0
Hartford Accident and Indemnity Company	453.0
Metropolitan Casualty Company of New York	168.3
National Surety Corporation	19.0
New Amsterdam Casualty Company	227.3
Travelers Indemnity Company	69.8
United States Casualty Company	4.0
NOT MEMBERS OF NATIONAL BUREAU OF CASUALTY UNDERWRITERS	
Continental Casualty Company, Chicago	1.0
Employees Liability Assurance Corporation	32
General Accident, Fire, and Life Company	6.0
American Employees Insurance Company	29.2
St. Paul Mercury Indemnity Company	253.2
American Casualty Company	42.6
Service Mutual Company	12.7
Medical Protective Company	In excess of 4,100

The names of the companies and the number of physicians insured represent the latest information available on file with the Casualty Division of the Board of Insurance Commissioners and in most cases represent the figures filed with the commission in 1951. The information on Medical Protective Company represents the latest information obtained from that company as of April 30, 1954.

At the hearing before the Casualty Commissioner and his technical staff, held on March 25, 1954, as reported in the Council's original report, the Texas Medical Association was represented by many of its key officers and council chairmen and other representatives. The National Bureau of Casualty Underwriters was represented by R. L. Jewell, Jr.; H. H. Winn represented the loyalty group which included Metropolitan Casualty; and Robert Lancaster, general manager of the Medical Protective Company, appeared and submitted in detail the position of the Medical Protective Company. Mr. Lancaster stated that insofar as his company was concerned, based on its premium income and loss ratio, a 10 per cent increase in rates was all his company felt would be justified.

For the information of the House of Delegates, the Council is listing below the experience in Texas covering a period of five years, showing the loss ratio by year of the Medical Protective Company:

Year	Loss Ratio (%)
1949	54.59
1950	28.73
1951	38.74
1952	26.03
1953	64.44

A jump will be noted in the loss ratio from 1952, when it was 26.03 per cent losses, to 1953, when it was 64.44 per cent; however, the average for the five years was 42.54 per cent.

The Council obtained information on April 30, 1954, that the rates in table 1 would be in effect on May 24, 1954. Also, for the first time in the history of our state, based on the filing of the National Bureau of Casualty Underwriters, physicians and surgeons are separated, which this Council thinks is inadvisable and is not a sound basis to be followed.

It will be noted from the table of rates that on a 25/75 insurance policy the rate has increased 33⅓ per cent and that on the 5/15 insurance policy, it exceeds 50 per cent. Based on the experience of the company carrying the coverage of over 4,100 physicians carrying malpractice insurance coverage, the increase is completely out of line.

TABLE 1.—*Malpractice Insurance Rates in Texas.*

	Rate Before 5/24/54 $2,500/$7,500	Rate 5/24/54 $2,500/$7,500	Rate Before $5,000/$15,000 5/24/54	Rate $5,000/$15,000 5/24/54
Physicians	$20.00	$30.00	$25.00	$38.00
Employed physicians	6.67	10.00	8.33	12.50
Physicians in military service	....	....	15.00	15.00
X-ray therapy by insured physician	30.00	46.00	50.00	57.00
X-ray therapy by employed physician	10.00	15.00	16.67	19.00
X-ray therapy by physician in military service	....	....	*	22.50
Partnership liability	33⅓%	33⅓%	33⅓%	33⅓%
Surgeons	20.00	30.00	25.00	38.00
Employed surgeons	6.67	10.00	8.33	12.50
Surgeons in military service	....	....	15.00	15.00
X-ray therapy by insured surgeon	30.00	46.00	50.00	57.00
X-ray therapy by employed surgeon	10.00	15.00	16.67	19.00
X-ray therapy by surgeon in military service	....	....	*	22.50
Partnership liability	33⅓%	33⅓%	33⅓%	33⅓%
Employed technicians	10.00	14.00	12.50	15.00
Employed technicians—x-ray therapy	10.00	10.00	12.50	13.00
Shock therapy by physician or surgeon	....	....	....	38.00
Shock therapy by employed physician or surgeon	....	....	....	12.50
Shock therapy by physician or surgeon in military service	....	....	*	15.00

*No additional rate for this coverage.

Texas is the only state in the Union at this time operating under a rating law. The law eliminates competitive rates between the companies desiring to write this type of business. Based on the action taken in increasing the rates, the Council feels it is absolutely unnecessary and discriminatory, and is considering the possibility of appealing from the action of the Insurance Commissioner authorizing the increase. If redress is not obtained by court action—if it is decided to take court action—then it will be necessary to present a bill in the Legislature repealing the rating law and allowing companies to operate on a competitive basis and on the basis of free enterprise. Such a bill would give the Board of Insurance Commissioners authority to examine the financial stability of the company and to see that the company is operating on a sound basis financially, but would allow a company to make a filing on a rate that it feels is fair to the insured.

In order that this may be accomplished, the Council recommends that all component county medical societies be alerted to contact their Senators and Representatives and discuss this matter in detail with them, asking for their active support and assistance in repealing this unfair and discriminatory law.

The Council feels that it is absolutely unfair to physicians of this state to be placed at the mercy of the companies writing a very small percentage of the malpractice insurance coverage in Texas. On the present basis, they can come in from time to time and, while writing a small percentage of the business, keep insisting year after year on increases in rates; this is not the first time the same group has filed with the commission an application for rate increase and also other types of filing which the Council feels are detrimental to the medical profession in Texas.

It is the opinion of this Council that the rate increase allowed by the commission could result in the physicians of Texas paying additional premiums in excess of $120,000 per year.

The Council recommends that each individual physician study the new rate increase, the experience of the company listed above as carrying the largest amount of coverage of physicians in Texas, and see the amount of coverage carried by the other companies which are requesting this filing. The bureau companies insure only 20 per cent of the doctors in Texas while the other companies insure 80 per cent. The bureau companies which requested the rate increase informed the Casualty Commissioner and his technical staff that their loss ratio had been approximately 183 per cent but they requested only a 100 per cent increase in rates, along with some other requests which will put an additional cost on the physicians of this state, such as the 33⅓ per cent of the base premiums where there are partners, which this Council does not feel is justified.

The filing of the National Bureau companies is based on a national experience as required under the Texas rating law, instead of the experience of companies operating and doing business and using only their experience in Texas. It is definitely unfair to the physicians of Texas, where the experience is good, to be thrown into a common experience with other states, where the experience is extremely bad. It is the feeling of this Council that if the companies experiencing this large loss ratio cannot operate on a basis equal to that of the Medical Protective Company, which has the largest coverage of physicians of any company in the state, then they should cease writing the business if they so desire.

It has been brought to the attention of this Council that some of the companies would not write malpractice coverage unless they could obtain most of the other insurance, such as automobile coverage, fire, and other types of casualty insurance.

Recommendations

There are many other phases of this matter that could be discussed at great length; however, it is the desire of the Council on Medical Defense to make the following recommendations:

1. That the Council on Medical Defense, the Board of Trustees, and the Council on Medical Jurisprudence take the necessary action to eliminate the unfairness of the Texas rating law.

2. That each physician in Texas be presented a copy of this report with the request that he take the matter up with his Senator and Representative and seek their support in repeal of the Texas rating law.

3. That each physician in Texas be furnished a list of the companies which are members of the National Bureau of Casualty Underwriters and write malpractice insurance in Texas and which, as members of the National Bureau of Casualty Underwriters, sought and obtained this unfair and discriminatory rate increase.

The Council on Medical Defense wishes again to commend the Medical Protective Company for its cooperation with this Council in furnishing its experience on premium income and losses and other pertinent information which has been of great assistance.

It is the feeling of the Council on Medical Defense that

in order to carry out its proper functions as set forth in the Constitution and By-Laws, it is necessary that adequate funds be made available so that the interest of the members of the Association can be adequately protected. Therefore, the Council is requesting that the Board of Trustees repay to the Medical Defense Fund the monies that were borrowed from said fund and used in the construction of the Library building. If the funds cannot be paid at one time, it is requested that the funds be repaid as soon as possible.

Respectfully submitted,
CHARLES L. MCGEHEE, Chairman,
JOE NICHOLS,
P. M. KUYKENDALL,
HAROLD M. WILLIAMS,
JOHN H. WOOTTERS,
GEORGE TURNER (ex-officio),
N. C. FORRESTER (ex-officio).

Speaker Deaton: These reports will be referred to the Reference Committee on Medical Service and Public Relations. The next report is from the Council on Medical Jurisprudence, Dr. Copeland.

Dr. J. B. Copeland, San Antonio: The Council on Medical Jurisprudence in addition to the printed report has also a supplemental report with information that we desire to make available to you. (The reports follow:)

REPORT OF COUNCIL ON MEDICAL JURISPRUDENCE

During the past year, the Council on Medical Jurisprudence has been active in its support of the Bricker Amendment, which is pending in our national Congress, and shall continue to support actively that amendment until it is finally disposed of.

It was during the first session of the Eighty-Third Congress that Senator John Bricker of Ohio and sixty-three cosponsors introduced S. J. R. 1, which proposed the adoption of a Constitutional amendment limiting the treaty making authority. This resolution was referred to the Senate Judiciary Committee along with S. J. R. 43, which was sponsored by the American Bar Association. On June 15, 1953, the committee submitted a favorable report on S. J. R. 1, with amendments, and recommended that it be adopted. The amended version of the resolution, as approved by the committee, stipulated that any provision of a treaty that violated the Constitution would be invalid and that the treaty power could be used to establish or modify internal law in the United States only through the enactment of domestic legislation that could have been adopted in the absence of such treaty.

It has been of paramount interest to the medical profession that the Bricker Amendment be adopted. It is important first to recognize the fact that treaties become the supreme law of the land if ratified by two-thirds of the Senate present and voting. In addition, it must be noted that significant changes have occurred during the past few years in the scope of treaties and executive agreements negotiated by the executive branch of the government. Although these instruments formerly involved only international matters, there are now pending treaties or executive agreements, the ratification of which would change our domestic laws.

In the health field three specific situations can be explored. They deal with the activities of the United Nations treaties of friendship with other countries and the conventions of the International Labor Organization. The United Nations charter, which was ratified in 1945, has two general sections that lay the framework for broad treaty provisions in the field of health.

Article 55 provides in part "The United Nations shall promote solutions of international, economic, social, health and related problems." Article 56 provides that ". . . all members of the United Nations pledge themselves to take joint and separate action in cooperation with the organization for the achievement of the purposes set forth in Article 55."

Agreements and treaties negotiated pursuant to these provisions could fundamentally change medical practice in this country if ratified by two-thirds of the Senate present and voting.

The second example deals with a series of friendship treaties that were before the Senate this past year. These include treaties with Denmark, Holland, Israel, and Greece, which dealt with immigration quotas, citizenship requirements, and *matters of professional licensure in the various states.* If these treaties had been ratified as originally prepared, some of the requirements of the state medical licensing boards, as set by the law of the individual states, would have been abrogated.

The International Labor Organization, an affiliate of the United Nations, in June, 1952, adopted a convention known as the "Minimum Standards of Social Security." This convention includes almost all of the socialistic medical proposals that until now have been rejected by the Congress. If this convention is ratified under the existing provision of the Constitution, government control of medicine will have been achieved. Because of the danger of the socialization of medicine by international treaty, the American Medical Association, supported by the component state medical associations, favors a redefinition of existing treaty-making powers.

A modified version of the Bricker Amendment was reported favorably by the Senate Judiciary Committee, as indicated above, on June 15, 1953. During the discussion of the amendment on the floor of the Senate numerous amendments to the resolution were presented. In voting on the resolution. the Senate considered the matter section by section. The most controversial and the one of greatest interest to the medical profession was the section which provided that executive agreements and treaties should become effective as internal law in the United States only through the enactment of legislation by the Senate and House of Representatives. The Senate defeated this section by a vote of fifty to forty-two. The next move was on a motion by Senator Wayne Morse, Oregon, to send the entire matter back to the Judiciary Committee. This motion was defeated by a substantial majority. An amendment was then presented by Senator Walter George, Georgia, which would require enabling legislation in the case of executive agreements affecting internal affairs. On the final balloting the vote was sixty for and thirty-one against. Sixty-one affirmative votes would have been necessary for the two-thirds required to amend the Constitution. Since the vote was taken, Senator Alton Lennon, North Carolina, who was absent on the day of the final vote, has filed a motion to reconsider the entire issue. It is probable that this matter will be discussed again in the Senate and voted on again early in April.

Senator Price Daniel of Texas was a co-author of the original Bricker Amendment and voted in support of it at all times and in opposition to substitutes that would have been detrimental to the amendment. He also voted for the George Amendment. Senator Lyndon B. Johnson of Texas was active in his support of the George Amendment. The George Amendment would definitely have supported the stand of the medical profession. The Association must continue its support of the Bricker Amendment if the preser-

vation of liberty in this country is not to be abrogated by some treaty or executive agreement.

Federal Aid to Medical Education

The Council has been active in support of the American Medical Association's position on federal aid to medical education. Among the bills considered by the Eighty-Second Congress dealing with federal aid to medical education was S. 337. That bill proposed that federal aid be provided to medical, dental, nursing, public health, osteopathic, and allied technical schools. The bill proposed the granting of funds based on formulas geared to the number of students normally enrolled with additional amounts for new students. Grants would also be authorized for constructing and equipping old and new schools. Scholarships and student maintenance would also be provided under certain circumstances. The Committee on Legislation of the American Medical Association voted to oppose the measure and in this it was supported by the component state medical associations across the country, for if the measure was enacted, it was felt it would establish a system under which an objectionable degree of federal control would be inevitable. The bill would create an opportunity for the exercise of political pressure and intervention and would jeopardize the academic freedom of medical schools. It is the intention of this Council to file a supplemental report at the meeting of the House of Delegates in order that members may be informed of the latest moves concerning this type of legislation at that time.

Veterans' Care

Medical benefits for veterans with nonservice connected disabilities is a recurring question considered by the American Medical Association House of Delegates, and the AMA stand is supported by the Council on Medical Jurisprudence.

In June, 1953, the American Medical Association adopted a firm policy with respect to the provision of medical care for veterans. Despite the fact that this question will not be considered by the Eighty-Third Congress, it is felt that the medical profession, generally, and key legislative medical personnel, particularly, should be completely briefed on the subject.

The AMA recommended that no change be made in the present law with respect to the provision of medical care for veterans with service connected disabilities. With respect to nonservice connected disabilities, it was recommended that except in neuropsychiatric and tuberculous cases responsibility for providing medical care revert to the individual or to the state or local government. In cases involving tuberculosis and neuropsychiatric conditions, it was recommended that temporarily, in view of the shortage of facilities in certain areas, responsibility be continued at the federal level if facilities are available.

The present law provides that medical care, hospitalization, and domiciliary care be allowed for all veterans with service connected disabilities. The law further provides that such care shall be available to veterans with nonservice connected conditions, within existing facilities, providing they are unable to pay for such care. The law provides that the signing of a prescribed statement under oath by a veteran with a nonservice connected disability shall constitute proof of his inability to pay.

The provision of medical care for veterans with nonservice connected disabilities was authorized approximately thirty years ago. At that time there were only about 5,000,000 veterans and there were in Veterans Administration hospitals approximately 16,000 beds, many of which were unoccupied, It was the surplus of beds at that time that suggested the expansion of the program to include veterans with nonservice connected disabilities. Today there are over 20,000,000 veterans; there are about 120,000 Veterans Administration hospital beds; and there is a waiting list of about 20,000 veterans every month, only a few of whom have service connected disabilities.

When the program began, the Veterans Administration medical load consisted of about 17 per cent nonservice connected cases. Today annual admissions and discharges approximate 525,000, of which 85 per cent are nonservice connected. It is impossible to predict what the extent of this program may be in the year 1975, although it has been estimated by General Frank Hines, past Veterans Administration Administrator, that there will be a need for 400,000 beds at Veterans Administration hospitals at that time, assuming that there is no change in the present law.

The cost of the Veterans Administration medical care program in 1934 was about $17,000,000. In 1944 it increased to $102,000,000, and for the past year it amounted to about $745,000,000. Thus, in the past ten years the cost of this program has increased by more than 700 per cent.

It should be noted that variations in statistics cited by representatives of veterans organizations and the medical profession are caused, to some extent, by the fact that one group is discussing the patient load as of a given day, and the other is discussing total annual admissions and discharges. The average daily patient load in Veterans Administration hospitals approximates 110,000, of which about 65 per cent are nonservice connected cases. The annual admissions and discharges now approximate 525,000, of which about 85 per cent are nonservice connected cases. In an attempt to explain away further the nonservice connected problem, the Veterans Administration has issued a breakdown of the nonservice connected load. The one thing to be borne in mind is that all of the figures and statistics used by the American Medical Association were obtained from the Veterans Administration and, therefore, it is logical to assume that they are accurate.

In discussing this very important problem it is preferable not to indulge in any lengthy consideration of the adequacy of the forms used by the Veterans Administration, the extent of the abuse in the utilization of Veterans Administration facilities, and the efficiency of the Veterans Administration in administering the program. Instead, complete emphasis should be placed on the more specific issues which follow:

1. The moral justification for the provision of medical care for veterans with nonservice connected disabilities.
2. The effect of the present program on civilian teaching establishments.
3. The resulting overlapping in federal medical facilities and an artificial shortage of physicians and allied health personnel.
4. The increased cost of medical care and hospitalization for the general public.
5. The justification for the huge federal tax burden.
6. The question as to whether veterans themselves actually desire this type of a handout.

The action of the House of Delegates of the American Medical Association is supported in full by the Council on Medical Jurisprudence.

Health Insurance Plans

Another question that it is necessary to consider is federal subsidization of private health insurance plans. There have been several bills introduced in the Eighty-Third Congress dealing with this matter, one of which is H. R. 6949 by Charles Wolverton of New Jersey. The administration bill has just been introduced and this matter will be covered in the Council's supplemental report.

Social Security

In regard to the question of social security coverage for physicians, numerous bills have been introduced at the present time concerning this matter. In June, 1949, and again in 1953, the House of Delegates of the American Medical Association adopted a resolution opposing the compulsory inclusion of physicians under the Social Security Act. Hearings will be held by the Ways and Means Committee of the House of Representatives at a very early date on the recommended changes to the Social Security Act. The key figure with respect to these changes in the law is Mr. Daniel A. Reed, of New York, the chairman of the House Ways and Means Committee. It is the intention of the Council on Medical Jurisprudence to cover this matter in greater detail in the supplemental report, bringing physicians up to date on what should be done by the rank and file of the Texas Medical Association. However, if it is necessary to take action prior to that date, the component county societies will be alerted and informed of what is taking place.

In the Council's supplemental report will be covered other federal legislation that the Council feels is of interest to members and should be supported or opposed.

For general information, the Council is reproducing an exact copy of a letter written by Dr. Frank Wilson to the Honorable Lyndon B. Johnson of Texas. The Council believes there should be one correction in the letter written by Dr. Wilson to Senator Johnson in that from the information available to the Council, Senator Johnson was active in support of the George substitute for the Bricker Amendment. The George Amendment was actively supported by the medical profession after the defeat of the original Bricker Amendment.

"AMERICAN MEDICAL ASSOCIATION
WASHINGTON OFFICE

March 3, 1954

Honorable Lyndon B. Johnson
United States Senate
Washington, D. C.
Dear Senator Johnson:

I want you to know that the American Medical Association is cognizant of and grateful for the leadership and understanding of world affairs which you showed by your vote for the 'Bricker Amendment' as announced on Page 2251 of the Congressional Record, February 26, 1954.

The medical profession is in favor of the principles embodied in this legislation for the reasons outlined in an editorial published in the Journal of the American Medical Association dated February 20, 1954, a copy of which was delivered to your office the morning of February 26, 1954.

Briefly stated, the physicians of the country believe that purely internal affairs such as medical care and licensure of physicians should not be subject to international legislation, without at least the Congress having the opportunity to pass on these subjects.

You may be assured that the physicians of your state are aware of your vote on this issue.

Yours sincerely,
F. E. Wilson, M. D.
Director"

State Appropriations

At the present time, the Texas Legislature is in session and there are certain appropriations which have been requested by Governor Allan Shivers in his message to the Legislature. Among the requests made by the Governor was one for an appropriation to the Southwestern Medical School of the University of Texas in the amount of $3,500,000 for a new clinical science building. Governor Shivers stated in his message: "It is a shame and a disgrace to the State of Texas and to the great University that bears its name to house a medical school in the shacks on this campus at Dallas. If you do not agree, you should visit them as I have done recently."

This request of the Governor is receiving the active support of the Council on Medical Jurisprudence.

Also, the Council is supporting a request to the Legislature for an increase in the appropriation covering the state health officer's salary. Recently, the State Board of Health of Texas was able to obtain the services of an outstanding physician trained in public health work, Dr. Henry A. Holle. Dr. Holle is a native Texan and received his education at Texas Agricultural and Mechanical College and the University of Texas Medical Branch at Galveston. He is recognized as one of the outstanding public health men in the nation today. It is hoped that the appropriation will be increased so that his salary will be $15,000 a year, for in accepting the position as state health officer of Texas, it was necessary that Dr. Holle accept a reduction in salary. It is the feeling of the Council that an increase in salary should be made.

There will be many other matters covered in the Council's supplemental report as mentioned above.

We wish to thank Mrs. E. W. Coyle, President of the State Woman's Auxiliary, the Board of Trustees, and the rank and file of the membership of the component societies for the fine support they have given the Council. On numerous occasions, the Council has called on them to support measures that have received action from this Council and it has always received wholehearted cooperation.

Respectfully submitted,
J. B. COPELAND, Chairman,
J. W. RAINER,
ROBERT D. MORETON,
JOHN K. GLEN,
G. W. CLEVELAND,
GEORGE TURNER (ex-officio),
N. C. FORRESTER (ex-officio).

SUPPLEMENTARY REPORT OF COUNCIL ON MEDICAL JURISPRUDENCE

Since the filing of its original report, certain other action has been taken by the Council on Medical Jurisprudence concerning the called session of the Texas Legislature. During the called session of the Legislature, the Council was active in support of and cooperated with the Council on Medical Education and Hospitals in obtaining $3,500,000 for a new clinical science building for the Southwestern Medical School, University of Texas. This was approved by the Legislature and the money has been appropriated and is available now for the building of this building.

Also, the Council supported and was able to obtain an increase in salary for the State Health Officer from $10,600 to $15,000 a year.

These were the only matters considered by the Council on Medical Jurisprudence during the special session.

In regard to the *Bricker Amendment* (S. J. R. 1), which failed to carry in the United States Senate by one vote, it is still pending, and although Senator Alton Lennon of North Carolina has filed a motion to reconsider the entire issue, no action has been taken as of this date. The Bricker Amendment was actively supported by the medical profession and this Council.

On the expansion of the *Hill-Burton Act* (H. R. 8149 and S. 2758), H. R. 8149 has passed the House of Repre-

sentatives and hearings are now being held in the Senate. The American Medical Association has made certain recommendations concerning certain amendments which it is felt should be adopted before the bill is passed, and representatives of the American Medical Association have appeared before the House and Senate committees setting forth their views.

On *social security* (H. R. 7199), hearings are being held at this time and Dr. F. J. L. Blasingame appeared before the House Ways and Means Committee as a representative of the AMA and testified at length in opposition of organized medicine to compulsory coverage and certain other phases of the social security bill.

On the *reinsurance bill* for health plans (H. R. 8356 and S. 3114), hearings are now in progress before the House Committee on Interstate and Foreign Commerce and the Senate Labor and Public Welfare Committee. This bill also has been opposed by the medical profession as it is believed it will not fulfill its intended purpose and may, in fact, inhibit the satisfactory progress which is now being made by voluntary insurance companies and health plans.

In cooperation with the Board of Trustees of the AMA, after making a study of the following bills, this Council recommends to the House of Delegates that it go on record as opposing the bills mentioned below:

H. R. 6950, which provides $40,000,000 over five years for long-term loans to assist voluntary nonprofit health associations to obtain facilities and equipment. The physicians of Texas, acting in their capacity as citizens, should be active in their opposition because such loans can be had privately, thereby eliminating the unnecessary intrusion of the federal government into private medical and financial affairs.

H. R. 6951, which amends the Public Health Service Act to provide federal mortgage loan insurance for medical facilities and would favor voluntary prepayment health plans. There should be active opposition to this bill as the program would be entirely federally controlled and would amount to class legislation for a special group and there would be no state surveys or state participation.

H. R. 7700, which supersedes H. R. 6951 as mentioned above and would provide federal mortgage loan insurance for medical facilities favoring prepayment plans. There should be active opposition to this bill for the same reasons as set forth in regard to H. R. 6951.

Another bill the Council wishes to call to your attention is H. R. 8300, dealing with certain *tax deductions for medical expenses,* which passed the House of Representatives on March 18, 1954, and on which hearings are now being held in the Senate. The Board of Trustees of AMA endorsed a section of the omnibus tax revision bill which has passed the House, as the section endorsed would ease the financial burden of families with unusual medical expense. Under the present law, only medical expense in excess of 5 per cent of taxable income may be deducted.

There are numerous other bills pending which will be reported to the component county societies by the Council on Medical Jurisprudence from time to time as the matters are presented to the federal Congress.

The Council sent to each president of the component county societies copies of resolutions on the social security bill and the reinsurance bill. The resolution and analysis on the social security bill was prepared by the Harris County Medical Society and the one on the reinsurance bill by the Tarrant County Medical Society. Also sent to the president of each component county medical society was the testimony of Dr. F. J. L. Blasingame which was presented to the House Ways and Means Committee.

If these resolutions have not been presented to your society for its information, you should see that the president of your local society does present these to the full membership, and it would be well that copies be furnished to each member of your component county society.

The Council would like to call to your attention the fact that this is an election year, and at the present time, some lively congressional races are in sight. For example: Congressman Wingate Lucas of Tarrant County is opposed by Jim Wright of Weatherford; Congressman Ken Regan is opposed by State Senator J. T. Rutherford of Odessa; Clark Thompson of Galveston is opposed by Clyde Kennelly of Hempstead; Congressman Brady Gentry of Tyler is opposed by Lindley Beckworth; Congressman O. C. Fisher of San Angelo is opposed by Sam Connally of San Saba. Incumbent Congressman Frank Wilson of Dallas is retiring from Congress and the following residents of Dallas have filed for his place: Wallace Savage, Leslie Hacker, and Todd Mitchell. One of the districts which has drawn the most candidates is for the vacancy in the Corpus Christi district where Congressman John Lyle is retiring. The candidates at the present time are State Senators John Bell and William Shireman and Representative Gabe Garrett and DeWitt DeWitt. There will probably be other candidates who will file in most of these places.

Sixteen of the incumbent state Senators are up for reelection and 150 members of the House of Representatives will be up for reelection.

It is most important that you, the members of your county societies and woman's auxiliaries become familiar with the candidates and the things they stand for. More information concerning these matters will be made available to members of the component county societies later.

Among other bills pending in the federal Congress is *H. R. 8857,* introduced in the House of Representatives by Chairman Reed of the House Ways and Means Committee, which would require all employers even of only one person to participate in the federal-state unemployment compensation program. Under present law, employers are required to participate only if they have eight or more employees. The only physicians exempted under the bill would be those with no employees. Under present law, employers may report and pay the tax quarterly or annually. The bill would eliminate the quarterly system. The United States tax is 3 per cent of the payroll but a credit of 2.7 per cent is allowed employers providing they pay this amount as state unemployment taxes. H. R. 8857 has the administration's support. The House committee is expected to be busy several weeks in executive session on the social security extension bill, and accordingly, no hearing date has yet been set for committee hearings on this bill.

The Council considered the report and recommendations from the Texas Society of Pathologists concerning the premarital and prenatal laws of Texas. After a discussion, the Council recommends that a committee from the Texas Society of Pathologists meet with the new state health officer and a committee from the State Board of Health to see if their differences can be adjusted, and if the matter cannot be adjusted, that the matter again be brought to the attention of this Council.

Respectfully submitted,
J. B. COPELAND, Chairman,
J. W. RAINER,
ROBERT D. MORETON,
JOHN K. GLEN,
G. W. CLEVELAND,
GEORGE TURNER (ex-officio),
N. C. FORRESTER (ex-officio).

Speaker Deaton: The reports will be referred to the Reference Committee on Medical Service and Public Relations. The next report will be that of the Council on Scientific Work, Dr. May Owen, Fort Worth.

(Dr. Owen then presented her report:)

REPORT OF COUNCIL ON SCIENTIFIC WORK

A 1954 annual session which would be of value and enjoyment to the great majority of the members of the Texas Medical Association has been the chief goal of the Council on Scientific Work during the past year. Details of the program are announced elsewhere, but attention should be called especially to the following features: (1) two simultaneous general section programs which cover in one and one-half days important developments in almost every field of medicine, (2) six out-of-state guest speakers, who are authorities in their respective fields and well known for their teaching ability, (3) well planned specialty society programs open to all members of the Texas Medical Association, and (4) streamlining of the opening exercises and other activities which in previous years may have tended to drag, an example being the President's entertainment, which this year will be an informal, outdoor supper and floor show full of gaiety and without speeches or introductions.

Plans already are under way for the 1955 session in Fort Worth, to be held April 25, 26, and 27, and suggestions from any member of the Association for making it a still better meeting will be welcomed by the Council.

The Council a year ago introduced amendments to Article III, Section 3, of the Constitution and Chapter VII, Section 1, of the By-Laws which would permit the House of Delegates to elect officers at any of its regular meetings during the annual session after other business has been completed. These amendments will be before the House for final action this year, being included in the report of the Committee on Revision of the Constitution and By-Laws. The Council heartily recommends adoption of these amendments so as to clear the latter part of the annual session period for strictly scientific purposes.

Respectfully submitted,

MAY OWEN, Chairman,
CLYDE A. STEVENSON,
L. BONHAM JONES,
KLEBERG ECKHARDT,
GEORGE W. WALDRON,
GEORGE TURNER (ex-officio),
N. C. FORRESTER (ex-officio).

Speaker Deaton: This report is referred to the Reference Committee on Scientific Work, except that part dealing with the amendments to the Constitution and By-Laws, which is referred to the Reference Committee on Amendments to the Constitution and By-Laws. The next item of business is the report of the Council on Medical Economics, Dr. Harvey Renger, Hallettsville.

Dr. Renger: The report is printed. We do have also a supplemental report:

REPORT OF COUNCIL ON MEDICAL ECONOMICS

Through the year's activity the Council on Medical Economics has finally clarified the position of the Texas Medical Association in regard to group insurance for its members. Investigation has revealed that the Metropolitan Casualty Insurance Company of New York had been approved by the Texas Medical Association and is the only company approved for group insurance for the Texas Medical Association members.

Significant Laws

The laws pertaining to premarital and prenatal examinations and certificates of health have been discussed with the State Department of Health and the law is rather specific in its outline. Portions significant in that they pertain to medical activity follow:

"Every physician or other person permitted by law to attend a pregnant woman during gestation shall, in the case of each woman so attended, take or cause to be taken a sample of the blood of such women at the time of the first examination and visit, and submit such sample to an approved laboratory for a standard serologic test for syphilis."—H. R. 597, Section 1, Fifty-First Legislature.

". . . that the bearer [employee in any type of food handling concern] had been actually and thoroughly examined by such physician within a week prior to the time of such employment, and that such examination disclosed the fact that such person to be employed was free from any transmissable condition of any infectious or contagious disease. . . ."—Texas Health Certificate Law, H. R. 142, Forty-Sixth Legislature, Approved April 26, 1939.

"The certificate shall state that the applicant has been given an actual and thorough examination, including a standard serologic test for syphilis. The examination shall not have been more than fifteen (15) days prior to the date of issuance of such license. . . ."—H. R. 588, Fifty-First Legislature.

Inquiries

The Council is interested in establishing some responsible group or individuals who could be in a position to answer the inquiries that are directed to the Texas Medical Association in regard to its various activities and functions as an organization and also in regard to statistical information of the individual members. Many such inquiries go unanswered because of lack of coordination of the various councils, and the Council on Medical Economics wishes to make a recommendation to alleviate such a condition.

Health Insurance

The Council is alarmed at the articles that have appeared in the Scripps-Howard newspapers against the voluntary health insurance companies. It seems that the companies of poor repute have cast a shadow on the many health insurance companies that have been giving such an excellent coverage to so many people over the United States.

Physicians Placement

The report of the Physicians Placement Service has been prepared by Mrs. Wacille Johnson of the Physicians Placement Service, who is to be complimented on the efficient manner in which she has attended to the duties of the Physicians Placement Service. The report follows:

Since January 1, 1953, the Physicians Placement Service has had requests from 601 physicians seeking locations in Texas for the practice of medicine. Of this number 108 have located in Texas, 52 selecting the available locations on file with this service and 56 accepting other positions throughout the state. One hundred and seventy-seven physicians were dropped for various reasons such as further training, military service, and location in other states. There are currently 323 physicians seeking locations in Texas.

From January 1, 1953, this service has had requests for aid from 196 locations. These locations include communities in need of general practitioners and clinics and physicians desiring associates. Of these locations 84 were filled, 52 by physicians on file in this office and 32 by other means. Thirty-nine locations were removed for various reasons. There are currently 73 locations on file seeking additional physicians.

It is interesting to note that in 1952 this office had requests from 399 physicians seeking locations and during the past year requests for aid came from 601 physicians. This is partly due to the increased publicity which the placement service has received during the past year and the improved manner in which the listings of locations are presented. For several years the locations were mimeographed as a list of opportunities giving all the openings together in one list regardless of whether or not they were specialty openings. This has been completely revised and separate booklets are maintained according to specialty. Each physician receives only that booklet which contains the specialty openings in which he is interested. These booklets have attractive covers and have been well received.

The placement service was very fortunate in having an article printed in *The Journal of the American Medical Association* giving a complete history of its activities in the December 19, 1953, issue. Also *Medical Economics* in January, 1954, featured pictures of the booklets of locations sent out by this office with captions describing them. This publicity has been a great factor in the increased amount of applications from physicians requesting aid in locating in Texas.

Recommendations

To assist in avoiding any possible detrimental public relations by letting inquiries to the Association go unanswered, the Council on Medical Economics recommends that some responsible group, possibly the Council itself, be authorized to direct inquiries to the respective chairman of the council or committee which is involved and if the inquiry does not normally fall under the jurisdiction of any council or committee of the Association, that the Council on Medical Economics solve the problems as best it is able.

The Council also recommends that after further investigation, the Texas Medical Association through its Committee on Public Relations and the voluntary health insurance companies issue a statement concerning the unfavorable newspaper articles recently published by Scripps-Howard newspapers.

Respectfully submitted,

HARVEY RENGER, Chairman,
A. G. BARSH,
R. R. ROSS,
H. H. CARTWRIGHT,
E. W. JONES,
GEORGE TURNER (ex-officio),
N. C. FORRESTER (ex-officio).

SUPPLEMENTARY REPORT OF COUNCIL ON MEDICAL ECONOMICS

The original report of the Council on Medical Economics has been approved by the Council except for the following recommendations and corrections:

1. In the "significant laws" regarding the issuance of health certificates for food houses, it was suggested that that law be referred to the Committee on Public Health for investigation and to see if it should be improved upon by the compulsory requirement of chest x-rays and serologic tests.

2. In the clarification of inquiries and of recommendations which have been noted about the central office receiving inquiries from outside sources in regard to the various acts and functions of the Texas Medical organization and requests for statistical information relative to the individual members, such as costs of operations and cost of education, it seems that there is no definite correlation of the different committees for the answering of these inquiries. It is suggested by this Council that some responsible group, possibly the Council on Medical Economics itself, be authorized to direct information to the respective chairmen of the councils or committees which are involved in the different inquiries. In the past, some of these inquiries have received a noncommittal answer which has been detrimental to public relations of the Texas Medical Association.

3. The Council went on record rejecting the plea of the premedical students' request for assistance in establishing a premedical loan fund.

Respectfully submitted,

HARVEY RENGER, Chairman,
A. G. BARSH,
R. R. ROSS,
H. H. CARTWRIGHT,
E. W. JONES,
GEORGE TURNER (ex-officio),
N. C. FORRESTER (ex-officio).

Speaker Deaton: The reports will be referred to the Reference Committee on Medical Service and Public Relations. The next report is from the Council on Medical Education and Hospitals, Dr. M. O. Rouse, Dallas.

Dr. Rouse: The main report is printed. We also have a supplemental report:

REPORT OF COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

Medical education in Texas—undergraduate, graduate, and postgraduate—makes slow but definite progress.

Finances for Medical Schools

Baylor University College of Medicine at Houston, under the leadership of Dean Emeritus W. H. Moursund, is carrying on an active campaign for regular financial support from its alumni and friends to supplement the income from other sources. The present Legislature at its last session made an appreciated increase in the regular budget for Southwestern Medical School of the University of Texas at Dallas but failed to appropriate money for the clinical sciences structure needed to round out the building program. Some increases were made by the Legislature for the maintenance of the departments of the Medical Branch of the University of Texas at Galveston, but the increases were not adequate to meet fully the needs for the expanded facilities of the new John Sealy Hospital. Likewise, the Legislature did not come through with additional funds needed to equip completely the new M. D. Anderson Hospital for Cancer Research at Houston, nor for the full building needs of the Dental College of the University of Texas. A "revolving fund" appropriation was made for the Postgraduate School of Medicine of the University of Texas, which it is hoped will result in permanent support of the main administrative costs of this branch.

The legislators, as individuals, seemed predominantly favorable to increased tax support of these medical projects

but professed to be unable to find sources of increased revenue. The Governor has indicated that he will submit to the Legislature, which convened March 15 in a special session, the matter of appropriations to meet the aforementioned needs.

The Council on Medical Education and Hospitals actively aided the administrators of the different medical branches of the University of Texas in appearances before the proper finance or appropriation committees of the Legislature last year, which action seemed to be appreciated greatly by the University officials. The Council feels that members of the Texas Medical Association can wield a powerful influence on their home legislators in stimulating the legislators to help provide the needed funds, so the Council calls on all physicians to contact personally the representative or senator from his district, stat. and p.r.n. There is likewise an obligation of physicians and their friends to accept cheerfully any slight increase in state taxes that may be necessary to meet the situation adequately.

Dr. Grant Taylor, with an illustrious record of medical education and service at Duke University School of Medicine, Durham, N. C., and elsewhere, has been selected as dean of the Postgraduate School of Medicine of the University of Texas, and under his aggressive leadership even more progress is anticipated.

Residencies in State Hospitals

At its January meeting, the Council on Medical Education and Hospitals had the privilege of conferring with medical staff members of the Board for Texas State Hospitals and Special Schools, who outlined their plans for the possible development of residencies in neuropsychiatry in some of the state hospitals and also reviewed a plan for organizing a consulting staff for the Austin State Hospital. The Council heartily commended and approved these plans and expressed a hope that the consultation staff organization worked out at Austin may serve as a model for similar consultation staffs in other localities where there are state hospitals. The Council feels that it is the obligation, as well as privilege, of a physician practicing near a state hospital to serve as he may in consultation with the full time staff of the state hospital in his vicinity.

Training for Office Assistants

To the Council on Medical Education and Hospitals was made an interesting suggestion that there is a need in Texas for one or more educational institutions to train young ladies who can furnish a superior type of assistance to physicians in private offices. Such a young lady not only should be a competent stenographer but also should know some simple principles of nursing so she can prepare a patient for examination and give simple hypodermic medications; she should know some bookkeeping; and she should have that well rounded culture which four years of college can give, with its attending knowledge of how to handle people.

Discussions are under way with the administration of the Texas State College for Women at Denton, where a favorable initial response has been met. By the time of the annual meeting in May, further details should be available. Meanwhile, St. Paul's Hospital in Dallas also has done some fine work in special evening training for medical stenographers.

Audio-Digest Foundation

Attention has been called to a splendid contribution to the field of postgraduate medical education which now has been made available to the entire country by the Audio-Digest Foundation of California. In brief, Audio-Digest prepares weekly tape recordings of digests of current medical literature, with tapes of one hour's duration, which can be played on any tape machine for individual physicians, staff groups, or county medical societies. By a special adapter, the tapes can be played by a machine carried in the physician's car as he goes from call to call. Audio-Digest goes a step further in making "digest" recordings for different specialty groups available twice each month. As a further service, Audio-Digest is accumulating hour-long lecture recordings by nationally recognized experts, which are available for more specialized audiences.

Audio-Digest Foundation is a nonprofit corporation, a subsidiary of the California Medical Association, and its profits will go entirely to medical education or other fields of medicine. The Council on Medical Education and Hospitals urges that individual physicians and county medical societies investigate the potentialities of this service because a wealth of excellent material is available at a minimum cost. The address is 800 North Glendale Avenue, Glendale, Calif.

Telephone Postgraduate Broadcasts

The special Committee on Telephone Postgraduate Broadcasts has arranged four unusually splendid programs, or symposiums, for 1954, the first one coming in February and the second in March. A fine plan of having all the faculty for each program from one center has been followed. There has been some decrease in the number of societies taking the programs, and the Council has carefully reviewed the matter.

The Council plans to record, on tape and on platters or disks, the two postgraduate programs scheduled for this fall in an effort to make superior programs given by Texas men available at minimal cost to participating societies and available at the regular meeting times of the societies. Further details on this will be available at the May meeting.

Collaborated Projects

It has been the pleasure of the Council on Medical Education and Hospitals to collaborate actively and sympathetically with other regular groups of the Texas Medical Association on interesting projects. With the Committee on Public Relations and other groups a program was presented for students on the campus of each of the three medical schools in Texas and was proclaimed an outstanding success at each. The Council has had conferences with representatives of the Texas Hospital Association and with the chairman of the Committee on Nursing Care of the Texas Medical Association relative to the problem of nursing education and the supply of nurses in the state.

Specific recommendations of this Council will be included in a supplemental report at San Antonio in May.

Respectfully submitted,
MILFORD O. ROUSE, Chairman,
J. L. MATTHEWS,
TRUMAN BLOCKER, JR.,
W. S. BARCUS,
R. LEE CLARK, JR.,
GEORGE TURNER (ex-officio),
N. C. FORRESTER (ex-officio).

SUPPLEMENTARY REPORT OF COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

The Council on Medical Education and Hospitals feels that one of the causes of the present nursing shortage is the diversion of many trained nurses for physicians' offices, and that such shortage might be lessened over a long range

period by the training of medical assistants capable of replacing nurses in these offices. Other considerations highlight the need for such training. The Council commends the Texas State College for Women for its manifested interest in this field and recommends that the House of Delegates commend this college for pioneering in this educational effort and offer the cooperation of the medical profession in providing the "on the job training" which will be required; also it urges other educational institutions to consider similar courses of varying lengths to train young women adequately to assist in doctors' offices.

Dr. James A. Bethea, executive director of the Board for the Texas State Hospitals and Special Schools, has pointed out that in Texas the present legislative appropriations for patients in state mental hospitals is approximately $2 per day per patient, a sum pitifully inadequate even for custodial care to say nothing of proper professional service. The Council recommends that all physicians heartily support the request of the board at the next session of the Legislature for more adequate appropriations for professional care of patients in state hospitals.

A canvass of all agencies engaged in postgraduate medical education shows increased interest and activity. This Council recommends increased postgraduate study by all physicians with more enthusiastic support of all postgraduate facilities, especially of the Postgraduate School of Medicine of the University of Texas.

Attention is directed to the forthcoming statewide election in November on a Constitutional amendment which will make possible the creation of special hospital tax districts in the larger centers of the state. This is of great importance to city-county hospitals and to medical education, and the Council recommends that all physicians work diligently in behalf of the proposed amendment.

The Council has made a comprehensive study of the postgraduate and other teaching facilities with tape recordings and illustrations offered by the Audio-Digest Foundation of 800 North Glendale Avenue, Glendale, Calif., which foundation has a booth in the technical exhibits at this meeting. Members of the Council recommend that all physicians acquaint themselves with the material offered, which gives a practical, inexpensive, and interesting method of keeping up with medical literature and securing outstanding medical programs for staff meetings, county societies, and similar groups.

A review of the telephone postgraduate programs for February and March shows some decline in the number of participating societies. For the pair of telephone postgraduate programs this fall, one in October on antibiotics and one in November on recent advances in the management of cancer, tape recordings will be made and released for use by county societies and hospital staffs immediately after the telephone broadcasts themselves. Full information on costs and other details will be published in the TEXAS STATE JOURNAL OF MEDICINE and sent to each county society. The broadcasts this fall will be used to check on possible ways of having the splendid programs given by Texas physicians utilized by many more groups and physicians. The Council feels that the postgraduate panels and symposiums given under the sponsorship of the Texas Medical Association will always serve a very useful purpose, and it recommends that another series of four such postgraduate programs for individual societies and other medical groups be planned and given in 1955 under the direction of a special postgraduate committee, with the technique of presentation by telephone, tape, or other method to be determined after the fall (1954) pair of broadcasts, with costs of the 1955 programs to be worked out equitably with the Board of Trustees.

Respectfully submitted,
MILFORD O. ROUSE, Chairman,
J. L. MATTHEWS,
TRUMAN BLOCKER, JR.,
W. S. BARCUS,
R. LEE CLARK, JR.,
GEORGE TURNER (ex-officio),
N. C. FORRESTER (ex-officio).

Dr. Rouse: You will be interested to know that the telephone broadcast costs have been less than half of what we estimated, but we are in hopes that more societies will make use of the broadcasts.

Speaker Deaton: These reports will be referred to the Reference Committee on Medical Service and Public Relations. The next item of business is the report of the Committee on Cancer from Dr. Porter Brown, Fort Worth. I have not seen Dr. Brown in the House; is there anyone else to make that report? If not, we will pass that. The next is the report of the Committee on Medical History. We are honored to have Dr. Felix P. Miller of El Paso to make this report.

REPORT OF COMMITTEE ON MEDICAL HISTORY

Dr. Miller: This is as much a surprise to me as it is to you. I was appointed on this Committee, but I understood Dr. Tate Miller was going to put this on.

Just the other day I had a visit with a grandson of Sam Houston and his wife. Her grandfather was one of the early doctors in Texas. I failed to find him in any list of early physicians in Texas. She has promised to give me the information I desire and will write to her relatives in his old home town for facts. From my conversation with them I believe it will be a very interesting history, and I hope some day to compile that and have it for you. This is my first experience on medical history.

I believe the Bible says, "By their records ye shall know them." Recently this man who is a grandson of Sam Houston told me of a doctor who had never made any mistakes. Recently he had operated on a child for intestinal obstruction and inadvertently opened the bladder, which was repaired immediately without any trouble. The patient got well, both of the intestinal obstruction and any possibility of injury to the bladder. The doctor wrote up the operation and described in detail and intimately the operation for intestinal obstruction and at the end he said, "The bladder was explored and no stones were found." That perhaps is not authentic medical history.

Only today coming down on the train I saw in the *Scientific American* an article on fifty years ago by Dr. Victor C. Vaughn of Michigan. Fifty years ago he said that typhoid fever in the United States caused over $50,000,000 worth of damage annually. It is strange that he estimated the value of each dead man at only $1,000. It reminds me of what a little girl in the paper said the other day; she said that life must be very valuable. It costs more and we are holding on longer. So I think his valuation of life taken by typhoid fever was certainly low enough fifty years ago. With the increased cost of things, that would be a very minimum.

I doubt if I would get ten hands if I asked how many of you have seen a case of typhoid fever in the past five years. How many of you have seen an epidemic of yellow fever? I had the pleasure in 1898 of being quarantined with Dr. Allen J. Smith, by some very celebrated men, Drs.

Agemonte and Guiteruez, during the epidemic of yellow fever in Galveston. The happiest two weeks of my life were spent with Dr. Smith, professor of pathology at the University of Pennsylvania. That day is past. I saw the ports of Galveston, Houston, Atlanta, New Orleans, Philadelphia, and others quarantined for weeks at a time—shotgun quarantine.

One of my classmates was caught by the rigid quarantine in Galveston and made his escape to the mainland but was met upon his arrival in Belton by his father, who promptly quarantined him in a graveyard. It was a common practice in such epidemics that most men fled in absolute terror, to return afterwards and live influential lives.

Those of you who have not read the Decameron of Bocaccio—I do not mean the love stories, but I mean the preface about the black plague which scourged Florence, Italy, in 1300 and 1400—have a treat in store: "When the living barely sufficed to bury the dead," and when a man took care of his wife the best he could; his family had all died and had been taken away by the dead wagon. His wife was carried out into the harbor in a rowboat to a worn out sailing ship where she was placed on the deck with hundreds of other victims, a hole bored in the bottom of the ship, and it sunk—the only way that they could be buried. I have read that the only way that they could bury the dead during similar epidemics in New Orleans was by digging trenches, which were dug and the yellow fever victims thrown in and covered up.

Few people realize the things that have been accomplished in the practice of medicine in a lifetime, in fifty years. A man's worth to a community or to medical science or to his medical association is in the things that he creates for the betterment of his fellow man. The earlier generation, of which I am a late member, blazed the trail upon which later generations travel. We have seen such wonderful improvements in a lifetime, in my lifetime. I have seen surgery placed upon a higher plane, hospitals, laboratories, and roentgen rays added to our armamentarium. I had a demonstrator's part early in the days of the medical school at Galveston in carrying on for Dr. Seth M. Morris and Dr. Mangunat in their lectures on physics. I taught, just like the book said, Steele and Gannaud, that the atom cannot be divided. On the title page in Steele's "Physics," that I had at the University, it says, "The works of God are far from naught, unless our eyes are blind in seeing."

The celebrated Dr. William Osler, Dr. Oliver Wendell Holmes, and others say that the credulity of man regarding medicine and disease has not changed in the centuries but is the same in all times and all ages. "The desire to take medicine is perhaps the greatest feature that distinguishes man from animals."

I had the pleasure of seeing Dr. William H. Welch, Baltimore, in the early days and hearing him tell how the practice of medicine had been liberated by Dr. Rudolf Virchow from, you might call it, a religious cult by demonstrating the microscopic cell life and the causes of diseases, and how other men have given their lives for the advancement of medicine. This we hope to present to you at some future time in some more connected course than we have today.

Speaker Deaton: This report on Medical History will be referred to the Reference Committee on Reports of Officers and Committees. I want to thank you, Dr. Miller, for this interesting report.

The next is the report of the Committee on Public Relations, Dr. Troy Shafer of Harlingen.

Dr. Shafer: The report is printed and is respectfully submitted without supplement:

REPORT OF COMMITTEE ON PUBLIC RELATIONS

The Committee on Public Relations has recognized that the future of American medicine continues in the hands of the "public climate of mind" and that medicine's vulnerable area with the public continues to lie in the socioeconomic area (costs, availability, distribution, and office operation and management). There is no quarrel with quality.

The Committee's program has been divided into three general areas: internal professional relations, relations with the public en masse, and relations with the public at the individual office.

In carrying out its program under the supervision of the Board of Trustees, the Committee properly has worked in close liaison with many of the councils and other committees of the Association.

Internal Relations

The Committee's broad objective regarding internal relations has been to assist in all ways possible in the stimulation of individual interest in attendance at state and county society levels.

The third annual Presidents and Secretaries Conference was successfully completed in January. The meeting's purpose was to provide factual information to elected officers throughout Texas medicine on the objectives and the activities of organized medicine at the county, state, and national levels. Increasing interest and attendance at these meetings is definitely noted.

Three Medical Students' Day programs were successfully completed during the same period. These meetings had as their objectives to bring future doctors into active county society participation at earlier dates, thus to strengthen attendance and interest in those societies in the future. In close liaison with the Council on Medical Education and Hospitals and with the cooperation of the local county medical societies and the three Texas medical schools, a meeting and open forum presented to junior and senior students the practical aspects of future practice in terms of: "Your Practice and Public Opinion," "Your Practice and the Medical Society," "The Legal Side of Your Practice," "The Business Side of Your Practice," and "Your Responsibility as Doctors."

In an effort to improve communication to the individual doctor, PR Diagnotes was added to the TEXAS STATE JOURNAL OF MEDICINE as a monthly feature, and numerous special bulletins on varying subjects were released periodically throughout the state.

External Relations

The Committee has continued to stress the desirability of efficient mediation committees, availability at the county society level of round-the-clock medical service (at the same time using all possible channels to educate the public that doctors will and do make home calls but that the best care is available at his office or clinic). Special effort also has been extended in the area of doctor distribution throughout Texas and in the field of office operation and management.

The Committee worked closely with the Council on Medical Economics, Committee on Rural Health, and the special Committee on Doctor Distribution, composed of representatives of all three groups, to overcome the generally accepted misnomer "doctor shortage." The Committee cooperated in the completion of a successful pilot survey in Councilor District 7 to determine community needs for additional doctors and was able to report the need in this district nonexistent. The extension of this survey with the

consequent improvement in public understanding of the adequacy of doctor distribution generally throughout Texas will come about rapidly with the provision of a competent field secretary to work with Councilors and society officers throughout the entire state.

Office Management

The Committee has completed and distributed outline guides for doctors' secretaries, "Better Secretaries—Training Tips." This guide is supplemented on request with a full lecture or study series. The Committee has urged the establishment at community level of actual training courses following this outline in business schools, high schools, night schools, or junior colleges.

Special Projects

Aside from its traditional role as information outlet for organized medicine in relations with press, radio, and television, the Committee has completed several separate special projects.

Twenty-nine major Texas newspapers cooperated with local county societies in publishing commemorative special sections observing the one hundredth anniversary of the Texas Medical Association and citing medicine's contributions during the century. Theme of the sections generally was "You Get Your Dollar's Worth in Medical Care Today." It is estimated that more than 80 per cent of the people in Texas had an opportunity to read one or more of the sections. It should be noted also that although many other state associations have conducted similar projects, the cooperation received from the Texas press was the most extensive ever afforded a state medical association.

The Committee completed the preparation and distribution of the following pamphlets and handbooks:

1. Presidents and Secretaries Handbook, 1954—a handbook of condensed helpful information on the organizational aspects of Texas medicine for county and state officers.
2. Outline Guide, PR Activities, County Medical Societies—a broad range of suggestions for public relations activity at the county society level.
3. My Town Needs a Doctor—a pamphlet of community responsibility in getting and keeping doctors.
4. The State Program, Public Relations Committee—a handbook of materials and programs available to county medical societies.
5. Information Kit, VA Medical Care—a collection of material on veterans' medical services from the American Medical Association's Department of Public Relations.
6. Handbook, Woman's Auxiliary to the Texas Medical Association—a detailed compendium of facts on Auxiliary organization, objectives, and activities.

The Committee wishes to underscore once more its desire to be of service to all other committees and councils at all times within the limit of its facilities.

Respectfully submitted,
TROY A. SHAFER, Chairman,
VAN D. GOODALL,
SAM BARNES,
HUGH SAVAGE,
H. M. ANDERSON,
M. C. OVERTON, JR.,
W. D. BLASSINGAME.

Speaker Deaton: This report is submitted to the Reference Committee on Medical Service and Public Relations. The next is the report of the Committee on Tuberculosis. Is Dr. W. D. Anderson of San Angelo, chairman of that committee, ready?

Dr. Anderson: This report is printed, but I should like to give this: The contract has been let and work is started on the South Texas Tuberculosis Sanatorium at Harlingen, which will give Texans in that area a 400-bed tuberculosis hospital which is to be completed in late 1955. Also the Committee has given its endorsement to the Texas Tuberculosis Association and its "Searchlight on Tuberculosis." This is an ambitious program to evaluate the tuberculosis program and problem in Texas in its every phase, from the grass-roots on up, and this the Committee believes merits the support of every Texas doctor. (The committee report follows:)

REPORT OF COMMITTEE ON TUBERCULOSIS

The Committee on Tuberculosis is pleased to report a noticeable improvement in the over-all picture of tuberculosis in Texas during the past year. The tuberculosis hospitals have shown progression in bed capacity, organization, personnel, and patient results. With the closing of the Weaver H. Baker Memorial Tuberculosis Sanatorium at Mission last year, approximately 400 of these patients were transferred to an unused portion of the Veterans Administration Hospital at Legion near Kerrville on a temporary basis. Others were moved to the new San Antonio State Tuberculosis Hospital, San Antonio. This unit is a new hospital well situated and well planned for 400 tuberculosis patients. With the appropriations made by the last State Legislature for a complete new plant for the East Texas Tuberculosis Hospital at Tyler, within a relative short period Texas will have another new, modern, tuberculosis sanatorium. Construction has recently started on the Harlingen State Tuberculosis Sanatorium which in time will accommodate 400 tuberculous patients from the Rio Grande Valley area. McKnight State Sanatorium near Carlsbad continues to be the most efficiently organized and operated hospital of the entire system.

With the recent appointment of Dr. Roger Hanna as director of the state tuberculosis hospitals, much more improvement and progress may be expected of these hospitals as contrasted to previous years when no tuberculosis specialist or even anyone remotely interested in tuberculosis control was a member of the executive staff of the Board for Texas State Hospitals and Special Schools. This was one of the recommendations of this Committee for the past several years that has been fulfilled at last.

The employment of capable, well trained personnel has been the crying need of every hospital in Texas. This is particularly true of the tuberculosis hospitals. During the past year favorable and substantial progress in procuring trained personnel has taken place in the tuberculosis hospital system. There are now three full-time hospital superintendents on the job. Otherwise, medical staff personnel is rather inadequate, and there are a number of alien, unlicensed and non-English speaking doctors on the staffs of the state tuberculosis hospitals. Again, this Committee would like to make a direct appeal to the House of Delegates for some suggestions toward solving this problem. This Committee continues to believe that Texas patients in state sanatoriums are entitled to talk their medical problems over with a doctor who can speak English well enough that they can understand each other! The personnel of other departments has shown a slow, gradual, but noticeable improvement in qualifications, abilities, and interest. At present there are occupational therapists at each hospital who in time will add much toward the rehabilitation of arrested, inactive cases. The interest and participation in rehabilitation has shown a phenomenal growth in these institutions during the past twelve months.

The waiting lists have grown considerably during the

past year. It now requires from two to three months for patients to be admitted for treatment. At first glance this is not a healthy situation and in some cases it is not, but underneath it does reflect better hospital care in that the patients remain hospitalized longer and the rate of patients leaving against medical advice is going down noticeably at each hospital. Too, a patient waiting at home now is not in such a serious situation as in previous years when there was nothing to do except rest. With the widespread use of antimicrobial therapy most patients who enter the sanatorium have had their drug therapy started at home by their family physicians. Frequently patients entering a sanatorium do not show enough on roentgen-ray, physical, or laboratory examinations to make a definite diagnosis of pulmonary tuberculosis. After reviewing roentgenograms made at their homes, the sanatorium physician is aware of the phenomenal clearing and healing of the disease. The Committee is encouraged to believe that within a few years the waiting list of state sanatoriums will have disappeared, even with the present bed capacity.

Likewise, the death rate in Texas from tuberculosis has decreased in the past year as it has throughout the nation. Even the number of cases reported to the State Department of Health has dropped from approximately 56 per 100,000 population in 1951 to 48 per 100,000 in 1953.

Inasmuch as the diagnosis, treatment, and cure of tuberculosis have evolved from the nonspecific, old-time rest treatment and hopes for a cure to our modern day specific antimicrobial therapy, sanatorium rest, and education along with proven surgical measures, physicians now are able to give a patient not only a promise of curing his tuberculosis but perhaps a complete eradication of his disease.

Recommendation

This Committee recommends that each county medical society in the state devote at least one meeting a year to keeping its membership up to date on tuberculosis developments. A letter to this effect has been mailed to each county society president and secretary.

Respectfully submitted,
W. D. ANDERSON, Chairman,
ORVILLE E. EGBERT,
JOHN A. WIGGINS,
RALPH E. GRAY,
ERNEST E. HOLT.

Speaker Deaton: The report of the Committee on Tuberculosis is referred to the Reference Committee on Scientific Work. Next is the report of the Committee on Library Endowment, Dr. B. E. Pickett, Carrizo Springs.

Dr. Pickett: Mr. Speaker, the report of the Committee on Library Endowment is already printed. It is submitted without recommendations, with this statement: that twelve days ago I was notified that I was appointed chairman of this Committee, taking the place of Dr. J. M. Travis, resigned.

REPORT OF COMMITTEE ON LIBRARY ENDOWMENT

The Memorial Library of the Texas Medical Association is one of the Association's most valuable assets because it is used by many doctors. It is the fountain of knowledge on which physicians can depend and from which they can draw at any time. The knowledge is valuable and the Library is essential. Many valuable books are available and many more are needed. These volumes are in constant use and therefore deteriorate, and these should be replaced. The Library should grow and must grow. It takes money to replace these volumes and to pay expenses and one source which is emphasized is the endowment from doctors and members. Some have made valuable contributions, and the Committee on Library Endowment hopes to have more.

The beloved Dr. L. H. Reeves, Fort Worth, recently has donated his library with a considerable sum of money by his will, for which the Committee extends many thanks. Others are contemplating a similar action—this procedure should be encouraged. It has been suggested that the representative from the TEXAS STATE JOURNAL OF MEDICINE, while securing information relative to deceased members in regard to the obituary, tactfully suggest to the family the donation of the library of the deceased which may contain some valuable books and also encourage them in making other contributions.

Recommendations

The Committee recommends that the woman's auxiliary of the different parts of the state be contacted and asked to make a contribution each year to the Library, even though it may be a small one, and that a suitable plaque be placed wherein names of the donors could be permanently inscribed. The Committee also urges that all the medical societies give publicity for the need of funds for this Committee.

Respectfully submitted,
B. E. PICKETT, Chairman,
JOE T. GILBERT,
V. R. HURST,
R. D. LITTLE,
AUGUST J. STREIT.

Speaker Deaton: This report is referred to the Reference Committee on Finance. The next is the report of the Committee on Mental Health, which is printed and will be referred to the Reference Committee on Scientific Work. (The report follows:)

REPORT OF COMMITTEE ON MENTAL HEALTH

The Committee on Mental Health has taken no concerted action on any specific project.

Some members of the Committee now serve on the advisory committee to the Board for Texas State Hospitals and Special Schools. This advisory committee is composed of representatives from the following organizations: the Hogg Foundation for Mental Hygiene of the University of Texas, Texas Society for Mental Health, Committee on Mental Health of the Texas Medical Association, Committee on Tuberculosis of the Texas Medical Association, Texas Neuropsychiatric Association, Texas Association for Retarded Children, Texas Association of School Administrators, Texas Dental Association, and the Texas Society for Crippled Children.

The advisory committee meets regularly in Austin every two months. While its function is purely advisory, yet, there are strong indications that it will have a definite influence on the shaping of medical, rehabilitative, and educational policies of the board. Additional reports on these activities, as well as recommendations for action by the Texas Medical Association, will be submitted in the future.

The Committee has had a conference with the budget officer of the Legislative Budget Council. This official is seeking advice on suitable research projects, a psychiatric residency training program, and other "in training programs," which can be adapted within the various state hospitals. The objective is to outline a program which will have an appeal to the Legislature and produce larger appropriations.

The Woman's Auxiliary, through its mental health committee, is now taking an active interest in mental health in Texas. This Committee is desirous of working in close cooperation with the Auxiliary.

To date there has been no definitive activity from or with the Committee on Mental Health of the American Medical Association.

Recommendation

It is recommended that the Texas Medical Association, through its Councils on Medical Jurisprudence and on Medical Education and Hospitals, give assistance to the Legislative Budget Council and/or the Board for Texas State Hospitals and Special Schools and that the Association take an active interest in securing sufficient appropriations for efficient conduct of the hospital system.

Respectfully submitted,
HAMILTON FORD, Chairman,
DAVID WADE,
A. B. COOPER,
ABE HAUSER,
EDGAR EZELL.

Speaker Deaton: Next will be the report of the Committee on General Arrangements for the Annual Session, Dr. Jones, chairman.

Dr. L. Bonham Jones: This Committee has little to say, for I am sure the work we have attempted to do will speak much louder than anything we can say. The Committee on General Arrangements on behalf of the Bexar County Medical Society again welcomes to San Antonio the delegates, members, and visitors to the annual session of the Texas Medical Association. We trust that your visit to our city will be pleasant and profitable.

The work of the Committee on General Arrangements appears somewhat minor compared to the extensive and detailed work of the central office in arranging the annual session. From a ringside seat, it is gratifying to see the efficiency and effectiveness of the administrative organization headed by Mr. N. C. Forrester. A session such as this would be very difficult to arrange without the help of such a person as our managing editor, Miss Harriet Cunningham. We are grateful to the local committee chairmen and their committeemen, who have given much of their time to make this meeting a success. The San Antonio Chamber of Commerce has given much help and advice in arranging the convention. The booklet on San Antonio which was mailed to every doctor in the state was provided by the Chamber of Commerce.

Your attention is directed to the President's Party with Buffet at La Villita on Tuesday evening. This is an occasion to honor our President, and we believe it will be long remembered.

(The Committee's formal report was submitted in print and follows:)

REPORT OF COMMITTEE ON GENERAL ARRANGEMENTS

The Committee on General Arrangements for the 1954 Annual Session has made available to the Texas Medical Association the best of San Antonio's facilities for such a meeting. The Municipal Auditorium will house the scientific sessions and exhibits. It will be subdivided to provide two large meeting areas to accommodate each of the two scientific sections.

It is anticipated that some visitors may not be able to secure accommodations in the downtown hotels, although a majority of their rooms have been made available during the session. However, there are many beautiful and comfortable tourist courts within a few minutes of the center of town, which may well be preferred by many members. A list of recommended facilities appears in the official program.

Special attention is directed to the "President's Party with Buffet" at La Villita. This has been planned as the social highlight of the meeting, primarily to honor the State President, but also to provide relaxation and diversion for all. Everyone should enjoy the evening, whether his taste runs to food or entertainment, to dancing, or just to socializing.

The Committee hopes that every member or visitor will feel when he leaves San Antonio that he has been to a real scientific meeting, and that he has had a lot of fun and recreation on the side.

L. BONHAM JONES, Chairman,
ROBERT R. NIXON,
CHARLES L. MCGEHEE,
EDWARD D. DUMAS,
JOHN M. SMITH, JR.

Speaker Deaton: This report is referred to the Reference Committee on Reports of Officers and Committees. The next item is the report of the Committee on Scientific Exhibits, Dr. James D. Murphy of Fort Worth. I believe Dr. Murphy had to leave, but he asked me to say that the committee has no supplemental report, but he did ask that the doctors please go by and see the exhibits. This report will be referred to the Reference Committee on Scientific Work. (The report follows:)

REPORT OF COMMITTEE ON SCIENTIFIC EXHIBITS

The Committee on Scientific Exhibits is proud to report that all medical societies, previous exhibitors, and prospective exhibitors were first notified about October 15, 1953, that exhibit space would be available at the forthcoming annual session in San Antonio. Twenty applications were received. These exhibitors have spent considerable time and effort in preparing their exhibits, which are from the fields of general medicine, radiology, urology, ophthalmology, gynecology, and surgery.

This year, as in the past years, two certificates of merit will be awarded, one to the institution or group presenting the best exhibit and the other to the best individual exhibit.

It is respectfully requested that each member of the Association visit these exhibits.

Respectfully submitted,
JAMES D. MURPHY, Chairman.
DEAN B. JONES,
J. E. MILLER,
H. F. CONNALLY, JR.,
EDWARD T. SMITH.

Speaker Deaton: Next is the report on rural health, Dr. Callan.

(Dr. Chester U. Callan, Rotan, then submitted his report:)

REPORT OF COMMITTEE ON RURAL HEALTH

It is the opinion of the Committee on Rural Health that the doctors of Texas should make some effort to assist people living in rural areas to solve their health problems. In the larger cities there is usually a city health organization which studies and attempts to solve all the health problems. However, the individual living in a rural area as a rule has little, if any, help. There are many counties in Texas that do not have a county health officer; as a result the persons living in rural areas have little assistance in solving their health problems.

Although the pressure on the medical profession toward the socialization of medicine has apparently eased, this is by no means permanent. Health is on the mind of every individual in this country. The President recently made plain that there are still problems in health that must be solved. The medical profession is given a time interval in which to solve its own problems. If it does not grasp this opportunity, public pressure will force the problems back into the hands of governmental agencies.

Recommendations

For several years the rural health problem has been one of the weak points in our defense against socialized medicine. Realizing that there is a need for a planned, aggressive program to overcome this weakness, the Committee on Rural Health recommends the following:

1. That the Texas Medical Association urge its members to take an active interest in local rural health committees when formed.

2. That the Texas Medical Association urge the Extension Service of Texas Agricultural and Mechanical College to provide a field worker for the formation of such committees.

Respectfully submitted,
CHESTER U. CALLAN, Chairman,
R. D. HOLT, JR.,
HAROLD LINDLEY,
STEPHEN B. TUCKER,
JAMES H. HARRIS,
GEORGE D. BRUCE.

Speaker Deaton: This report is referred to the Reference Committee on Medical Service and Public Relations. Next we will ask for the report of the Committee on Revision of Constitution and By-Laws, Dr. Charles Hardwicke, Austin.

Dr. Hardwicke: The report of the Committee on Revision of Constitution and By-Laws is contained in the printed reports:

REPORT OF COMMITTEE ON REVISION OF CONSTITUTION AND BY-LAWS

A number of amendments involving changes in the Constitution were introduced before the House of Delegates at the 1953 annual session and are subject to final action this year. The Committee on Revision of the Constitution and By-Laws wishes to call attention to these proposals.

Trustees

Dr. L. C. Powell of Beaumont introduced a series of amendments to the Constitution and By-Laws providing for an increase in the number of Trustees from five to seven, for changing the term of office for Trustees from five to three years, and for dividing the state into trustee districts to assure geographical representation by the Trustees. Dr. Powell's proposed amendments to the Constitution as introduced and recorded in the transactions of the House on page 425 of the June, 1953, JOURAL follow:

"Be it resolved: That Article III of the Constitution of the Texas Medical Association be amended so that, as amended, said article shall provide as follows:

" 'Sec. 1. The officers of this Association shall be a President, a President-Elect, a Vice-President, a Secretary, a Treasurer, seven Trustees, a Councilor for each councilor district, a Speaker, and Vice-Speaker of the House of Delegates.

" 'Sec. 2. The President shall automatically assume office at the expiration of his term as President-Elect. The President-Elect, Vice-President, Speaker, and Vice-Speaker of the House of Delegates shall be elected for terms of one year each. The Secretary, Treasurer, and Councilors shall be elected for terms of three years each. The Trustees shall be elected for terms of three years each. All officers shall serve until their successors are elected and installed.

" 'Sec. 3. The officers of this Association shall be elected by the House of Delegates on the morning of the last day of the annual session, and no person shall be elected to any such office who is not in attendance on that annual session, and who has not been a member of the Association for the preceding two years.'

"Be it further resolved: That Article IV of the Constitution of the Texas Medical Association be amended so that, as amended, said article shall provide as follows:

" 'Sec. 1. The business affairs of the Association shall be managed by a Board of Trustees, comprising seven members, elected in accordance with this Constitution and By-Laws. All funds of the Association shall be subject to the exclusive control of the Board of Trustees, except as otherwise provided in this Constitution and By-Laws. The Board of Trustees shall decide all questions not specifically delegated to other authorities by this Constitution and By-Laws. It shall in general serve as a board of directors, within the meaning of the corporate laws of the State of Texas.'

"Be it further resolved: That Article IX of the Constitution of the Texas Medical Association be amended so that as amended, said article shall provide as follows:

" 'Sec. 1. The House of Delegates shall divide the state into appropriate trustee districts.

" 'Sec. 2. The House of Delegates shall divide the state into appropriate councilor districts.

" 'Sec. 3. The House of Delegates shall provide for the organization and chartering of such district societies as will promote the best interests of the profession. Such societies shall be composed only of members of component county societies of their respective councilor districts and shall be exclusively scientific and educational in character.' "

Dr. Powell called for amendments to Chapter III of the By-Laws to conform with his proposed constitutional amendments. In studying Dr. Powell's amendments, the Committee on Revision of the Constitution and By-Laws became aware of additional internal changes in the By-Laws which would be necessary to avoid discrepancy in fact and intent if Dr. Powell's proposed constitutional amendments are adopted. The Committee therefore wishes to offer the following substitute amendments to the By-Laws which would be in keeping with the constitutional amendments, provided that the constitutional amendments are adopted. The By-Law changes can go into effect at the same time as the constitutional changes and there will be no internal conflict between parts of the Constitution and By-Laws. The proposed substitutes, which have been approved by Dr. Powell, follow:

Amend Chapter III, Section 1, of the By-Laws so that the first portion will read: "The Board of Trustees shall have charge of all properties and moneys of the Association, and shall manage its financial affairs after the manner and with the usual authority of boards of directors of corporations under the laws of the State of Texas. The Board of Trustees shall consist of one Trustee from each trustee district elected by the House of Delegates upon nomination from the floor. The term of office of Trustees shall be three years, and their election shall be arranged in such manner that one-third, as nearly as possible, shall be elected each year. Tenure of office as Trustee by election and by appointment, either or both, shall not exceed three terms, provided, however, that serving as much as one year of the three-year

term shall be considered as serving a full term. Trustees shall be ex-officio members . . ." (continue with the old wording from there).

Amend Chapter III, Section 1, so that in the last three sentences "four members" instead of "three members" may call a meeting of the Board of Trustees and shall constitute a quorum.

Amend Chapter III by the addition of the following new sections:

"Sec. 2. The House of Delegates shall divide the state into appropriate trustee districts as provided for in Article IX of the Constitution of the State Association.

"Sec. 3. There shall be seven trustee districts as follows: District 1—Councilor Districts 1, 2, 3, and 4; District 2—Councilor Districts 5 and 6; District 3—Councilor Districts 7, 8, and 12; District 4—Councilor District 9; District 5—Councilor Districts 10, 11, and 15; District 6—Councilor District 13; and District 7—Councilor District 14.

"Sec. 4. The House of Delegates at its next election following adoption of amendments providing for the seven-member, district-representative type of Board of Trustees shall elect one Trustee from each trustee district. These Trustees shall draw lots for terms of office of one, one, two, two, three, three, and three years respectively, after the completion of which terms successors in office shall be members of the trustee districts of those whom they succeed, be nominated from the floor, be elected by the House, and serve regular three-year terms. Members of the Board of Trustees at the time of adoption of the amendments establishing the seven-member Board shall complete their current terms of office, serving in addition to the seven new Trustees, but their places on the Board shall not be filled upon expiration of their terms."

Amend Chapter VII, Section 1, by substituting in the first sentence for "a Trustee" the following: "two or three Trustees (depending upon which terms have expired)."

Honorary and Inactive Membership

Two series of amendments dealing with honorary and inactive membership, primarily to eliminate dues for these classifications, were introduced at the 1953 annual session and are subject to final action this year.

Dr. Thomas J. Vanzant of Houston, on behalf of the Harris County Medical Society, presented the following amendments to the Constitution (page 426, June, 1953, JOURNAL):

"Amend Article II, Section 1, of the Constitution so that it will read: 'This Association shall consist of the several component county medical societies, duly and constitutionally chartered. Its membership shall comprise only those members of said component county societies who have been duly elected, who have been reported to the office of the Executive Secretary as members, and for whom the Executive Secretary has received the annual per capita assessment, made in accordance with the By-Laws of the Association.

" 'The House of Delegates, upon nomination of component county societies, may elect to honorary membership those physicians of honorable standing who have contributed notably to the advance of ethical medicine, and who may have, because of age or other laudable reasons, reached a point of inactivity or comparative inactivity in the practice of medicine, or who have been members of organized medicine for a period of fifty years or longer; provided that when so nominated and elected said honorary members shall be entitled to all the privileges of membership as set out in this Constitution and By-Laws. The county society secretaries shall include all such honorary members in their respective annual reports, with such notations thereon as will at once declare their status. Failure so to report honorary membership shall terminate the same as in the case of other membership.

" 'It is also provided that county societies may elect to military membership those members or physicians otherwise eligible and accepted for regular membership who are at the time serving with the Armed Forces of our country, including the Coast Guard, and such similar services in time of war, such membership to terminate with their discharge from service.

" 'It is also provided that county societies may elect to inactive membership those members who have retired from the active practice of medicine. The House of Delegates, upon nomination of component county societies, may elect those physicians to inactive membership, provided that when so nominated and elected said inactive members shall be entitled to all of the privileges of membership as set out in this Constitution and By-Laws; provided further that county society secretaries shall include all such inactive members in their respective annual reports, with such notation thereon as will at once declare their status. Failure so to report inactive membership shall terminate the same, as in the case of other membership.'

"Amend Article XI, Section 2, of the Constitution so that it will read: 'The House of Delegates shall provide for an equal per capita assessment of component county societies, and for the proper distribution of the amount so raised into the several funds of the Association, as established by the Board of Trustees or the House of Delegates; provided that no assessment shall be made upon inactive members or honorary members or members emeritus of the Texas Medical Association elected in accordance with this Constitution and By-Laws.' "

Dr. Vanzant also introduced changes in the By-Laws to amend Chapter I, Section 3; Chapter X, Section 5; Chapter XIII, Section 5; and Chapter XIII, Section 6, as corollaries to the proposed constitutional amendments.

The Board of Councilors introduced a set of amendments covering essentially the same changes as those proposed by the Harris County Medical Society and Dr. Vanzant. However, those of the Board of Councilors were slightly more comprehensive and covered such details as refund of dues. The Board of Councilors included military as well as honorary and inactive members in the elimination of dues and stated that prior membership in the Texas Medical Association would be prerequisite to election to honorary, inactive, or military membership. The entire series of amendments, both to the Constitution and the By-Laws, proposed by the Board of Councilors (pages 431-432, June, 1953, JOURNAL) follow:

"Amend Article II, Section 1, paragraph 1, beginning with line 10, to read as follows: '. . . provided that the House of Delegates, upon nomination of component county societies, may elect to honorary membership those physician members of honorable standing who have contributed notably to the advance of ethical medicine, and who may have, because of age or other laudable reasons, reached a point of inactivity or comparative inactivity in the practice of medicine, or who have been members of organized medicine for a period of fifty years or longer; and when so nominated and elected said honorary members shall be entitled to all of the privileges of membership as set out in this Constitution and By-Laws; provided that county society secretaries shall include all such honorary members in their respective annual reports, with such notation thereon as will at once declare their status.

" 'It is also provided that county societies may elect to military membership those members who are at the time serving with the Armed Forces of our country, including the Coast Guard, and such similar services in time of war, such membership to terminate with their discharge from service.'

"Amend Article II, Secton 1, paragraph 2, to read as follows: 'It is also provided that county societies may nominate for inactive membership those physician members who have retired from the active practice of medicine. The House of Delegates, upon nomination of component county societies, may elect those physician members to inactive membership; when so nominated and elected said inactive members shall be entitled to all of the privileges of membership as set out in this Constitution and By-Laws; provided that county society secretaries shall include all such inactive members in their respective annual reports, with such notation thereon as will at once declare their status.'

"Amend Article XI, Section 2, to read as follows: 'The House of Delegates shall provide for an equal per capita assessment of component county societies, and for the proper distribution of the amount so raised into the several funds of the Association, as established by the Board of Trustees or the House of Delegates; provided that no assessment shall be made upon honorary members, inactive members, or members emeritus of the Texas Medical Association elected in accordance with this Constitution and By-Laws.'

"Amend Chapter I, Section 3, beginning with line 5, to read as follows: '. . . allowed all of the privileges of membership, including subscription or right to subscribe to the TEXAS STATE JOURNAL OF MEDICINE, pending decision on appeal. Any member dropped from the rolls of a component county society for non-payment of dues, or any honorary or inactive member dropped for cause, is to be considered as coming within the provisions of this section.' The rest of the section will remain unchanged.

"Amend Chapter X, Section 5, to read as follows: 'Component county societies may nominate for honorary membership in the Texas Medical Association, physician members of good professional and moral standing in their respective jurisdictions who have rendered extraordinary service to the cause of ethical medicine, and who have for good and sufficient reason withdrawn partially or entirely from the practice of medicine, in accordance with Section 1 of Article II of the Constitution of the Association; and when elected by the House of Delegates to the State Association the said honorary members shall be carried on the rolls of their respective county societies and reported in the annual reports of the county societies, as provided herein.'

"Amend Chapter X, Section 5, by the addition at the end of the following sentence: 'Physician members who have paid state dues to cover another type of membership for the year in which they are elected to honorary status shall be refunded the originally paid dues in full.'

"Amend Chapter X, Section 7, to read as follows: 'County medical societies may nominate for inactive membership those physician members who have retired from the active practice of medicine. The House of Delegates, upon nomination of component county societies, may elect those physicians to inactive membership in the Association. When so nominated and elected, the inactive members shall be entitled to all of the privileges of membership. County society secretaries shall include all such inactive members in their respective annual reports with such notation thereon as will at once declare their status.'

"Amend Chapter X, Section 7, by the addition at the end of the following sentence: 'Physician members who have paid state dues to cover another type of membership for the year in which they are elected to inactive status shall be refunded the originally paid dues in full.'

"Amend Chapter X, Section 8, to read as follows: 'County medical societies may elect to military membership those members who are on temporary duty in the Armed Forces of our country.'

"Amend Chapter X, Section 8, by the addition at the end of the following sentence: 'Physician members who have paid state dues to cover another type of membership for the year in which they are elected to military status shall be refunded the originally paid dues in full provided that such election occurs within the first six months of the membership year. One-half of the originally paid dues shall be refunded provided that such election to military membership occurs after the first six months of the membership year.'

"Amend Chapter XIII, Section 4, to read as follows: 'Military members, as provided for in the Constitution and these By-Laws of the Texas Medical Association, shall pay no dues but may subscribe to the TEXAS STATE JOURNAL OF MEDICINE.'

"Amend Chapter XIII, Section 5, to read as follows: 'Honorary members, as provided for in the Constitution and these By-Laws of the Texas Medical Association shall pay no dues, but may subscribe to the TEXAS STATE JOURNAL OF MEDICINE.'

"Amend Chapter XIII, Section 6, to read as follows: 'Inactive members, as provided for in the Constitution and these By-Laws, shall pay no dues, but may subscribe to the TEXAS STATE JOURNAL OF MEDICINE.' "

The Committee on Revision of the Constitution and By-Laws recommends the adoption of the amendments dealing with honorary, inactive, and military members as submitted by the Board of Councilors in preference to those offered by the Harris County Medical Society and Dr. Vanzant.

Election of Officers

The Council on Scientific Work offered amendments which would permit the election of officers at a meeting of the House of Delegates other than on the last day of the session (pages 407 and 430-431, June, 1953, JOURNAL). These amendments, subject to final action by the House this year, follow:

"Amend Article III, Section 3, of the Constitution to read as follows: 'The officers of this Association shall be elected by the House of Delegates in regular session at the time of the annual session, after the completion of all other business, and no person shall be elected to any such office who is not in attendance on that annual session, and who has not been a member of the Association for the preceding two years.'

"Amend Chapter VII, Section 1, so that the first part shall read: 'The House of Delegates in regular session at the time of the annual session shall elect . . .,' the remainder of the section to continue unchanged."

Alternate Delegates

Dr. Thomas J. Vanzant, Houston, on behalf of the Harris County Medical Society last year introduced an amendment to Chapter VI, Section 6, of the By-Laws with the intent of simplifying the procedure for replacing a delegate by an alternate delegate. When the amendment was discussed by the House of Delegates, it was pointed out that the proposed wording would create complications not anticipated by the Harris County Medical Society, and the amendment was tabled despite what seemed to be a general feeling that the idea behind the amendment had merit. The Committee on

Revision of the Constitution and By-Laws has prepared an alternate amendment, approved by Dr. Vanzant, which it is believed will serve the purpose of the original amendment without creating the same difficulties. The suggested amendment follows:

Delete Section 6, Chapter VI, of the By-Laws, and substitute for it the following: "Sec. 6. If a delegate, once seated by the House of Delegates, is unable to continue in attendance because of unavoidable circumstances, he may be replaced by an alternate delegate. Under such circumstances, the delegate's alternate, or another alternate elected by his society, may be seated in the delegate's stead by complying with the requirements of these By-Laws pertaining to the seating of delegates."

Committee on Blood Banks

The Committee on Revision of the Constitution and By-Laws wishes to offer for consideration new By-Laws providing for the establishment of a Committee on Blood Banks as a standing committee of the Association. In its report to the House of Delegates in 1952, the special Committee on Blood Banks recommended that a "permanent committee" be established to continue activity in the field of blood banking. The Reference Committee on Scientific Work, to which the report was referred, concurred in the recommendation, which then was adopted by the House of Delegates (pages 384-385 and 399, June, 1952, JOURNAL). However, no amendments to implement the recommendation were submitted at that time or at the 1953 session. The following amendments, based largely on the recommendations in the 1952 committee report and approved by the present Committee on Blood Banks, are submitted for immediate adoption:

Amend Chapter II, Section 3, of the By-Laws by adding to the list of standing committee members appointed by the President-Elect, a member of the Committee on Blood Banks. Thus, the listing of standing committees will be concluded ". . . Committee on Library Endowment, Committee on Mental Health, and Committee on Blood Banks."

Amend Chapter VIII of the By-Laws by the addition of a new Section 17, subsequent sections to be renumbered accordingly, to read:

"Sec. 17. (b-8) The Committee on Blood Banks shall consist of five members, each with a term of office for five years and with one term expiring each year. Succession in office shall be on appointment by the President-Elect at the time of election of officers and shall not require confirmation by the House; provided that the Speaker shall allow a motion, if made, requesting another appointment. The members of the first Committee shall be appointed for one, two, three, four, and five years, and thereafter succession in office shall be in accordance with the aforementioned procedure. Tenure in office shall not exceed two terms, provided, however, that serving as much as two years of the five-year term shall be considered as serving a full term. The President shall appoint the chairman when the position may become vacant.

"It shall be the duty of this Committee to study current problems of blood banking, to encourage the establishment of blood banks where needed, to formulate minimum standards for the approval of blood banks in Texas and to urge the adoption of such standards by all blood banks in the state, to cooperate in the development of a system of exchanging blood with appropriate reciprocal credit among the blood banks meeting the minimum standards throughout the state, and in general to foster an integrated system of blood banks which can meet best the needs for blood and blood products within the state and, as feasible, throughout the nation."

Respectfully submitted,

CHARLES P. HARDWICKE, Chairman,
ROBERT B. HOMAN, JR.,
G. V. EDGAR,
HARVEY RENGER,
D. SCOTT HAMMOND,
HOBART O. DEATON,
JACK G. KERR,
J. J. HINCHEY.

Speaker Deaton: This report is referred to the Reference Committee on Amendments to the Constitution and By-Laws.

Vice-Speaker Charles P. Hardwicke, Austin: Next is the report of the Committee on Nursing Care, Dr. A. C. Scott, of Temple.

Dr. Scott: This report is printed:

REPORT OF COMMITTEE ON NURSING CARE

The Committee on Nursing Care has had only one formal meeting since the last annual session. It met January 23 and presented a report to the Executive Council on January 24.

Last fall the Association President appointed two members of this Committee, Dr. C. Forrest Jorns, Houston, and Dr. A. C. Scott, Jr., Temple, as representatives of the Association on a joint committee requested by the State Board of Nurse Examiners to study the curriculum required of registered nurses, the problem of nurse recruitment, and other nursing problems.

The chairman attended a meeting in Austin on November 19, 1953, of this joint committee with representatives of the Texas Hospital Association, the Texas League for Nursing, and all members of the State Board of Nurse Examiners.

A subcommittee of this group was selected to meet and propose definite changes in the curriculum of the training program for registered nurses. The chairman of the Medical Association's Committee on Nursing Care was appointed on this subcommittee.

At the meeting of the Committee on Nursing Care January 23 the following business was transacted:

1. A letter from Mrs. Myrtle Dehn Lane, state president of the Licensed Vocational Nurses' Association, addressed to the President of the Texas Medical Association, demanding answers to six questions pertaining to her association, was studied at the President's request. After full consideration and upon the advice of Mr. Philip Overton, general counsel of the Association, the Committee recommended that the President write Mrs. Lane that without more information about her organization, the Texas Medical Association is not in a position to answer her questions.

Mrs. Lane's letter contained an accusation that Dr. Harvey Renger, Hallettsville, chairman of the Council on Medical Economics, as a private physician, used the prestige of his office to form a competing organization to the Licensed Vocational Nurses' Association. The Committee feels that Dr. Renger was entirely within his rights in stimulating or assisting in any organization that would work for the betterment of patient care, that Dr. Renger was only one of many professional individuals who had participated in the formation of the competing vocational nurses' organization, and that the Association should without doubt back Dr. Renger in his action.

2. Two members of the Committee, who are members of the State Board of Vocational Nurse Examiners, brought

up matters relative to needed changes in the law, and the Committee has recommendations it wishes to make.

3. The Committee recommended in its January report to the Executive Council that the Association stimulate and assist in establishing nurse recruitment programs in high schools, patterned after the Michigan plan.

4. The Committee also recommended that the State Association, through its President, participate in the organization of a Joint Commission for the Improvement of the Care of the Patient similar to that of the National Joint Commission as recommended by the American Medical Association, American Hospital Association, American Nurses Association, and the National League for Nursing; and that the President appoint three representatives, preferably from the Committee on Nursing Care or the Council on Medical Education and Hospitals or from both, who would meet jointly with representatives from the Texas League for Nursing, Texas Graduate Nurses Association, and Texas Hospital Association to consider the feasibility of forming such a state commission.

Following approval of the Committee's report by the Executive Council on January 24, the President requested members of the Committee on Nursing Care to meet with hospital administrators and representatives of the nurses' organizations on January 30, 1954, to help organize a state Joint Commission for the Improvement of the Care of the Patient similar to the national organization. Dr. G. E. Brereton, Dr. Truman Blocker, and the chairman attended this meeting and assisted in formulating by-laws for this organization, which herewith follow:

BY-LAWS OF TEXAS JOINT COMMISSION FOR THE IMPROVEMENT OF THE CARE OF THE PATIENT

Article I.—Name.

The name of this organization shall be "Texas Joint Commission for the Improvement of the Care of the Patient."

Article II.—Purposes and Objectives.

The major purpose of this commission is to stimulate, implement, assist in, and sponsor activities which will contribute to the care of the patient as may be mutually satisfactory to the appointing organizations.

To achieve this objective, the commission performs as a service agency to the parent organizations. It shall be the intention of the commission to obtain a better understanding of the problems and programs of all represented groups; to serve as a source of information on trends within the programs of the participating organizations; to facilitate the development of a more unified public relations approach by the participating organizations; to explore the needs for and stimulate studies in areas of patient care in which the organizations participate; and to perform such functions and carry on such activities contributing to the major objectives as may be mutually satisfactory to the appointing organizations and to the commission.

Article III.—Membership.

A. The appointing organizations shall consist of the Texas Medical Association, Texas Hospital Association, Texas Graduate Nurses Association, and Texas League for Nursing.

B. The *appointed membership* shall consist of four representatives from the Texas Medical Association, four representatives from the Texas Hospital Association, two representatives from the Texas Graduate Nurses Association, and two representatives from the Texas League for Nursing.

The representation from nursing shall be divided equally between the Texas Graduate Nurses Association and the Texas League for Nursing and should encompass representation of the interests of practical nursing, public health nursing, hospital nursing service, and nursing education.

C. *Ex-officio membership,* without vote, shall be (1) The presidents of the Texas Hospital Association, Texas Medical Association, Texas Graduate Nurses Association, and the Texas League for Nursing, or their duly appointed alternates; (2) the secretaries or executive secretaries of Texas League for Nursing, Texas Graduate Nurses Association, Texas Medical Association, and Texas Hospital Association; and (3) editors of official organs of each association respectively.

Article IV.—Authority for Appointment.

Each of the parent organizations shall have authority to appoint representatives in accordance with Articles III and V. The four organizations shall be known as the *appointing organizations.*

Article V.—Terms of Appointment.

Each appointment shall be for two years.

Article VI.—Voting Privileges and Quorum.

Only appointed members present shall have a vote, except that in the absence of an appointed member a designated ex-officio member of the appointing group shall have the power to vote. *A decision shall be reached by a majority vote.*

A quorum shall consist of seven voting members providing all of the appointing organizations shall be represented.

Article VII.—Officers.

There shall be a chairman, a vice-chairman, and a secretary-treasurer. The first two shall not be from the same major group (nursing, medicine, and hospitals).

The chairman shall be elected for a one-year term at the annual meeting and may be re-elected for one additional term. He shall take office the following January 1.

The vice-chairman shall be elected in the same manner and at the same meeting as the chairman and may be re-elected for one term.

The secretary may be an employee of the commission, or a member of the staff of an appointing organization. He shall be elected for a two-year term.

The chairman shall preside at meetings and perform the usual functions of presidents of similar organizations. The vice-chairman shall have the duties generally ascribed to vice-chairmen. The secretary shall perform the functions customary for that position in similar organizations.

Article VIII.—Meetings.

There shall be at least two regular meetings annually. The first regular meeting of the year will be the annual meeting. Special meetings may be called by the chairman.

Attendance to meetings shall be limited to appointed members, ex-officio members, and other individuals who may be invited by the chairman to participate in the program or whose presence may be requested by one of the appointing organizations and approved by the chairman.

Article IX.—Committees.

There shall be an Executive Committee of four members consisting of the chairman, vice-chairman, and one other elected annually at the annual meeting to represent the third group, and the secretary-treasurer, ex-officio. Vacancies may be filled by the chairman from the group represented.

The Executive Committee shall carry on the activities of the commission between commission meetings. Other committees may be appointed by the chairman.

ARTICLE X.—FINANCING.

A. The expenses of representatives to attend commission meetings shall be a responsibility of the respective appointing organization.

B. Other organizational expenses, such as those for clerical service, meeting space, and office work, shall be divided equally between the three major groups (nursing, medicine, and hospitals).

C. Other finances may be promoted and cared for as may be recommended by this commission and approved by the four appointing organizations from time to time.

ARTICLE XI.—RELATIONSHIP OF THE COMMISSION TO APPOINTING ORGANIZATIONS.

A. The commission shall be a service group to the organizations represented. It shall be a sounding board for a constructive exchange of opinions. Actions of the commission are advisory to and not mandatory on the appointing organizations. The commission may originate actions for consideration by, or may receive actions for consideration from the appointing organizations. The Texas Joint Commission will keep in touch with the National Joint Commission for the Improvement of the Care of the Patient, ask for help and advice as necessary, make suggestions and recommendations, and submit an annual report to the National Commission.

B. The failure of an appointing organization to approve or disapprove a commission conclusion within a period of three months shall be accepted as approval of the conclusion, and an extension of three months will be granted on request.

C. Such items as are unanimously approved by the commission and deemed suitable for publication by all four presidents of the appointing organizations may be released by the Texas Joint Commission to the public through professional and other media.

ARTICLE XII.—AMENDMENTS.

These rules may be amended without previous notice by unanimous vote, or by a two-thirds vote, if the amendment has been presented to the membership of the commission at least two weeks in advance of the meeting at which the vote is taken.

ARTICLE XIII.—EFFECTIVE DATE.

These rules and/or amendments shall become effective when approved by the commission and appointing organizations.

ARTICLE XIV.—RULES OF ORDER.

Deliberations of all meetings of the commission shall be governed by Robert's Rules of Order, Revised.

It is believed by members of the Committee on Nursing Care that this organization can and will be of great benefit in helping to solve the serious nursing shortage, in effecting beneficial changes in the training program of three categories of nurses, and in materially improving the care of patients throughout the state.

Recommendations

The Committee on Nursing Care wishes to make the following recommendations:

1. That the House of Delegates endorse Dr. Renger's stand in participating in the formation of a vocational nurses' organization.

2. That the Texas Medical Association, through its Council on Medical Jurisprudence, work for three proposed changes in the vocational nurse law: (1) an increase in the renewal fee from $1 to $2, (2) a reduction in the number of members of the board from six to three members who must be present during an examination, and (3) a change in the dates of the fiscal year to permit use of funds for a full year; and that through the Council on Medical Jurisprudence the Association oppose any efforts at reopening or changing the waiver clause in the vocational nurse law.

3. That the Association stimulate and assist in establishing nurse recruitment programs in high schools, patterned after the Michigan plan.

4. That the House of Delegates endorse the Texas Joint Commission for the Improvement of the Care of the Patient and authorize the Board of Trustees to participate in paying the Association's pro rata part of the expenses of that organization as provided for in its by-laws.

Respectfully submitted,

A. C. SCOTT, JR., Chairman,
C. FORREST JORNS,
R. H. BELL,
NEIL BUIE, JR.,
R. D. HOLT,
G. E. BRERETON,
JOSEPH F. MCVEIGH,
TRUMAN G. BLOCKER,
J. L. STOWE.

Vice-Speaker Hardwicke: This report will be referred to the Reference Committee on Medical Service and Public Relations. The next report is that of the State Council on National Emergency Medical Service, Dr. Woods of Dallas.

REPORT OF STATE COUNCIL ON NATIONAL EMERGENCY MEDICAL SERVICE

Dr. Ozro T. Woods: As all of you know there has been a considerable change in the whole philosophy and intent of civil defense in the country. The simple plans this Council made, which were approved by this House of Delegates, are that the responsibility lies in the communities and that the leadership lies in the county medical societies. They have been confirmed throughout the country. We had a long meeting last night with Dr. Holle, the new state health officer, and we are very happy that Dr. Holle and the Council are in almost complete agreement about the general procedures and our plans and what we should do. It is up to this Council to get to work and it is our only recommendation that this committee, which is a large one, be reduced to five members and that Dr. Holle be a member of it.

Vice-Speaker Hardwicke: The report is referred to the Reference Committee on Medical Service and Public Relations. Next is the report of the Committee on Doctor Distribution. That is Dr. Chester U. Callan, Rotan.

Dr. Callan: Our report is printed and there is no supplemental report:

REPORT OF COMMITTEE ON DOCTOR DISTRIBUTION

The Committee on Doctor Distribution, created in May, 1952, by the House of Delegates of the Texas Medical Association, has completed the first phase of its program of work and has reported its findings relating to doctor distribution as viewed by the medical profession. This report was submitted and approved in Houston at the 1953 annual session of the Association.

The Committee is well into the second phase of the program originally outlined. This contemplates a direct survey of Texas communities to determine whether or not qualified representatives of these communities, in most cases chamber of commerce committees, believe doctor shortages

exist in those areas and then by actual on-the-spot survey either to confirm or dispel the question of such shortage. The Committee is well aware of the magnitude of this undertaking, and for that reason it conducted a pilot survey of ten counties of the Seventh Councilor District.

Working in cooperation with Dr. J. M. Coleman, Councilor of the Seventh District, a detailed analysis of community needs in the ten counties composing this medical district was completed in January, 1954. Twenty communities in the district with population over 800 were contacted directly asking whether the community itself believed there existed a need for additional doctors.

Each doctor in the district and all society officers were advised in advance of the purpose of the survey and the method by which it would be completed. All communities were provided with pamphlets prepared by this Committee advising the steps by which the community itself could assist in the problem of providing adequate medical care and the responsibilities of the community in keeping a doctor there.

The Committee is pleased to report that not one request for additional doctors was received. In the Committee's judgment this is clear proof that the number of doctors in this district is adequate and that physicians are located properly in various communities.

Since the Board of Trustees has secured the services of a trained field secretary, this survey can be completed in a period of several months and, if the pilot survey is any index, should bring to light much valuable materials.

Recommendation

The Committee on Doctor Distribution would like to recommend that the life of this Committee be prolonged for at least one more year to complete this survey and assemble the results.

Respectfully submitted,

CHESTER U. CALLAN, Chairman,
HARVEY RENGER,
TROY SHAFER,
ALLEN T. STEWART,
J. C. TERRELL.

Speaker Deaton: Dr. Callan's report is referred to the Reference Committee on Medical Service and Public Relations. Next is the report of the State Chairman of the American Medical Education Foundation, Dr. Thorn.

Dr. S. W. Thorn, Houston: The complete report is found printed:

REPORT OF STATE CHAIRMAN OF AMERICAN MEDICAL EDUCATION FOUNDATION

The purpose of this Committee for the American Medical Education Foundation, created in Texas in 1953, is to provide an instrument through which individual physicians, state and county medical societies, and interested lay groups can make contributions in support of medical education. This need for support for medical education has come about as a result of the radical changes in our national economy and the increased demands made upon the medical schools to expand their enrollments and to adapt their curriculums to the ever-changing science of modern medicine.

The Committee consists of a Chairman for the state and local chairmen from each component society who direct the campaign for funds at the county level. In 1953, there were seventy-three physicians who accepted appointments to this Committee and directed the campaign in their local medical societies.

The Committee is pleased to report that in 1953 there was a marked increase both in the total number of doctors participating in this program and also in the total amount of money raised for the American Medical Education Foundation from Texas. In 1953, 202 doctors contributed a total of $8,903.28. This compares favorably with the 1952 totals when only 27 doctors in Texas participated in this work and contributed a total of only $1,065. In 1953, one Texas physician, Dr. Stuart Wallace of Houston, received from the American Medical Education Foundation the Award of Merit, given to each doctor who contributes $1,000 or more. The Woman's Auxiliary to the Texas Medical Association and Mrs. George Turner of El Paso also will receive this award.

In addition to the 202 Texas doctors who contributed through the American Medical Education Foundation, many doctors contributed funds directly to the medical schools. Baylor University College of Medicine, Houston, reports contributions of $11,800 by 148 doctors. Tulane University reports 1,332 doctor-contributors, many of whom, the Committee believes, are Texas doctors. The University of Texas did not report the number or amount of direct contributions during 1953.

During 1953, the Foundation contributed a total of $73,540 to the three Texas medical schools. This amount represents an increase over 1952 of $5,738. Of this total amount Southwestern Medical School of the University of Texas in Dallas received $23,595; Baylor University College of Medicine in Houston, $22,490; and the University of Texas School of Medicine at Galveston, $27,455. From a comparison of these figures, it is apparent at once that Texas schools have benefited in excess of $64,000 more than has been contributed from the state to the American Medical Education Foundation.

The Committee feels that the prospects for 1954 are much better than in 1953. Many doctors had never heard of the American Medical Education Foundation prior to this first campaign. Many doctors who did not contribute in 1953 will wish to take a part in this work during 1954. This is reflected in the report of contributions from Texas for January, when 61 doctors contributed $1,343. With proper cooperation from members of the State Association, 1954 will be a more successful year and Texas can match more nearly the amount of money its schools are receiving.

Audio-Digest Foundation

At the national meeting of state Foundation chairmen in Chicago this past January, a nonprofit subsidiary foundation of the American Medical Education Foundation was announced. It is known as the Audio-Digest Foundation, which has as its purpose the national distribution of tape recordings of the latest medical information. The basic service is the weekly issuance of a one-hour recording for general practitioners. On it are recorded twenty to thirty abstracts of the best in current literature embracing all medical fields. Articles are screened by a board of medical editors headed by Dr. Edward C. Rosenow, Jr., Pasadena, Calif., editor-in-chief. As a corollary service, Audio-Digest offers semimonthly digests in the fields of surgery, internal medicine, and obstetrics and gynecology. The third service is lectures and panel discussions on one-hour reels for individual or group purchase. Many of these lectures are illustrated by film strips made from the speaker's own slides. This service will be available to physicians for $3.75 for each one-hour tape recording. The profit derived from this service will be turned over to the American Medical Education Foundation for its use in assisting the medical schools to meet their basic educational needs.

Recommendations

The Committee recommends that each and every member of the Texas Medical Association actively support the American Medical Education Foundation in 1954.

The Committee recommends for consideration the services of the Audio-Digest Foundation.

The Committee further recommends that the president of each county medical society appoint a local chairman to serve on this Committee.

Respectfully submitted,
S. W. THORN, Chairman.

Speaker Deaton: Dr. Thorn's report is referred to the Reference Committee on Reports of Officers and Committees. Next, if they are ready, we will have the report of the Committee for Liaison with Workmen's Compensation Insurance Companies.

Dr. Sam N. Key, Jr., Austin: Mr. Speaker, our Committee does not have a complete report at this time.

Speaker Deaton: Thank you. Next are the Appointees to Cooperate with the Board of Nurse Examiners.

Dr. A. C. Scott, Temple: Gentlemen, you will find that incorporated in the report of the Committee on Nursing Care.

Speaker Deaton: Now we have a Joint Commission for the Improvement of Care of the Patient. Who has that report?

Dr. A. C. Scott, Temple: That is incorporated in the report of the Committee on Nursing Care. The Joint Commission was set up through stipulation of the American Hospital Association and American Medical Association and American Nursing Association, and the American Medical Association recommended that each constituent state organization set up a similar commission. The initial steps have been taken in this state, and Dr. Turner has appointed four of us (Dr. G. E. Brereton of Dallas, Dr. Truman Blocker of Galveston, Dr. Joseph F. McVeigh of Fort Worth, and me) to represent the Texas Medical Association. At this meeting you will be given the opportunity after the reference committees have gone over this thing to determine whether or not you want this organization to cooperate in the proceedings of that Joint Commission.

Speaker Deaton: We come now to the reports of special delegates. Dr. T. C. Terrell was to give the report for the Texas Hospital Association, but he is not here, and the delegate to the Texas State Nutrition Council, Dr. Joe Nichols, is not in the room at this time. Are you ready with the report at this time, Dr. Callan, for the State Rural Health Council?

Dr. Chester U. Callan, Rotan: The report is printed:

REPORT OF SPECIAL DELEGATE TO STATE RURAL HEALTH COUNCIL

The Committee on Rural Health met with members of the State Rural Health Council on July 18, 1953. The results of the first survey, made by the Committee on Doctor Distribution, were presented and discussed with this group. The State Rural Health Council agreed that a definite plan should be made to improve health conditions in rural areas.

The Delegate, with several representatives of the Texas Medical Association, including Dr. F. J. L. Blasingame, Dr. Robert W. Kimbro, and Dr. Stephen B. Tucker, met with the State Rural Health Council on November 22, 1953, at College Station. Ways and means of improving health conditions in rural areas were discussed. The possibility of getting the Extension Service of Texas Agricultural and Mechanical College to hire a field worker for formation of local health committees was discussed. The Extension Service was interested in this project, provided there was enough interest manifested by the doctors of Texas.

The past year has shown a marked change in the attitude of the Rural Health Council toward the Texas Medical Association, and the Delegate attributes this change to the increased interest shown in rural health problems by the doctors of Texas.

Respectfully submitted,
CHESTER U. CALLAN.

Speaker Deaton: This report is referred to the Reference Committee on Medical Service and Public Relations. The delegate to the Lone Star Medical Association, Dr. L. L. D. Tuttle of Houston. Dr. Tuttle does not seem to be here, but this report is printed and will be referred to the Reference Committee on Medical Service and Public Relations. (The report follows:)

REPORT OF SPECIAL DELEGATE TO LONE STAR STATE MEDICAL ASSOCIATION

The Lone Star State Medical Association met in Houston, June 2, 3, and 4, 1953. The total number of registrants as of June 2 was forty-four. The meeting was held at the Texas Southern University. There were some twenty-two scientific papers presented, and a business session was held.

The minutes show that the main address was made by the president-elect, Dr. P. W. Beal. Dr. J. L. Dickey was presented, and the fact that Dr. Dickey had been chosen as outstanding citizen of Taylor, Texas, for the year was indeed a source of gratification to the whole group.

The Lone Star State Medical Association went into extra session at Marlin December 6, 1953, at which time its members accepted the resignation of Dr. Beal. At this same meeting Dr. H. L. Williams of Marlin was made president. The records show that at that same meeting Dr. Howard O. Smith of Marlin addressed the group. The group has chosen Beaumont as its 1954 meeting place, this meeting to be held June 8, 9, and 10.

Respectfully submitted,
L. L. D. TUTTLE.

Speaker Deaton: The delegate to the Arkansas Medical Society is Dr. J. M. Travis of Jacksonville; do you have a report, Dr. Travis?

Dr. Travis: Mr. Speaker, the Arkansas association met on April 19 at Fort Smith. I had made preparations to attend, but on account of my health, I did not get to attend.

Speaker Deaton: The report of the Committee on Blood Banks is published and will be referred to the Reference Committee on Scientific Work. (The report follows:)

REPORT OF COMMITTEE ON BLOOD BANKS

The Committee on Blood Banks wishes to reemphasize certain segments of the report before the Executive Council in January, 1953, and to relate developments in the field of blood banking during the past year which potentially affect the entire state. In connection with one of these developments the Committee submitted a resolution to the Executive Council in January, 1954.

The Committee considers it fundamental that the relation between blood banking and the practice of medicine continually be emphasized. It must be accepted that the collection of blood from a donor is as much the practice of medicine as the infusion of a blood transfusion. Evaluation of the health of a donor to determine his eligibility for donation of blood is as much a medical function as the use of a local anesthetic, the puncture of veins, the withdrawal of a portion of the circulatory blood volume, and

the complications which these manipulations may precipitate, such as thrombosis, thrombophlebitis, reactions to the anesthetic, emotional disturbances, and even convulsions. Accordingly, it can be considered that the procurement of blood is as much a part of medicine as its dispensation and infusion. Yet, the medical profession naturally tends to be more concerned with the problems of the recipient, such as the indication for the transfusion, the quantities involved, the accuracy of the compatibility, and potential reactions and their management, thus tending to overlook the source of the blood.

Accordingly, the Committee wishes to urge that members of local medical societies and other interested parties continue to educate themselves on these points, particularly that blood banking matters should be under proper medical supervision. Conversely, it is hoped that all concerned with this question will continue to oppose the attitude that accepts blood without the knowledge or concern over its source, mode of processing, and therefore its integrity, purity, and general meaning.

The Committee, through three of its members, is aware of certain developments in blood banking in the state which should be brought to the attention of the Association. The Committee's report of January, 1953, emphasized the need for the integration of blood banks throughout the state in a system of exchange for blood and blood credits. For this purpose a central clearinghouse was discussed. Such a structure provides "credit forms" to all reciprocating banks, to be forwarded to the clearinghouse, for the proper exchange of blood and blood credits as their needs arise; records credits and debits; adjusts credits and debits at the end of each month; and directs the shipment of blood to cancel blood indebtedness at the end of each month. By these functions the clearinghouse integrates inter–blood bank transactions, authorizes blood shipments to cancel indebtedness, collects and pays processing fees, and maintains a perpetual inventory of blood available throughout the state. Such a clearinghouse program is considered effective and essential as a means of improving the availability of blood; minimizing the percentage of blood that is unused through becoming outdated or overage; and integrating blood banks by standardizing equipment and procedures, by insistence on accurate methods, by a continual automatic system of self-education, and by the development of habit patterns of cooperation and communication. A system is developed wherein most eligible donors throughout the state can be rapidly mobilized in times of peace or war for the care of casualties. Such a system is in a better position to lower the cost of blood to patients. Moreover, the success of such a program becomes an outstanding insurance against the encroachment in this field in this state by centralized governmental or quasigovernmental agencies.

The Committee wishes to mention that such a clearinghouse program is in the process of being launched under the sponsorship of the Texas Association of Blood Banks. Already the initiating fund is sufficiently advanced to indicate a beginning of this program by March or April. There is adequate indication of greater voluntary donations in support of the initial phase of this program. An agreement concerning the major features of the program has been reached by twelve of the larger blood banks in the state, extending from Amarillo to Houston and Galveston and from El Paso to Tyler. There is every indication that many other organizations will join the program.

Since the potentialities of this mechanism for the exchange and supply of blood for transfusions were thoroughly discussed at the January, 1953, Executive Council meeting and since the Council and the House of Delegates considered the question favorably, the Committee on Blood Banks requested by resolution before the January, 1954, Executive Council endorsement of such a clearinghouse program, and such endorsement was given.

Respectfully submitted,
E. E. MUIRHEAD, Chairman,
T. P. CHURCHILL,
TOM OLIVER,
C. B. SANDERS,
O. J. WOLLENMAN, JR.

FRATERNAL DELEGATES

Speaker Deaton: This brings us to the presentation of some fraternal delegates. The delegate from the Private Clinics and Hospitals Association of Texas, Dr. William T. Sadler of Merkel.

Dr. Sadler: I am happy to be here as a guest and I will file my report:

The 175 members of the Private Clinics and Hospitals Association appreciate the privilege of having one of its members present as a guest of the House of Delegates of the Texas Medical Association, and I am grateful to have received this assignment.

Our organization came into being by reason of the fact that there were certain peculiar problems which need to be considered. Its existence in no way limits our allegiance to the parent organization. The board of councilors has asked me to extend an invitation to this group to designate one of your members to be present at the state meeting of the Private Clinics and Hospitals Association on December 4 and 5 at Corpus Christi. We have no measures peculiar to our organization which we need to submit to the House of Delegates.

Speaker Deaton: This report will be referred to the Reference Committee on Medical Service and Public Relations. The fraternal delegate from the Texas Dental Association, Dr. Kenneth W. Thomas of San Antonio.

Dr. Thomas: I was speaking to one of your local members the other day and told him I had a little speech of about four lines to make to this body. He replied that the idea was all right but couldn't I cut it down to two. I have taken that into consideration, and I will come and go in practically the same breath. I come with greetings from the Texas Dental Association with best wishes for a fine convention and go with the hope that our two societies will enjoy the same cooperation and mutual understanding that they have in the past.

RESOLUTIONS AND AMENDMENTS

Speaker Deaton: That brings us to the reading of communications. Apparently we have no communications, so the next item of business is the reading of memorials and resolutions. If you have a resolution, this would be a good place to read it. Dr. E. P. Hall of Fort Worth is recognized.

Dr. Hall: This is a resolution opposing compulsory social security taxation and its extension:

Resolution: Extension of Compulsory Social Security

Whereas, the social security system is based on a completely compulsory principle that is contrary to the essential principles of individual liberty and freedom; and

Whereas, numerous federal court decisions have held that the social security tax is just another income tax, which creates no contractual or moral obligation for payment of benefits; and

Whereas, legislation is now pending which will force 6,500,000 persons, including physicians, into the system; and

Whereas, the Texas Medical Association, in April, 1953, stated its opposition to the extension of compulsory social security taxation; therefore, be it

RESOLVED: That the Texas Medical Association, through its House of Delegates, in regular session, assembled this second day of May, 1954, does hereby instruct its delegates to the American Medical Association to present to the House of Delegates of the American Medical Association at the annual session in 1954, a resolution requesting that that body state its unequivocal opposition to compulsory social security taxation and its extension; and be it further

RESOLVED: That a copy of this resolution be spread upon the minutes of this meeting and provided to each member of the Texas Medical Association who is a member of the House of Delegates of the American Medical Association.

Speaker Deaton: Inasmuch as Dr. Copeland's report has been referred to the Committee on Medical Service and Public Relations, Dr. Hall's resolution will be referred to the same committee. The chair will recognize Dr. Pickett.

Dr. B. E. Pickett, Carrizo Springs: I wish to submit herewith two resolutions. The first resolution pertains to reclassification of membership.

Resolution: Reclassification of Membership

Whereas, the American Medical Association is considering the various classifications of membership as set up in the constitution and by-laws of its various component state medical associations; and

Whereas, the American Medical Association is recommending to the component state medical associations types of classifications of membership in order that the American Medical Association can expedite its work with the various component state medical associations; now therefore be it

RESOLVED: That the House of Delegates request the Committee on Revision of the Constitution and By-Laws to study and reevaluate the classifications of membership as set forth in the Constitution and By-Laws of the Texas Medical Association so that, if possible, the classifications for membership in the Texas Medical Association will conform with the classifications as set up by the American Medical Association; be it further

RESOLVED: That the Committee on Revision of the Constitution and By-Laws consider making the changes in the classification of membership in the Texas Medical Association on the basis of the recommendation of the American Medical Association as attached hereto and made a part hereof.

(The recommendations mentioned in the resolution follow:)

January 11, 1954

"B. E. Pickett, Sr., M. D.
Carrizo Springs, Texas
Dear Dr. Pickett:

We appreciate very much your offer to do some spadework toward the simplification of membership classifications.

On the attached sheet, we have summarized the various classifications of membership in the Texas Medical Association, according to the information given in the copy of your Constitution and By-Laws, dated May 7, 1952, which we have on file.

On Sheet No. 2, we have indicated possible changes, cutting the number of types of membership to three, but preserving as much as possible the present rights and privileges given to these members.

We have indicated, for example, that both 'Active' and 'Inactive' members should simply be designated as 'Active.' The use of 'Inactive' for a classification of membership that includes the right to vote and hold office is rather unusual, and apt to be misleading. As far as we can see, members in this classification are actually those who could be exempted from the payment of A.M.A. dues because of retirement or financial hardship.

The 'Honorary' and 'Emeritus' members of your society could be combined, we believe, in a new classification called 'Life' members. All of these would be eligible to Active membership in the A.M.A., and those who are retired or who have attained the age of 70 could be exempted from the payment of A.M.A. dues. We are not sure of just what the differences are between 'Inactive' and 'Honorary' under your present constitution; if the differences are not too great, you may prefer to switch the 'Inactive' also to the new classification of 'Life.'

It would be well to get away from the use of the classification of 'Honorary' for active members, because it is so generally used to designate out-of-state men who are given a nominal, honorary membership, often simply because they have taken part in an annual meeting. Generally, it is the type of membership that does not include the right to vote and hold office.

Your 'Intern,' 'Resident,' and 'Military' members could be easily changed to a classification of 'Associate,' and they would then be given Associate Membership in the A.M.A., just as they now are. We have added the information that they would not have the right to vote or hold office, as this information should be specifically mentioned in your Constitution and By-Laws. We should like to call your attention to the fact that most states provide a type of active membership, rather than associate membership, for members who are temporarily serving in the Armed Forces. If it should be desired to give these physicians the privilege of voting and holding office, they could be changed to the Active classification, and made exempt from the payment of A.M.A. dues, regardless of whether they are required to pay full or partial dues in the state.

There is another matter relating to your membership that I should like to mention at this time. I wonder if it would be possible, in publishing your Annual Directory of Members, to arrange the list alphabetically by counties, and after each county indicate by number the district to which the county belongs. Under the present arrangement, which is by district and then alphabetically by name of member under the district, it is very difficult to ascertain whether a man is a member because one has to look through fifteen districts and locate the county before one can then refer to the section of the book containing the members for that particular county. If the present arrangement is continued, it would help to provide at least a complete alphabetical list by name, followed by a number or key to show the district under which the member's full address appears.

We are very grateful for your interest in these various problems of membership, and shall be glad to furnish any further information that will be of service to you.

Very truly yours,
FRANK V. CARGILL
Director of Records and Circulation
American Medical Association

Type of Membership	AMA Status	Texas
Active	Active	Only white physicians, licensed in Texas shall be members, except that white medical officers of the federal government and teachers in Class A schools who do not practice and are not required to be licensed, who are

		bona fide residents of Texas shall be eligible.
Honorary	Active	Those physicians of honorable standing who have contributed to the advance of medicine or, who may have, because of age or other laudable reasons, reached comparative inactivity in practice of medicine or completely retired; pay reduced dues.
Emeritus	Active	Any member of the Association who has rendered exceptional and distinguished service; pays no dues.
Inactive	Active	Members of county societies who have retired permanently and who are not eligible to Honorary membership; pay reduced dues.
Residency	Associate	County medical societies may elect to
Intern	Associate	intern or resident membership physicians who are serving internships or residencies in hospitals as a part of their educational qualifications and who are not in private practice, provided they meet the other requirements in the constitution and pay the annual dues of $4.00.
Military	Associate	Members who are at the time serving the Armed forces, including the Coast Guard, the membership ending with discharge. Military members will be required to pay a yearly fee of $1.00 to cover Medical Defense."

Speaker Deaton: This resolution will be referred to the Reference Committee on Amendments to the Constitution and By-Laws. All right, Dr. Pickett.

Dr. Pickett: This next resolution is one directing attention to the proper method of correcting unethical conduct:

Resolution: Correction of Unethical Conduct

Whereas, numerous articles concerning ghost surgery, fee splitting, and other types of unethical and unprofessional conduct have appeared in national publications and articles in daily papers; and

Whereas, said articles are of such a nature as to lead the public to believe that said fee splitting, ghost surgery, and other types of unethical conduct are prevalent within the ranks of organized medicine; and

Whereas, it is the opinion of the House of Delegates that said articles do not reflect the true facts and are having a detrimental effect upon the members of the medical profession; and

Whereas, the Texas Medical Association and its component county societies have provided public grievance committees to consider matters of this nature when brought to their attention; and

Whereas, under Chapter XIV of the By-Laws of the Texas Medical Association it is provided:

"Sec. 1. The Principles of Medical Ethics of the American Medical Association, as at present published, or as hereafter amended, shall govern the conduct of the members of this Association in their relationship to each other and the public.

"Sec. 2. In consultation, the dictates of humanity shall be the governing principle, but it shall be considered unprofessional and unethical for a physician to enter into any business relations with a practitioner of sectarian medicine or a cultist, which would tend to commend such limited practices or establish them in the confidence of the public, or bring reproach upon the good name of the medical profession.

"Sec. 3. It shall be considered unprofessional and unethical to engage in the practice commonly known as fee splitting, in any of its forms as defined by the Board of Councilors"; and

Whereas, adequate means are provided under the Constitution and By-Laws of the Texas Medical Association and its component county societies to conduct investigations and suspend or revoke the membership of any of its members who are guilty of such practices; and

Whereas, it is the desire of this House of Delegates of the Texas Medical Association to eliminate any of the unethical practices mentioned above when the information is furnished to the Texas Medical Association or any of its component county societies; now therefore be it

RESOLVED: That this House of Delegates go on record as being in full accord with the By-Laws of the Texas Medical Association and its component county societies and is desirous that said By-Laws be strictly enforced concerning fee splitting, ghost surgery, or any other type of unethical conduct; and be it further

RESOLVED: That copies of this resolution be sent to each hospital administrator in Texas and to the secretaries of the component county societies in order that they may be fully informed concerning the By-Laws relative to ghost surgery and fee splitting; and be it further

RESOLVED: That the delegates to the American Medical Association from Texas introduce a similar type of resolution in the House of Delegates of the American Medical Association calling upon the House of Delegates of the American Medical Association to recommend to its component state medical associations the enforcement of the code of ethics of the American Medical Association concerning fee splitting, ghost surgery, and other types of unethical conduct of its members in order that the public might be informed of the avenues open to them to file charges or complaints against any physician who is guilty of fee splitting, ghost surgery, and other types of unethical practices.

Dr. Pickett: This resolution was passed unanimously by the LaSalle-Frio-Dimmit Society. The first resolution was by request of the Department of Records and Circulation of the American Medical Association, Mr. Frank Cargill, directing head.

Speaker Deaton: It has been suggested that this last resolution should be referred to the Board of Councilors as a reference committee. Is there anyone else who has a resolution?

Dr. Homer E. Prince, Houston: Mr. Speaker, this is an amendment for Article X, Section 4 of the Constitution and By-Laws:

Amendment: Probationary Membership

BE IT RESOLVED: That Chapter X, Section 4 of the By-Laws of the Texas Medical Association be amended and they are hereby amended so that the same shall hereafter read as follows:

"Sec. 4. Each component county society shall judge of the qualifications of its own members, but it shall have all due regard for the fact that only through a component county society may a physician become a member of the Texas Medical Association and of the American Medical Association, and shall consider that all white, legally registered physicians within its jurisdiction holding the degree of Doctor of Medicine, and all white medical officers of the Army or Navy or of the Federal Government, or teachers in "Class A" medical schools of this State who do not

practice medicine and who are not required to register under the Medical Practice Act of Texas, who are at the time bona fide residents of the State, who do not hold themselves out as practitioners of sectarian medicine and who shall subscribe to the Principles of Ethics of the American Medical Association, are entitled to membership.

"Component county societies shall have the right to provide a probationary period for applicants seeking membership in their county society, provided that the probationary period shall be determined by the individual component county societies but under no circumstances shall the probationary period exceed twenty-four months. New members accepted on a probationary basis may have all the privileges of regular membership in the society, including the right to vote. However, at the end of the probationary period, as provided in the Constitution and By-Laws of the component county society, the member shall again be considered by the board of censors of said component county society and elected by the county society before his membership can become permanent."

Speaker Deaton: This resolution is referred to the Reference Committee on Amendments to Constitution and By-Laws. The chair will recognize Dr. C. F. Jorns of Harris County.

Dr. Jorns, Houston: This is a resolution which pertains to the National Blood Foundation:

Resolution: National Blood Foundation

Whereas, it appears that the Blood Bank Committee of the American Medical Association has made a report to the AMA Board of Trustees in which it is proposed that the AMA join with certain other national organizations, to wit, American National Red Cross, American Association of Blood Banks, American Hospital Association, the American Society of Clinical Pathologists, and others to be determined, in the formation of a National Blood Foundation; and

Whereas, the purposes of this organization, among others are:

To develop ways and means to make blood and its derivatives available to all persons in the United States;

To stimulate and advise on areas of research in the collection, preservation, and use of blood and its derivatives;

To collect, study, and disseminate information on blood and blood derivatives;

To establish a national blood clearing house to expedite the exchange of blood credits;

To serve upon invitation, for arbitration of disputes arising in the collection and use of blood and its derivatives; all of which purposes are laudable but are probably being performed in whole or part by the American Association of Blood Banks and other organizations nationally interested in blood banking; and

Whereas, certain other proposed purposes of the National Blood Foundation do not relate to medical aspects of blood banking but propose to regulate on a national basis, administrative policies, personnel qualifications, and to set up standards for the approval and accreditation of approved banks in addition to the present licensing procedure for blood banks now administered by the United States Public Health Service; and

Whereas, it is believed that regulation of administrative policies and practices of blood banks on a national basis would achieve no useful purposes, but would take away from the local county medical society the determination of the kind and type of blood banking service desired in the local community and would subject any local blood bank to national regimentation in order to obtain approval and accreditation of the National Blood Foundation; therefore be it

RESOLVED: That the Texas delegates to the American Medical Association be instructed to request the American Medical Association to reexamine its position and viewpoint concerning the National Blood Foundation to the end that the AMA should approve, foster, and support a program related to the medical operation of blood banking that will provide for coordination of blood bank activities in times of national disaster or emergencies, but will oppose a program that would take from a local county medical society the local determination of the need for and type of blood banking program that shall serve the community, including any attempt at regimentation of blood banking activity at the local level which would interfere with free enterprise.

This resolution is not to be construed as opposing proper accreditation by the American Medical Association of blood bank facilities.

Speaker Deaton: This resolution is referred to the Reference Committee on Scientific Work. The chair will recognize Dr. R. R. Ross, Austin:

Dr. Ross: Mr. Speaker, this is a proposed amendment to the By-Laws:

Amendment: Committee on Maternal Mortality

1. Amend Chapter VIII, Section 3, Subsection b to form a standing Committee on Maternal Mortality.

2. Amend Chapter VIII, setting up a new Section 17 after Section 16, the proposed Section 17 to read as follows: "The Maternal Mortality Committee shall consist of six members, each with a five year term of office, with one term expiring each year. Succession in office shall be on nomination by the President-Elect at the time of election of officers and shall not require confirmation by the House. Tenure of office is not limited. Three members of the Committee are to be appointed from each of the obstetrical departments of the three medical schools in Texas. An ex-officio member of this Committee will be the director of the Division of Child and Maternal Health of the Texas State Department of Health. A second ex-officio member is to be appointed by the president of the Texas Association of Obstetricians and Gynecologists. A third ex-officio member is to be appointed by the president of the Texas Academy of General Practice. The duties of the Maternal Mortality Committee are to conduct a continuous survey of maternal deaths in the State of Texas in an effort to reduce the preventable deaths in Texas by eliminating all possible hazards in pregnancy and childbirth."

3. Amend Chapter XI, setting up new Section 3 following Section 2, the proposed Section 3 to read as follows: "District Maternal Mortality Committees will be elected by each of fifteen district medical societies at their annual meetings. Each District Committee will consist of three members, each with a three year term of office, with one term expiring each year. The duty of the District Maternal Mortality Committee is to investigate every maternal death in the district in accordance with the type method of case study specified by the state Maternal Mortality Committee. The reports on each death will be forwarded to the state Maternal Mortality Committee. The state Maternal Mortality Committee will anonymously study and review each maternal death report and will make and return constructive recommendations back to the District Committee."

Speaker Deaton: This resolution will be referred to the Reference Committee on Amendments to Constitution and By-Laws. We recognize Dr. Cox of Wichita Falls.

Dr. E. Aubrey Cox: Mr. Speaker, I have a resolution:

Resolution: Fluoridation of Water Supplies

Whereas, fluoridation of municipal water supplies has been proven beyond doubt to be beneficial in the reduction of dental caries and has been approved and recommended by the American Dental Association and other nationally recognized dental organizations; and

Whereas, the Council on Pharmacy and Chemistry of the American Medical Association has stated that chronic ingestion of water containing one part per million of fluoride does not have a harmful effect on any organ or structure of the human body; and

Whereas, the American Medical Association, United States Public Health Service, National Research Council, Commission on Chronic Illness, and many other national health organizations have endorsed the principle of fluoridation; therefore be it

RESOLVED: That the House of Delegates of the Texas Medical Association endorse the fluoridation of community water supplies.

Speaker Deaton: The resolution on fluoridation of water will be referred to the Reference Committee on Medical Service and Public Relations. Are there any other resolutions to be presented?

Dr. Alvis Greer, Houston: This is a resolution opposing H. R. 6949, H. R. 8356, and S. 3114:

Resolution: Federal Reinsurance of Health Policies

Whereas, some 91,000,000 Americans are holders of health insurance policies purchased on a voluntary basis; and

Whereas, private commercial and nonprofit insurance companies are now writing major medical expense coverage and have consistently shown a willingness to expand coverage as public demand develops, and sound insurance principles indicate; and

Whereas, the principle of reinsurance is already employed in the insurance field and is no magic formula for selling protection to the unwilling buyer, nor does it reduce the cost of insurance or make insurance available to any class of risk or geographic area not now within the capabilities of voluntary insurers to reach; and

Whereas, it has been abundantly illustrated and made a matter of United States Supreme Court record that the government has the right to regulate that which it subsidizes and the bills H. R. 6949, H. R. 8356, and S. 3114 place extensive regulatory authority in the hands of the federal government; and

Whereas, it is our opinion that H. R. 6949, H. R. 8356, and S. 3114 would not accomplish the desired results; therefore be it

RESOLVED: That the House of Delegates of the Texas Medical Association in business session assembled this second day of May, 1954, does hereby go on record as opposing the enactment of H. R. 6949, H. R. 8356, and S. 3114; and be it further

RESOLVED: That a copy of this resolution be spread upon the minutes of this meeting and copies forwarded to the Secretary of Health, Education, and Welfare; the President of the United States; all members of the Congress of the United States; the chairmen of the Democratic and Republican Parties.

Speaker Deaton: This resolution is referred to the Reference Committee on Medical Service and Public Relations. Dr. York of Harris County has a resolution.

Dr. Byron P. York, Houston: I have the following resolution:

Resolution: Gamma Globulin

Whereas, the national policy for the control and distribution of gamma globulin is now limited to one national philanthropic organization and is not generally available to those engaged in the practice of medicine except for specific purposes and with specific limitations; and

Whereas, a number of physicians have used gamma globulin for several years as an aid in the management of certain infectious complications of allergic disorders, frequently recurring respiratory infection, particularly in children, and for other nonspecific conditions; and

Whereas, it is believed that the public interest would be better served by a more liberal distribution of gamma globulin; now therefore be it

RESOLVED: That the Texas Medical Association in session on May 2, 1954, go on record as instructing its delegates to the American Medical Association that the American Medical Association recommend that the national policies relative to the distribution of gamma globulin be reevaluated; that the National Foundation for Infantile Paralysis be requested to discontinue the purchase of gamma globulin produced by the commercial houses; and that this gamma globulin be released for normal distribution.

Speaker Deaton: The resolution will be referred to the Reference Committee on Scientific Work.

Dr. Tom Kennerly, Houston: This is a resolution opposing the "waiver of premiums" provision (Section 106 and Sections 221 and 222) of H. R. 7199:

Resolution: Waiver of Premiums

Whereas, Section 106 of H. R. 7199 establishes a "waiver of premiums" for individuals with extended total disability who are included in the social security system; and

Whereas, This provision would become an entering wedge for the regimentation of the Medical profession by creating the mechanism for the adoption of a federal cash permanent and total disability benefit program; and

Whereas, Sections 221 and 222 place the final authority for determining the disability of the patient in the hands of the Secretary of Health, Education, and Welfare; therefore be it

RESOLVED: That the House of Delegates of the Texas Medical Association in business session assembled this second day of May, 1954, go on record as opposing Sections 106, 221, and 222 of H. R. 7199; and be it further

RESOLVED: That a copy of this resolution be spread upon the minutes of this meeting and a copy forwarded to the Secretary of Health, Education, and Welfare; the President of the United States; all members of the Congress of the United States; the chairmen of the Democratic and Republican Parties.

Speaker Deaton: This resolution is referred to the Reference Committee on Medical Service and Public Relations.

Dr. Clement C. Boehler, El Paso: We have a resolution here to change the Constitution and By-Laws in one respect:

Amendment: Deletion of "White" for Membership

Whereas, the first sentence in Article I, Section 2 of the Constitution and By-Laws of the Texas State Medical Association reads: "The purpose of this Association shall be to federate and to bring into one compact organization the entire medical profession of the State of Texas . . ."; and

Whereas, the inclusion of the word "white" as a requisite for membership in the Texas Medical Association in Section 3, Article II, defeats the stated purpose of this Association and further creates an injustice to the Negro doctors of the state; now therefore be it

RESOLVED: That Section 3, Article II, of the Constitution of the Texas Medical Association be amended to delete the word "white" so that the first portion of the sentence of the section shall read as follows: "Only physicians, holding the degree of Doctor of Medicine and legally registered to practice medicine in Texas. . . ."

Speaker Deaton: This resolution is referred to the Reference Committee on Amendments to the Constitution and By-Laws. Inasmuch as it involves a constitutional change, it will have to lay over, but the committee can bring in its report and recommendation and it can be discussed at that time. Is there any unfinished business to come before the House of Delegates? Are there some committee reports left over? I see Dr. Tate Miller of Dallas is here, and he will give us a report of the Committee on Negro Medical Facilities.

REPORT OF COMMITTEE ON NEGRO MEDICAL FACILITIES

Dr. Miller: Since there is no actual concrete thing to be done to improve Negro facilities as long as we intentionally keep them out of organized medicine, our efforts have been directed wholly toward this end. The chairman of the Committee has visited all of the southern states within the last four months to learn what they have done, what they plan to do, and what the consequences up to now have been.

It is brought out that the only nation in the world that discriminates against the Negroes is the United States of America. The only portion of the United States of America that still discriminates is the South. The only part of the South that still discriminates is made up of seven states. In earlier years I had an ambition to be present when Texas was the first to take a broadminded realistic attitude toward that problem. My ambition now is to keep Texas from being the very last. There are seven states which have not yet taken the word "white" out of the requirements.

I won't go into the methods of each state, but I will say that Louisiana has not made the step; Alabama has; Florida has, and with three years' experience the doctors there state that they are very happy with the situation. Georgia of the Old South has taken it, and if there is a South of the South, in the State of Georgia, it is the City of Macon, where the doctors took it upon themselves, instead of selecting the Negroes one at a time, to admit the whole thirteen colored doctors into the society. Their executive secretary expressed to me and to the audience there that it was the most constructive thing they had done and had contributed much to the understanding of the doctors and had contributed materially to the health program in their section of the country. Kentucky has. The Carolinas—I understand one of the Carolinas has taken the word "white" out and both of them have the matter underfoot. Tennessee has the motion under way but has not reached any conclusion. Missouri has gone even to the extent of putting no possible limitation, socially or otherwise. The bugbear of social contacts has been in existence there and none of them from the state, from the ladies' auxiliary, from the president, has found an objectionable feature.

I hope very much that eventually we will think as progressively as the other forty-one states in the United States have done. One individual I met on my tour attended an international convention, held primarily for cussing Russia for her inconsiderate treatment of the masses, and Russia came back and said, "What is your United States in certain sections still doing to the Negro?" I hope that we can soon get from under the desecrating situation that exists in our own southern states towards the profession of medicine.

Speaker Deaton: I will refer Dr. Miller's report to the Reference Committee on Amendments to Constitution and By-Laws. Is there any new business? This about brings us to the end of the morning session. Dr. Bob Homan, who usually presides where I am standing, is ill and unable to attend this session. I think we should give him a big wish for an early recovery.

Dr. B. E. Pickett, Carrizo Springs: I move that this House of Delegates send Dr. Homan a telegram or authorize our Executive Secretary to do so. (Thereupon said motion was seconded and unanimously carried.)

Speaker Deaton: It has been moved and seconded that we recess and we will now recess until 8 this evening.

(The morning session ended at 1 p. m.)

Sunday, May 2, 1954

MINUTES OF THE HOUSE OF DELEGATES

SECOND MEETING

(The House of Delegates reconvened Sunday, May 2, 1954, at 8 p. m. with a quorum present.)

Speaker Deaton: The first item in the order of business for this session is the report of the reference committees. First we have the Reference Committee on Reports of Officers and Committees, and Dr. E. P. Hall of Fort Worth is chairman of that committee.

REPORT OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND COMMITTEES

Address of President

Dr. Hall: The address of Dr. George Turner was read. We of the Reference Committee recommend that the House of Delegates commend him on his address and compliment him for the excellent work he has done as President of the Association for the year 1953.

Dr. Turner's reference to the fact that hospitals and/or incorporate institutions are at times actively engaged in the practice of medicine has been considered. The Reference Committee recommends that the Texas Medical Association go on record as condemning such infringement and also that the special Committee on Infringements on Private Practice consider this problem for further investigation and recommendation.

Dr. Turner's recommendation that the policy of the Medical Students' Day program be permanently established as an annual affair is recommended by the Reference Committee.

Our President's recommendation that the meeting of the county medical society presidents and secretaries be made an annual event in conjunction with the January Executive Council meeting is heartily endorsed by the Reference Committee. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Executive Secretary

Dr. Hall: The reports of the Executive Secretary have been read, and the Reference Committee recommends acceptance of such reports. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Board of Councilors

Dr. Hall: The report of the Board of Councilors has been studied, and we recommend acceptance of this report. There is one recommendation which states that the Board of Councilors strongly recommends that county society members, especially officers, familiarize themselves with those portions of the Association's Constitution and By-Laws and of the Principles of Medical Ethics of the American Medical Association dealing with the individual conduct and obligations of members and the responsibilities and action of county medical societies. This recommendation is made because many questions submitted to the Board of Councilors for ruling are clearly answered in these two publications and the matter could be handled on a local or county level. We approve the adoption of this recommendation. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Delegates to American Medical Association

Dr. Hall: The report of the delegates to the American Medical Association was carefully read and studied, and the Reference Committee wishes to commend them for a job well done in presenting the mandates of the Texas Medical Association and bringing them to a successful and effective conclusion. The House of Delegates should recognize that the actions of our delegates have given them a position of influence in the AMA House in excess of their numerical strength. We recommend the acceptance of their report. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Executive Council

Dr. Hall: The report of the Executive Council was studied and we recommend acceptance of this report. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Medical History

Dr. Hall: The report of the Committee on Medical History as presented by Dr. Felix P. Miller of El Paso was read with interest. We commend Dr. Miller for his long years of work on behalf of the Texas Medical Association and his interest in medical history, and we recommend the acceptance of his report. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on General Arrangements for the Annual Session

Dr. Hall: The report and supplementary report of the Committee on General Arrangements were studied, and we recommend the acceptance of both reports.

The Reference Committee suggests that in the future the House of Delegates be provided with tables and chairs, where feasible, for the use of the elected delegates and that chair seating space be provided for visitors and alternate delegates behind the seated delegates. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of State Chairman of American Medical Education Foundation

Dr. Hall: The report of the State Chairman of the American Medical Education Foundation was studied, and we recognize the fact that a great deal of progress has been made in this endeavor during the last twelve months. The Reference Committee approves the recommendations of this committee which are:

1. "The Committee recommends that each and every member of the Texas Medical Association actively support the American Medical Educational Foundation in 1954."

2. "The Committee recommends for consideration the services of the Audio-Digest Foundation."

3. "The Committee further recommends that the president of each county medical society appoint a local chairman to serve on this Committee." (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Dr. Hall: I move the adoption of the report of this Reference Committee as a whole. (Thereupon said motion was seconded by Dr. James D. Murphy, Fort Worth, and the same was duly carried and the report adopted.)

Speaker Deaton: The Reference Committee on Resolutions and Memorials; I understand that it had no assignment. The next is the Reference Committee on Finance, Dr. E. W. Jones of Wellington.

REPORT OF REFERENCE COMMITTEE ON FINANCE

Dr. Jones: The Reference Committee on Finance submits the following report for consideration:

Report of Treasurer

Dr. Jones: We have examined the report of the Treasurer in detail and do not find any corrections or suggestions for any changes in regard to same; we recommend that this report be accepted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Board of Trustees

Dr. Jones: The report of the Board of Trustees was read and each paragraph studied separately.

Especially do we want to commend the Board's cooperation with the Blue Cross and Blue Shield in publishing of the new directory of members. We feel that this directory will be of much value to members in many ways.

We wish to commend the Board and its action in regard to the student delegates to the American Medical Association. We feel that this is a move in the right direction in creating good public relations with the doctors of tomorrow.

Also in their cooperation with the Committee on Public Relations, we commend the Trustees in their stand in helping to finance the Medical Students' Day as we feel that this also furthers good public relations.

We further commend the support given by the Board of Trustees to the essay contest sponsored by the Association of American Physicians and Surgeons and we recommend its continuance, feeling that it will do much good as stated above.

The sending of the TEXAS STATE JOURNAL OF MEDICINE to all the seniors in the three medical schools, acquainting them with the workings of the State Medical Association and all of its committees and councils, is a good step in the direction for preparing them to be workers in the Association as soon as they graduate.

Cooperation with and wholehearted support of the efforts of the Committees on Rural Health, Doctor Distribution, and Public Relations should be continued.

We especially commend the action of the Board of Trustees in employing a business manager of the Association. We feel that this will implement and increase the efficiency of the business of the Association in no small way. Also, the employment of a field man will be of much benefit in contacting the members in the local societies and acquaint-

ing them with the many different facilities of the Association, also acquainting them with the duties they should perform in regard to endowment and contributions to our Library fund.

We have examined the budget as set up by the Trustees for 1954. We feel that they have adequately taken care of all of the items to our knowledge and that sufficient funds have been allocated for each.

The supplemental report was reviewed and discussed, particularly in regard to all the questions submitted, and we feel that the debts incurred in the construction of the headquarters building have been taken care of in a good business-like manner, and we recommend the adoption of the supplemental report together with the original report. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Library Endowment

Dr. Jones: This report should stir the minds of all of us as doctors that we need and will ever need a good library and that, to follow the example of one of our former presidents, Dr. L. H. Reeves, many should be willing and anxious to aid and assist by donating their libraries or should be in the future.

The recommendation to the Woman's Auxiliary is well taken, and we urge that all delegates carry back to their medical societies a message for publicity in the need of funds for this committee. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Dr. Jones: Mr. Speaker, I move that the report as a whole be adopted. (Thereupon said motion was seconded and the same was duly carried.)

Speaker Deaton: That brings us to the Reference Committee on Amendments to the Constitution and By-Laws. They had an awful lot of work to do and are still working. We will pass on at this time to the report of the Reference Committee on Scientific Work, Dr. A. C. Scott of Temple.

REPORT OF REFERENCE COMMITTEE ON SCIENTIFIC WORK

Dr. Scott: This is a report of the Reference Committee on Scientific Work:

Report of Council on Scientific Work

Dr. Scott: The Reference Committee has reviewed the report of the Council on Scientific Work, excepting that portion pertaining to changes in the Constitution and By-Laws. This Committee wishes to commend the council for its zealous efforts in preparing the scientific and general programs and its work in attempting to bring before the entire medical profession a pleasing program.

This Reference Committee recommends that the House of Delegates request the Council on Scientific Work to make every effort in the future to set the meeting dates of the annual session at a time which conflicts with the fewest possible meetings of large national organizations; and that if the council finds it impossible to avoid such conflicts, the council alternate meeting dates from one year to the next so that such conflicts will not always be with the meeting dates of the same national organizations. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Cancer

Dr. Scott: No report was received from the Committee on Cancer.

Report of Committee on Tuberculosis

Dr. Scott: The report of the Committee on Tuberculosis was considered. This Reference Committee recommends the adoption of the original report, but it doubts the wisdom of this Association giving its endorsement to the Texas Tuberculosis Association's "Searchlight on Tuberculosis" without further enlightenment on the nature and extent of that endeavor. This Reference Committee does not recommend the adoption of this addition to the report but does recommend the adoption of the original report. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Mental Health

Dr. Scott: The report of the Committee on Mental Health and its activities was reviewed, and this report is approved by this Reference Committee. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Public Health

Dr. Scott: No report was received from the Committee on Public Health.

Report of Committee on Scientific Exhibits

Dr. Scott: The Reference Committee wishes to compliment the Committee on Scientific Exhibits and its zealous efforts to produce a fine presentation this year, and we recommend that the House of Delegates commend this committee for its continuing excellent work. (Upon motion made, seconded, and carried, the above porton of the report was adopted.)

Report of Committee on Study of Alcoholism

Dr. Scott: No report was received from the Committee on the Study of Alcoholism.

Speaker Deaton: The Committee on the Study of Alcoholism has been abolished.

Report of Committee on Blood Banks

Dr. Scott: The Reference Committee has reviewed the report of the Committee on Blood Banks, and it approves the report as written. This Reference Committee particularly wishes to emphasize a statement contained in this report: "It is fundamental that the relationship between blood banks and the practice of medicine continually be emphasized." (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Resolution: National Blood Foundation

Dr. Scott: In connection with the report of the Committee on Blood Banks the Reference Committee considered the resolution of Dr. C. F. Jorns, representative of Harris County Medical Society, and recommends that the House of Delegates adopt this resolution as presented. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Resolution: Gamma Globulin

Dr. Scott: The Reference Committee considered the resolution presented by Dr. Byron P. York, a delegate of Harris County Medical Society, relative to the control and distribution of gamma globulin and recommends that one phrase of the resolution be deleted and that the resolution be changed to read: "RESOLVED: That the Texas Medical Association, on May 2, 1954, go on record as instructing its delegates to the American Medical Association to request that the

American Medical Association recommend that the national policies relating to the distribution of gamma globulin be reevaluated and that gamma globulin be released for normal distribution." (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Dr. Scott: Mr. Speaker, I might say that this report was signed by the members of the Reference Committee who were present, being C. F. Jorns, John L. Otto, C. C. Boehler, G. V. Edgar, and A. C. Scott, Jr., chairman. I move the adoption of the report as a whole. (Thereupon said motion being duly seconded, the same was carried and the report was adopted.)

Speaker Deaton: Next is the Board of Councilors as a Reference Committee, Dr. Baker, chairman.

REPORT OF BOARD OF COUNCILORS AS REFERENCE COMMITTEE

Resolution: Correction of Unethical Conduct

Dr. R. G. Baker, Fort Worth: This is the report of the Board of Councilors as a Reference Committee on a resolution presented by Dr. Pickett directing attention to the proper method of correcting unethical conduct:

It is the opinion of the Board that the resolution simply sets out existing rules and agencies to regulate unethical conduct and that certain provisions could provide material for adverse publicity and poor public relations in the hands of unfriendly individuals outside of the profession. Because of these possibilities and the lack of any apparent need for it, the Board felt that the resolution should not be approved.

I move the adoption of this report. (Thereupon said motion was seconded and duly carried, and the report was adopted.)

SUPPLEMENTARY REPORT OF BOARD OF COUNCILORS

Dr. Baker: The Board of Councilors wishes to submit the following addition to the By-Laws at the end of Section 2, Chapter IV: "When appointed, the term of office of the Vice-Councilor shall correspond to the current term of office of the Councilor of his district unless previously relieved by action of the Board of Councilors."

Speaker Deaton: This supplementary report will be referred to the Reference Committee on Amendments to the Constitution and By-Laws.

The House is now ready to receive the report of the Reference Committee on Amendments to the Constitution and By-Laws, Dr. Jack Kerr, chairman.

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

Dr. Kerr: Mr. Speaker, our report is not yet complete, but we have considered and are ready to report at this time on some matters.

Report of Committee on Revision of Constitution and By-Laws

Dr. Kerr: That portion of the report of the Committee on Revision of Constitution and By-Laws relating to an increase in the number of Trustees from five to seven, for changing the term of office for Trustees from five to three years, and for dividing the state into trustee districts to assure geographical representation by the Trustees was considered by the Reference Committee.

Changes in the Constitution encompassing these provisions and which were presented to this House at its 1953 session and recorded in the transactions of the House on page 425 of the June, 1953, JOURNAL, are as follows:

"BE IT RESOLVED: That Article III of the Constitution of the Texas Medical Association be amended so that, as amended, said article shall provide as follows:

" 'Sec. 1. The officers of this Association shall be a President, a President-Elect, a Vice-President, a Secretary, a Treasurer, seven Trustees, a Councilor for each councilor district, a Speaker, and Vice-Speaker of the House of Delegates.

" 'Sec. 2. The President shall automatically assume office at the expiration of his term as President-Elect. The President-Elect, Vice-President, Speaker, and Vice-Speaker of the House of Delegates shall be elected for terms of one year each. The Secretary, Treasurer, and Councilors shall be elected for terms of three years each. All officers shall serve until their successors are elected and installed.

" 'Sec. 3. The officers of this Association shall be elected by the House of Delegates on the morning of the last day of the annual session, and no person shall be elected to any such office who is not in attendance on that annual session, and who has not been a member of the Association for the preceding two years.'

"BE IT FURTHER RESOLVED: That Article IV of the Constitution of the Texas Medical Association be amended so that, as amended, said article shall provide as follows:

" 'Sec. 1. The business affairs of the Association shall be managed by a Board of Trustees, comprising seven members, elected in accordance with this Constitution and By-Laws. All funds of the Association shall be subject to the exclusive control of the Board of Trustees, except as otherwise provided in this Constitution and By-Laws. The Board of Trustees shall decide all questions not specifically delegated to other authorities by this Constitution and By-Laws. It shall in general serve as a board of directors, within the meaning of the corporate laws of the State of Texas.'

"BE IT FURTHER RESOLVED: That Article IX of the Constitution of the Texas Medical Association be amended so that as amended, said article shall provide as follows:

" 'Sec. 1. The House of Delegates shall divide the state into appropriate trustee districts.

" 'Sec. 2. The House of Delegates shall divide the state into appropriate councilor districts.

" 'Sec. 3. The House of Delegates shall provide for the organization and chartering of such district societies as will promote the best interests of the profession. Such societies shall be composed only of members of component county societies of their respective councilor districts and shall be exclusively scientific and educational in character.' "

The changes in the By-Laws are not ready for presentation at this time. The necessity of their consideration by this House of Delegates will be dependent upon your decision on the above constitutional changes. The above changes in the Constitution were looked upon favorably by the Reference Committee with the exception of the change as proposed in Section 3 of Article III, which states that the officers of this Association shall be elected by the House of Delegates on the morning of the last day. This section as submitted is in conflict with the proposed change submitted by the Council on Scientific Work dealing with the time of the election of officers. The Reference Committee approves these changes with the above exception.

I move the adoption of this report with the exception of Section 3 of Article III.

Speaker Deaton: That has to do with the division of the state into trustee districts; is that correct?

Dr. Kerr: It has to do with the increase in the number of Trustees from five to seven; changing the term of office of Trustees from five to three years; and dividing the state into districts to assure geographical representation by the Trustees.

Speaker Deaton: The Committee has recommended approval of this change. It was proposed last year and has laid over for the customary year. It has been moved and seconded and now it's open for discussion.

Dr. H. T. Jackson, Fort Worth: I have no objection to raising the Trustees from five to seven, but I would like to call the attention of the House to the fact that when we need leadership, we need it badly. Let's get it wherever we can find it, and let's not control it by making it come from some isolated area. We tried this on a national level in another organization, and it did not work. We now try to follow it in general principle, but not an iron-fast rule, and we find that much better. I think we would make a grave mistake if we had to confine our leadership to certain districts.

Dr. A. C. Scott, Temple: I would like to raise a point of order. We are considering amending our Constitution here, and we don't know all we are voting on. For instance, we are voting on a change in districts, and yet, as I understand it, there are a great many other things that concern this not in the Reference Committee's report, that will be brought in later, and that have to do with the By-Laws and certain changes in them. I don't think it is quite fair to ask us to vote on something when we are taking it out of context, so to speak, and don't know exactly what we are voting on. I grant you, some of us do know something about the redistricting proposition, but I would like to know what the whole story is before I make up my mind as to how I want to vote. I will tell you now, I am against the redistricting, but I don't think it is fair to ask us to vote on this thing when we don't know the whole Committee's report.

Speaker Deaton: The changes in the By-Laws will follow and conform to this change in the Constitution.

Dr. Kerr: That was our idea. Our thought was if the House does not act favorably upon the constitutional changes, there was no point in having a secretary write for an hour and a half on the proposed changes in the By-Laws which will have to be made. You will read in the committee reports that the permanent committee recommended changes in the By-Laws to conform with these constitutional changes, if the constitutional changes are adopted. There is no point in writing up the By-Laws if this is not voted on favorably by the House.

Dr. Scott: The only information we have is that the Trustees are entitled to redistrict the state as they see fit; is that right?

Dr. Kerr: No, our understanding about it is what was printed in the committee report, which you have and which I read. That's all the Reference Committee knows, Dr. Scott. These are the constitutional changes as submitted to us which will, as we interpret them, increase the Trustees from five to seven, change the term of office of the Trustees from five years to three years, and divide the state into trustee districts.

Dr. Scott: I take it that I was out of order on my point of order, since it was not maintained, so am I now in order in speaking against the motion?

Speaker Deaton: Go ahead.

Dr. Scott: I think this is a very serious matter. I am not opposed to having more Trustees. There is such a thing as getting a board that is too big and unwieldy and not workable, but probably seven is not too big.

I am opposed to districting the state and saying that a man must come from District 1 and another must come from District 3 and so on. It is a totally different proposition from having councilors and delegates from various districts. We do need districts and subdivisions for the minor offices of the organization. I have watched this organization a long time; we have had some fine officers all up and down the line, and in my opinion we have had some fine Trustees, but there is such a thing as having an area where we don't have a man who has had a lot of experience in this organization and who is qualified on that basis to serve as a Trustee.

I grant that there are a lot of doctors in West Texas and a lot in South Texas and Central Texas and other parts of Texas that are just as bright and capable as any other man, but to my mind, a man who will be Trustee should be a man who has had long experience in this organization. He should be a man who has shown by his endeavors that he has a tremendous amount of energy and a tremendous amount of capability for work and clear thinking.

You are putting this huge organization into the hands of five men largely to control, and we have been very fortunate in the past in having excellent top-notch men. It could, however, conceivably occur that in one or two districts we might not have a man who had those qualifications of long experience and training in this organization, and I think it would be a grievous mistake just to reach out and pick a man because he comes from a given district. I think we will do ourselves irreparable harm if we do it on that basis in the future.

I grant you, there will be times it might seem unfair; there might be two men from North Texas or two men from Central Texas or from West Texas or from somewhere else, but as the preceding speaker, Dr. Jackson, said, I think we should pick the best men wherever they come from and up to this time this body has exercised excellent judgment. It has not been a political matter, but if you get the Trustees based off into districts, it will really become political to my mind, and I think it will become a grievous mistake.

Dr. Andrew Tomb, Victoria: I would like to speak against this change. In the first place, when we elect a man to this Board of Trustees, it means just exactly what it says. He is one of our Trustees—he is elected to the highest deliberative body that we have in the Texas Medical Association. As such, the selection of this man is based on his integrity, his enthusiasm for the Medical Association, his business acumen, and those types of considerations, and certainly not where he lives.

Another point of interest is that since this is a deliberative body and since major business problems arise, many of which cannot be resolved in a period of one or two or three years, a long term of years in which a man can become completely familiar with what he has to deal with is likewise important. If we sheer off a year or two of a man's term, we likewise sheer off a year or two of his efficiency. I feel definitely the man who is elected to the Board of Trustees should be chosen on these considerations instead of where he lives. I am against this measure.

Dr. E. A. Rowley, Amarillo: I don't know why we are making this change. Is it something that the Board has done or failed to do, or is it something that the people who wanted to change this did or did not do—did we disappoint somebody? I want you to understand that the more people we disappoint, the more money you have after they leave.

We don't try to disappoint anybody and make anybody mad, but if it becomes necessary, we can. You already have the state districted and the councilors represent the districts. I see no reason why it should be redistricted again. I see no reason why you should increase to seven members; five is plenty. You have a good Board; there is not a man on that Board that would not quit if you did not like him. I think in a few years you would have all your Trustees elected from the cities and nobody would be elected again from out in the sticks. I am against this change and hope you don't do it.

Dr. L. C. Powell, Beaumont: There are always two sides to every subject. This project originated in the Jefferson County Medical Society, and since that time it has been approved unanimously by District 10 and District 15. Under the terms of the change, the present Trustees will continue on until their terms expire. The only conflict that the Reference Committee had was on the time of election of officers, and members of the House of Delegates who were here last year will remember that after Dr. May Owen presented her resolution to the effect that the Council on Scientific Work wanted to change the election of officers to the time when the House of Delegates had finished its work, I arose and spoke to the point that we were willing to have our election of officers correspond with the time that the other officers were elected. That is in the record in the June, 1953, issue of the JOURNAL.

Texas is a large state. I have some maps there that show even dividing it into trustee districts, how large an area each district covers. Someone said this afternoon that no other state had ever found it necessary to do such a thing. Where is there another state in the United States that is nearly as large as Texas? Our problem is different. We are six times and more the size of New York. We have to face Texas problems with Texas people and the Texas House of Delegates.

It has been my observation that the councilors, year after year, have functioned well, not only locally but as state officers. They are elected by the House of Delegates and we have had no trouble even in the smaller districts in finding someone capable of acting as a councilor. I have confidence enough in the House of Delegates and the doctors of Texas to believe that any of those districts have several men who have spent years of service in the House of Delegates and who are willing and able to function well on the Board of Trustees.

About the idea of raising from five to seven members, we have had five Trustees for many, many years, and in the meanwhile, the Texas Medical Association has grown and grown and grown. The Executive Secretary reported today that we had about the largest membership we have ever had. Now, this change is based not only on a geographic distribution, but also on a doctor population.

This afternoon when the reference committee was considering this item, someone said supposing some calamity should strike one broad area like the Panhandle—some dust storms and droughts; if the doctors moved away, there would be one Trustee representing but a very few people. But the Board of Councilors has the power to change the councilor district boundaries when they are approved by the House of Delegates. It is just a change of the By-Laws and can be done at any session. If the trustee district consists of several councilor districts on a doctor population basis, when the councilors adjust their district, the trustee district would automatically take care of itself.

The main reason that this proposition has impressed me is that I am an East Texas boy. I was born and raised on the banks of the Sabine River. I have consulted many of the oldtimers and have looked in the Texas history written by Dr. Pat Nixon, and we can't find any record in the 101 years that the Texas Medical Association has been in existence that an East Texas doctor from the Arkansas boundary to the Gulf of Mexico has served on the Board of Trustees.

Now, I am talking not only as an East Texas man, but I believe in fairness to the whole state. Dr. Rowley is retiring from the Board of Trustees, and he has made us a wonderful Trustee. We have no complaint about the present Board of Trustees. They have done a good job, but unless someone is elected from there this session, the vast Panhandle area will not be represented on the Board. The changes are designed to meet our present needs.

Dr. John L. Matthews, San Antonio: There are apparently those among us who believe the number of the Trustees should be expanded in order to share the burden and the responsibilities of the trusteeship. Certainly the responsibility of these five men is tremendous, and this body may believe that a larger group might possibly administer our affairs even more efficiently and wisely. The thought of making our Trustees representative of certain fixed geographic areas seems to us in Bexar County the wrong way to accomplish this expansion. I prefer to think that these five Trustees represent our entire membership of nearly 7,000 rather than that each member shall speak for 1,000 of that membership. If expansion is indicated, wouldn't it be better to increase the number to be elected from the state as a whole rather than to specify that each Trustee shall represent a certain geographic area?

If it is still the wish of this body that representation shall be strictly geographic, isn't it illogical that one Trustee should represent the southeast and the northeast corners of this great state, whereas another shall represent the interests of those residing in Erath County out in near West Texas, and Galveston County on the Gulf Coast. It is true that the amendment to the By-Laws has not yet been presented to this body this evening, but the report as printed indicates that those are the contemplated boundaries of the trustee districts.

Dr. E. A. Rowley, Amarillo: I just wanted to answer Dr. Powell about the people up in the Panhandle. The people up there don't blow away that easily, Doctor. We have had about 50,000 people that blew in up there instead of away in the last few years, and if you fellows get that chronic malaria out of your system, you could be elected.

Dr. Truman Terrell, Fort Worth: Being a has-been, I still want to express my opinion in regard to this proposition. I think it will be a mistake to district your state. If you want to increase your number of Trustees, that is all right, but don't limit them to any particular part of the state. Pick the man that you want and see that he does a job.

Dr. Ridings E. Lee, Dallas: We have lived in the United States that has been governed for a number of years by people from districts—from states. We have lived in a state that has been governed by people coming from separate districts of our state. We have had good government most of the time.

I feel that so far as this organization is concerned, it is only fair that representation on this Board be by districts. Certainly the qualifications of a good Trustee are that he be honest and stable and that he have an adequate knowledge of the business interests of this organization. With as many men as we find in any district, I feel that there must be one man available at all times in any district to be represented who would be capable of carrying on the duties of a Trustee.

I think if we omit personalities and think of this as a democratic organization, we cannot do other than district this thing for our Trustees the same as we district it for our councilors. I am sure that this is not the most perfect way that could be designed to govern the business and financial interests of this organization, but I do feel that this amendment gives us the best solution that we have at hand.

Dr. J. M. Coleman, Austin: I feel that this is a dangerous resolution and I am opposing it purely on my personal feelings about it and not through the direction of my district. I am fearful in this situation that we might create a sectionalism within the medical society.

Now, we have our delegates who represent our counties, and the county with five members and the county with fifty members have the same number of delegates, so that there is representation geographically from that angle. Then we have our councilor districts which are divided into the areas of service of councilors. This problem that has been brought up about counties shifting from councilor district to councilor district is not as simple as it sounds. It has been done, yes, but it amounts only to a shift of one county or two counties with maybe four or five doctors who want to attend another medical society.

We are faced with the problem that whenever we divide on the number of doctors in a district, we have inequities. We have two districts here with 600 doctors; we have four districts there with 800 to 900 doctors; and we have one district with 1,000 doctors. For the district with the 1,000 doctors, the doctor is proportionately less represented on the pure mathematics of the thing, but the changes that occur from year to year as our population changes in the state may rapidly produce a condition where the representation is more distorted than ever before. Those of you who have followed the fights for redistricting in the State Senate and the House of Representatives recognize the terrific problems tied to breaking down the districts or changing the district lines once they are formed. It is not like a councilor district. It is more extensive and deeper than that, and I am fearful that if the medical society does approve this amendment, we will create an opportunity for sectionalism which may split the society.

There has been no complaint about our Board of Trustees. Those men, to my mind, have contributed a tremendous amount to the effectiveness of this society. What they have done with your funds in reducing the indebtedness; the hours they have spent on the various tasks have been almost more than we could ask from individuals of our society. Therefore, I feel that the plan which has been in existence has produced top-flight Boards of Trustees, and I am in favor of seeing them continue that way.

Dr. James D. Murphy, Fort Worth: I move that this portion of the report be tabled. (Seconded by Dr. J. M. Coleman, Austin.)

Speaker Deaton: The motion has been made to table, and it is not debatable. The motion has been made by Dr. Kerr favorable to the changes you heard discussed, and now Dr. Murphy moves the tabling of that motion. Are you ready for the question—we will have to have a standing vote. The motion to table is lost.

Now, all those in favor of the motion by Dr. Kerr will please stand so that we may count you. There are 43 votes in favor of the motion. Now, those please stand who are opposed—I count 64 noes. A two-thirds vote is necessary for the adoption of a motion to change the Constitution and By-Laws, and so the motion for redistricting fails. Dr. Kerr, will you proceed?

Dr. Kerr: We have only one other portion of the report ready for consideration by the House at this time; it has to do with the honorary and the inactive membership.

The following amendments to the Constitution and By-Laws were proposed by the Board of Councilors to the House of Delegates at the 1953 annual meeting and published on pages 431 and 432 of the June, 1953, JOURNAL:

"Amend Article II, Section 1, paragraph 1, beginning with line 10, to read as follows: '. . . provided that the House of Delegates, upon nomination of component county societies, may elect to honorary membership those physician members of honorable standing who have contributed notably to the advance of ethical medicine, and who may have, because of age or other laudable reasons, reached a point of inactivity or comparative inactivity in the practice of medicine, or who have been members of organized medicine for a period of fifty years or longer; and when so nominated and elected said honorary members shall be entitled to all of the privileges of membership as set out in this Constitution and By-Laws; provided that county society secretaries shall include all such honorary members in their respective annual reports, with such notation thereon as will at once declare their status.

" 'It is also provided that county societies may elect to military membership those members who are at the time serving with the Armed Forces of our country, including the Coast Guard, and such similar services in time of war, such membership to terminate with their discharge from service.'

"Amend Article II, Section 1, paragraph 3, to read as follows: 'It is also provided that county societies may nominate for inactive membership those physician members who have retired from the active practice of medicine. The House of Delegates, upon nomination of component county societies, may elect those physician members to inactive membership; when so nominated and elected said inactive member shall be entitled to all of the privileges of membership as set out in this Constitution and By-Laws; provided that county society secretaries shall include all such inactive members in their respective annual reports, with such notation thereon as will at once declare their status.'

"Amend Article XI, Section 2, to read as follows: 'The House of Delegates shall provide for an equal per capita assessment of component county societies, and for the proper distribution of the amount so raised into the several funds of the Association, as established by the Board of Trustees or the House of Delegates; provided that no assessment shall be made upon honorary members, inactive members, or members emeritus of the Texas Medical Association elected in accordance with this Constitution and By-Laws.'

"Amend Chapter I, Section 3, to read as follows: 'Members of whatsoever classification who are under sentence of suspension or expulsion from a component county society, or whose names have been dropped from its roll of members, shall be allowed all the privileges of membership, including subscription or right to subscribe to the TEXAS STATE JOURNAL OF MEDICINE, pending decision or appeal. Any member dropped from the rolls of a component county society for non-payment of dues, or any honorary or inactive member dropped for cause, is to be considered as coming within the provisions of this section.' The rest of the section will remain unchanged.

"Amend Chapter X, Section 5, to read as follows: 'Component county societies may nominate for honorary membership in the Texas Medical Association, physician members of good professional and moral standing in their respective jurisdictions who have rendered extraordinary service to the cause of ethical medicine, and who have for good

and sufficient reason withdrawn partially or entirely from the practice of medicine or who have been members of organized medicine for fifty years or longer in accordance with Section 1 of Article II of the Constitution of the Association; and when elected by the House of Delegates to the State Association the said honorary member shall be carried on the rolls of their respective county societies and reported in the annual reports of the county societies, as provided herein.'

"Amend Chapter X, Section 5, by the addition at the end of the following sentence: 'Physician members who have paid state dues to cover another type of membership for the year in which they are elected to honorary status shall be refunded the originally paid dues in full.'

"Amend Chapter X, Section 7, to read as follows: 'County medical societies may nominate for inactive membership those physician members who have retired from the active practice of medicine. The House of Delegates, upon nomination of component county societies, may elect those physicians to inactive membership in the Association. When so nominated and elected, the inactive members shall be entitled to all of the privileges of membership. County society secretaries shall include all such inactive members in their respective annual reports with such notation thereon as will at once declare their status.'

"Amend Chapter X, Section 7, by the addition at the end of the following sentence: 'Physician members who have paid state dues to cover another type of membership for the year in which they are elected to inactive status shall be refunded the originally paid dues in full.'

"Amend Chapter X, Section 8, to read as follows: 'County medical societies may elect to military membership those members who are on temporary duty in the Armed Forces of our country.'

"Amend Chapter X, Section 8, by the addition at the end of the following sentences: 'Physician members who have paid state dues to cover another type of membership for the year in which they are elected to military status shall be refunded the originally paid dues in full provided that such election occurs within the first six months of the membership year. One-half of the originally paid dues shall be refunded provided that such election to military membership occurs after the first six months of the membership year.'

"Amend Chapter XIII, Section 4, to read as follows: 'Military members, as provided for in the Constitution and these By-Laws of the Texas Medical Association, shall pay no dues but may subscribe to the TEXAS STATE JOURNAL OF MEDICINE.'

"Amend Chapter XIII, Section 5, to read as follows: 'Honorary members, as provided for in the Constitution and these By-Laws of the Texas Medical Association, shall pay no dues, but may subscribe to the TEXAS STATE JOURNAL OF MEDICINE.'

"Amend Chapter XIII, Section 6, to read as follows: 'Inactive members, as provided for in the Constitution and these By-Laws, shall pay no dues, but may subscribe to the TEXAS STATE JOURNAL OF MEDICINE.'"

The Reference Committee on Amendments to the Constitution and By-Laws recommends the adoption of the amendments dealing with honorary, inactive, and military members as submitted by the Board of Councilors.

I move the adoption of this portion of our report.

Speaker Deaton: Is there any discussion of this portion of the report? (Thereupon said motion was seconded and the same was duly carried.)

Dr. Kerr: That is all we have ready for you tonight.

Speaker Deaton: The Reference Committee on Medical Service and Public Relations—are they ready to report?

REPORT OF REFERENCE COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

Dr. Van Goodall, Clifton: Our Reference Committee first wishes to congratulate all of the councils and committees whose work came before us this afternoon for the good work obviously done all through the year. We also wish to thank those interested parties who came in at 2 o'clock and were not seen until 6:30. We commend you for your tenacity; maybe next year we will have less things to get off the agenda and you will not have to wait so long.

Report of Council on Medical Defense

Dr. Goodall: The report as published and the supplemental report of the Council on Medical Defense presented May 2 have been approved by the Reference Committee. I move that this part of the report be accepted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

This does not require a vote, but I might mention that the Reference Committee requested Mr. Overton to write for the JOURNAL an explanatory article which would be brought to the attention of the individual physicians concerning the details of this issue. To refresh your memory, that was the good work done by the Council on Medical Defense in regard to the proposed changes in our insurance set-up. We thought that each member should have full knowledge of this matter.

Report of Council on Medical Jurisprudence

Dr. Goodall: Next is the report of the Council on Medical Jurisprudence: As a supplement to the section entitled "Veterans' Care" in the report of the Council on Medical Jurisprudence, this Reference Committee recommends that the program of the AMA and the material available through that program for education of the physicians and the public be brought forcibly to the attention of each county society. I move that this report and the supplementary report be accepted as presented. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Council on Medical Economics

Dr. Goodall: The report of the Council on Medical Economics as published and the supplementary report submitted May 2 are accepted as presented. I move that this report and the supplementary report be accepted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Council on Medical Education and Hospitals

Dr. Goodall: The report of the Council on Medical Education and Hospitals and the supplementary report made May 2 are accepted as presented. I move this report and the supplementary report be accepted as presented. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Public Relations

Dr. Goodall: The report of the Committee on Public Relations is accepted as published. I move this report be accepted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of State Council on National Emergency Medical Service

Dr. Goodall: The report of the Council on Emergency Medical Service recommending that the Council be reduced to five members and that Dr. Henry A. Holle be made one of them is accepted. I move this report be accepted as presented. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Nursing Care

Dr. Goodall: The report of the Committee on Nursing Care is accepted as printed. I move this report be accepted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Doctor Distribution

Dr. Goodall: The report of the Committee on Doctor Distribution is accepted as printed. I move this report be accepted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Delegate from Private Clinics and Hospitals Association of Texas

Dr. Goodall: The report of the delegate from the Private Clinics and Hospitals Association of Texas is accepted as presented. I move this report be accepted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

President's Address

Dr. Goodall: The address of the President, Dr. George Turner, has a paragraph referring to health insurance in which he states: "In several references to health insurance through the year, I stated that in my judgment, the minor costs of medical care such as an illness requiring only a few home visits by the doctor or a few visits to his office are no more than a part of the normal cost of living and should be optionally included in his health insurance protection. I, therefore, suggest that this House go on record as approving a $50 deductible clause in health insurance policies." The Reference Committee recommends that this recommendation be referred to the Council on Medical Economics for further study and recommendations. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

In the paragraph referring to the utilization of television by county medical societies in which Dr. Turner states: "The utilization of television by county medical societies has come to rank along with the press in importance as a modality of presenting the picture of American medicine and furthering health education. I would like to recommend in this connection that a policy outlining regulations regarding physicians appearing on TV be formulated for the guidance of county medical societies." The Committee wishes to add a supplementary recommendation that the Committee on Public Relations be instructed to formulate a policy outlining regulations regarding physicians appearing on television for the guidance of county medical societies in formulating their own group of regulations peculiar to their localities.

So far as the Committee understands, virtually all of the larger towns and cities have adopted a press, radio, and television code. We all know that in each constituent society there is a public relations representative, and it was our suggestion that each individual county public relations committee and/or their regulatory code handle the situation. I move that this portion be accepted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

This Reference Committee accepts the remaining recommendations referring to the dissemination of information for training technical assistants and to our support of the public health service. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Resolution: Fluoridation of Water Supplies

Dr. Goodall: The resolution presented by Dr. E. Aubrey Cox, Wichita Falls, pertaining to fluoridation of municipal water supplies presents a controversial issue pertaining to public health. It is recommended by the Reference Committee that this resolution be referred to the Committee on Public Health for further study.

In other words, it was our feeling that within the one or two or three hours that we had allotted to us this afternoon, and with good strong evidence on both sides, we should not make a recommendation to the House. In view of the fact it is of such a controversial nature, not only in Texas, but elsewhere, we thought that the Committee on Public Health should go over the situation and report to us one year from today. I move that this portion of our report be accepted. (Thereupon said motion was seconded.)

Speaker Deaton: The motion is that this be referred to the Committee on Public Health for further study. Is there any discussion?

Dr. Joe D. Nichols, Atlanta: Mr. Speaker, I have no voting rights, but I am on the Council on Medical Defense. May I speak?

Speaker Deaton: Do you want to hear Dr. Nichols? (Thereupon, being put to a vote, Dr. Nichols was given the privilege of the floor.)

Dr. Nichols: Last year, as most of you know, I introduced a resolution asking the Texas Medical Association to condemn the fluoridation of water. That was a pretty strong resolution, as I well know. I went before the Reference Committee on Scientific Work, which came out with a recommendation asking you to pass a resolution asking the Texas Medical Association not to condemn or endorse the fluoridation of public water until such time as its value could be proved or disapproved. That was a resolution presented by the chairman of the reference committee, Dr. A. C. Scott, and I seconded the motion and it passed unanimously.

That was sort of a half victory. The truth is that the public fluoridation of water is one of the gravest threats this nation faces. Four years ago, I would have voted for it because I had been told by good authority it was all right. That was before I knew anything about it. I decided to study the matter. Fluoridation is wrong. The people of Texas, the common ordinary citizens, look to us to guide them on such things, and I say to you that its safety has not been proved and its value has not been proved. I challenge you to go home and pick up your Sallman's "Pharmacology" and study your pharmacology on fluorine. I promise you that sodium fluoride and sodium soda fluoride, the two most toxic salts of fluorine, are deadly poison.

The people who are for it—first of all, the man who is for it is a man that you have heard of, Oscar Ewing, who is also in favor of socialized medicine and a left-winger of the first order. I don't know whether you want him to trap you or not, but you almost got trapped last year.

I pray you will defer it for this year and next year you will kill it. I want you to go home and study your pharmacology, not calcium fluoride, not the fluoride that occurs

naturally in the water in West Texas. That is an entirely different thing, but sodium fluoride is rat poison. The naturally occurring fluorides that occur out in West Texas are chiefly calcium fluoride which is insoluble and relatively nontoxic. It also occurs with other salts of fluoride. They say people in West Texas have been drinking fluoridated water all their lives and it didn't hurt anybody, so what's wrong with it. There is a vast difference between the relatively nontoxic and insoluble fluorides and the kind of stuff they are trying to put into your water. Sodium fluoride and sodium soda fluoride are very, very toxic. I challenge you as doctors to look up the subject. I think if you will do that, next year when this thing comes up again, you will kill it.

Dr. Alvis Greer, Houston: I don't believe I can exactly concur with Dr. Nichols. I have read Sallman. When Sallman wrote most of his books, we knew little about the use of sodium fluoride or salts in water. Of course, if taken in excessive amounts, there is no doubt about it, fluoride is toxic, but in my opinion a small concentration or 1 part in 1,000,000 is not. I carried on experiments for three years on my ranch with sodium fluoride with fifteen thoroughbred mares. The average mare would drink about 10 gallons of water in twenty-four hours. We apportioned that much water to these mares and gave sodium fluoride in the water in the concentration of 1 to 1,000,000, and I noticed absolutely no toxicity. We were experimenting with mineral mixtures at that time attempting to find the amount of various trace minerals that cattle and horses need per day just the same as you write prescriptions.

It is a mistake to say that fluoridation has not been used because it has in many places in the country. For instance, Evanston, Ill., has used it without any bad effects. I want to know from Dr. Nichols what date and what volume of Sallman's he got this information from. Personally, I think it is too important for us to throw it by the board. I think the thing to do is to refer this to committee for sober thought rather than emotional action.

Dr. E. Aubrey Cox, Wichita Falls: I presented this petition this morning. I think the statements Dr. Nichols has made have all been pretty well refuted. Of course, about this cry of rat poison, you realize if you take a teaspoon of poison or add a teaspoon to a million gallons of water, there is a lot of difference. The amount you would get in one drop of sodium fluoride is distributed in 16 gallons of water, which takes on an average of over a month to be consumed.

Dr. James H. Harris, Marshall: We have been fluoridating the water in Marshall for five or six years. I practice pediatrics there and see the children, and I know what is going on in the school health program and the dental program. I know it has reduced the incidence of dental caries. My own children drink the water. There have been absolutely no signs of any toxic effect on any population group in Marshall. At the National Conference on Rural Health I had an opportunity to talk to a man from the New York State Health Department, and later he sent me a packet of information. They are very enthusiastic about fluoridation in New York State. So, Joe, I wanted to say that those of us who are using it do not concur in your belief.

Speaker Deaton: The motion before the House is to refer this to a committee for further study. Those in favor of referring it to the Committee on Public Health will say aye—the motion is adopted and the proposal is so referred.

Dr. Goodall: I believe the House can see that your Committee rightly recognized that this was a controversial issue.

Resolution: Extension of Compulsory Social Security

Dr. Goodall: The Reference Committee approves the acceptance of the resolution opposing compulsory social security taxation and its extension presented by Dr. E. P. Hall, Fort Worth. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Delegates to American Medical Association

Dr. Goodall: The Reference Committee recommends the adoption of the resolution presented by Dr. J. B. Copeland for the Delegates to the AMA concerning the American Osteopathic Association. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Resolution: Federal Reinsurance of Health Policies

Dr. Goodall: This Reference Committee recommends that the resolution opposing H. R. 6949, H. R. 8356, and S. 3114, presented by Dr. Alvis E. Greer be adopted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Resolution: Waiver of Premiums

Dr. Goodall: The Committee recommends the acceptance of the resolution opposing "waiver of premiums" provisions in Section 106 and Sections 221 and 222 of H. R. 7199, presented by Dr. Tom Kennerly, Harris County Medical Society. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Mr. Speaker, that completes the reports and resolutions submitted to us up to this date, and I move that our entire report be accepted. (Thereupon said motion was seconded and the same was duly carried and said report was adopted.)

SUPPLEMENTARY REPORT OF COMMITTEE ON MENTAL HEALTH

Dr. David Wade, Austin: I have a supplementary report of the Committee on Mental Health. Dr. Hamilton Ford of Galveston, the chairman of this Committee, has asked that I read this report.

On April 13, 1954, the chairman of this Committee, in official capacity as a member of the Advisory Committee to the Board for Texas State Hospitals and Special Schools, attended a called meeting of this committee at which thirty-one representatives of state and community organizations were present. The meeting was held at the Austin State School.

The organizational representatives present were there at the invitation of Robert L. Sutherland, Ph. D., chairman of the advisory committee, and for the purpose of assisting to formulate plans for a statewide campaign to help better conditions in the Texas state mental hospitals, special schools, and tuberculosis hospitals.

Representatives of the central office staff of the Board for Texas State Hospitals and Special Schools presented in their reports the urgent needs of these institutions, the standards of which are far below the large majority of the remaining states in the nation.

Because of the proximity of the purposes of these institutions and the Texas Medical Association in the ultimate relief of individual suffering of both the patient and his loved ones, the Committee on Mental Health respectfully presents this resolution to the House of Delegates of the Texas Medical Association:

Whereas, conditions in the Texas state mental hospitals, special schools, and tuberculosis hospitals are far below the standards which are necessary to the comfort, health, and happiness of the individuals received there for treatment and education; and

Whereas, the Texas Medical Association represents the profession most dedicated to the welfare of the sick of both mind and body; therefore be it

RESOLVED: That the Texas Medical Association lend its efforts on both state and local levels toward the ultimate success of the statewide campaign to help better conditions in the aforementioned institutions; specifically, that it will give official and other necessary support to the Texas Neuropsychiatric Association, which is to conduct an educational program within the state hospitals. When completed by the latter organization, the details of this program will be submitted for approval.

Speaker Deaton: This report will be referred to the Reference Committee on Scientific work and will come up later for adoption.

Now, there is a notation on your program for a meeting of the House of Delegates tomorrow night. So far as I know, the only remaining business that we have with regard to the committee work is the completion of Dr. Kerr's committee report and this little matter that came up here a moment ago. The Board of Councilors and the Trustees and scientific sections may bring up matters on the last day, but others may not.

Dr. Van D. Goodall, Clifton: As I recall, Mr. Speaker, we did not complete all of the committee reports this morning. I recollect distinctly that Dr. Terrell's report on the infringements of medical practice was not completed and two or three others were not completed.

Speaker Deaton: Yes, I know. We will call on Dr. Terrell for his report at this time, if he will give it to us.

Dr. Truman Terrell, Fort Worth: This Committee reported to the Executive Council in January, and I move that this be accepted as our report.

(The report follows:)

REPORT OF COMMITTEE ON INFRINGEMENTS ON PRIVATE PRACTICE OF MEDICINE

Before the meeting of the Committee on Infringements on Private Practice of Medicine the deans of the three medical schools; the director of the M. D. Anderson Hospital and the presidents of the Dallas, Harris, and Galveston Counties Medical Societies were asked to notify their membership that anyone who desired may appear before this Committee with complaints or information of infringement on private practice by the faculty of these institutions.

Representatives of the Southwestern Medical School, Universiy of Texas Medical Branch in Galveston, and M. D. Anderson Hospital of Houston appeared before the Committee. No representative from Baylor University was present. No individuals or representatives of Harris, Dallas, or Galveston Counties Medical Societies were present. The representative of the various institutions was asked to explain as to their manner of handling the salaries and time given to teaching, research, and private practice.

The policy of the Board of Regents of the University of Texas shall be to request a written letter of referral from the referring physician.

We are led to believe that all groups have worked out their local differences satisfactorily.

Respectfully submitted,
TRUMAN C. TERRELL, Chairman,
LARIED S. OATES,
C. F. CRAIN,
NEIL D. BUIE,
ROBERT A. JOHNSTON,
JOE D. NICHOLS.

Speaker Deaton: I will refer that report to the Committee on Medical Service and Public Relations. I believe we can complete our business on Wednesday without a meeting tomorrow evening; I suggest that we meet at 8 o'clock in the morning.

Dr. James D. Murphy, Fort Worth: I move that we recess as suggested. (Thereupon said motion was seconded and the same was duly carried. The meeting was recessed at 10:15 p. m.)

Monday, May 3, 1954

MINUTES OF MEMORIAL SERVICES AND FIRST GENERAL MEETING

(The eighty-seventh annual session of the Texas Medical Association was called to order for the opening exercises by Dr. George Turner of El Paso, President, at 8:45 a. m., Monday, May 3, 1954, in the Municipal Auditorium, San Antonio.)

MEMORIAL SERVICES

(The Rev. George Mauze, D. D., pastor of the First Presbyterian Church of San Antonio, gave the opening prayer, which was followed by a vocal solo, "Twenty-Third Psalm" by Malotte, by Morris Whitehead of San Antonio.)

(A memorial address for deceased members of the Woman's Auxiliary was given by Mrs. G. V. Brindley, Temple, chairman of the Committee on Memorial Services of the Auxiliary. Her address will be published as part of the transactions of the Auxiliary in the July issue of the JOURNAL. The Rev. E. J. Gregory, superintendent of the Mexican Baptist Orphans Home of Texas, San Antonio, then delivered the memorial address for deceased physicians, which appears in the original articles section of this JOURNAL.

(The names of physicians and Auxiliary members who were memorialized were printed in a program distributed to those present for the services. The physicians paid tribute follow:)

Deceased Members of Texas Medical Association, 1953-1954

Dr. James H. Agnew (Hon.), Houston
Dr. Lewis G. Aide, Bellmead
Dr. J. A. Allison (Hon.), Grapevine
Dr. C. C. Anderson (Hon.), Venus
Dr. Nicholas Andronis, Galveston
Dr. Ernest King Armistead, El Paso
Dr. B. M. Avent (Hon.), Rosebud
Dr. Joseph Knox Bates, Pittsburg
Dr. C. R. Berry, Houston
Dr. C. W. Boring, Port Arthur
Dr. Albert H. Braden, Sr., Houston
Dr. Joseph Hyal Brown, Fort Worth
Dr. Charles B. Buck (Hon.), Mercedes
Dr. J. S. Buie, Mertens
Dr. George Lawson Carlisle, Dallas
Dr. Carl C. Carrico (Hon.), Houston
Dr. Edward H. Cary (Emer.), Dallas
Dr. Harry Walton Cochran (Hon.), Dallas
Dr. Randall Elias Cromeans, Mexia
Dr. John R. Dale, Diboll
Dr. Alfred W. Davisson (Hon.), Corpus Christi

Dr. Howard R. Dudgeon, Sr., Waco
Dr. Joseph C. A. Eckhardt, Austin
Dr. George W. Edgerton, Corpus Christi
Dr. A. J. Evans, Mineral Wells
Dr. George Clayton Farish, Houston
Dr. M. A. Forbes (Hon.), San Antonio
Dr. C. C. Garrett, Fort Worth
Dr. James P. Gill, San Antonio
Dr. George E. Glover, Sr. (Hon.), Tivoli
Dr. M. L. Graves (Emer.), Houston
Dr. L. L. Handly, Houston
Dr. C. M. Hendricks (Hon.), El Paso
Dr. William R. Houston (Hon.), Austin
Dr. J. M. Jackson, Port Arthur
Dr. Berry L. Jenkins (Hon.), Clarendon
Dr. John B. Jenkins, Waxahachie
Dr. Harold D. Kearby, Houston
Dr. John T. Lawson, Bowie
Dr. Erwin Richard Lochte, Sr., San Antonio
Dr. Victor Melton Longmire, Temple
Dr. Edgar W. Loomis, Dallas
Dr. John E. McClung, Corsicana
Dr. Robert G. McCorkle, San Antonio
Dr. Joe H. McCracken (Hon.), Mineral Wells
Dr. Alex G. Marshall, El Paso
Dr. T. W. Martin, Port Arthur
Dr. Walter E. Martin, Dallas
Dr. Edmund Dumas Mills, Beaumont
Dr. Rufus D. Moore, Jr., Houston
Dr. J. D. Motheral (Hon.), Katy
Dr. J. F. Pattison (Hon.), Big Lake
Dr. P. M. Payne (Hon.), Asherton
Dr. Lee T. Pruit, Beaumont
Dr. M. A. Ramsdell, San Antonio
Dr. Robert L. Ramsdell, Norman, Okla., formerly Dallas
Dr. Farley S. Reasonover, Grand Prairie
Dr. L. M. Reaves, Dallas
Dr. J. A. Riebel, Kingsville
Dr. F. L. Robbins (Hon.), Baytown
Dr. W. L. Robinson, Texarkana
Dr. C. H. Rulfs (Hon.), San Augustine
Dr. John G. Schilling, Houston
Dr. Joseph A. Seay, Wichita Falls
Dr. Jerome H. Smith, San Angelo
Dr. J. L. Spivey (Hon.), Wichita Falls
Dr. Merle B. Stokes, Houston
Dr. Martin E. Taber (Hon.), Dallas
Dr. William Thomas (Hon.), Terrell
Dr. G. F. Thornhill, Austin
Dr. Michael M. Walker (Hon.), Wichita Falls
Dr. LeRoy T. Waller, Commerce
Dr. Cleburne M. Williamson, Corpus Christi
Dr. Louis E. Williford, Houston
Dr. Samuel A. Woolsey (Hon.), Austin

Deceased Texas Physicians, Not Members of Texas Medical Association, 1953-1954

Dr. Robert Perry Addison, Dallas
Dr. A. A. Bailey, Beaumont
Dr. Sidney L. Bailey, Center
Dr. T. R. Bassett, Mount Pleasant
Dr. Alex J. Black, Kerrville
Dr. Leonard Fredric Bland, Dallas
Dr. O. C. Bowmer, Corsicana
Dr. Harry Arthur Briggs, Albany
Dr. Robert L. Brown, Pearsall
Dr. Thomas B. Busbee, Rising Star
Dr. John F. Campbell, O'Donnell
Dr. Eugene R. Chapman, Los Angeles, Calif., formerly San Antonio
Dr. Floyd E. Clark, Cisco
Dr. Leonard James Collins, Jr., Sherman
Dr. Thomas C. Dobbins, Denton
Dr. Richard Christopher Elliott, San Diego
Dr. Robert E. Forrester, Moran
Dr. James Luther Fowler, Kerrville
Dr. William R. Fowler, Hamilton
Dr. James L. Gammill, Haslet
Dr. T. N. Goodson, San Antonio
Dr. J. L. Guest, Plainview
Dr. Thomas C. Hairston, Columbus
Dr. William P. Harrison, Teague
Dr. R. C. Hartman, Alamo
Dr. A. L. Hatcher, Amarillo
Dr. Angelo Hillman, Brownwood
Dr. Erly Earnest Johnson, Montague
Dr. Leonce J. Kosminsky, Texarkana
Dr. John Thomas Mantooth, Melissa
Dr. William Norman Marshall, Florence
Dr. Ernest C. Mead, Gainesville
Dr. Garnett Miller, Moody
Dr. J. E. Moffett, Silsbee
Dr. John Jay Moore, San Antonio
Dr. George L. Morgan, Hankamer
Dr. William W. Nesbit, Galveston
Dr. James R. Nichols, Austin
Dr. Jack C. Perry, Abilene
Dr. Barney Bertrand Prestridge, Donna
Dr. Alfred L. Ridings, Washington, D. C., formerly Sherman
Dr. Aaron Lamar Roberts, Fort Worth
Dr. E. B. Rogers, El Paso
Dr. Robin R. Shepperd, Bisbee, Ariz., formerly Crockett
Dr. Bernard F. Smith, San Antonio
Dr. F. B. Stafford, Trenton
Dr. George S. True, Big Spring
Dr. William Thomas Webb, Breckenridge
Dr. Walter E. Whitfield, Edna
Dr. Paul A. Woodard, Bryan
Dr. John R. Worley, Dallas
Dr. John T. Wylie, Dallas

GENERAL MEETING

Dr. Turner: Before continuing with the program of the morning, I should like to present some of the distinguished persons seated on the platform who will not otherwise be introduced. They will stand and be recognized as I call their names:

Dr. F. J. L. Blasingame of Wharton, a member of the American Medical Association Board of Trustees, a former member of the Texas Medical Association Board of Trustees, and President-Elect of the Texas Medical Association.

Mrs. Mark H. Latimer of Houston, an active member of the Harris County Auxiliary and now President-Elect of the Woman's Auxiliary to the Texas Medical Association.

Dr. Merton M. Minter of San Antonio, a past chairman of the Board of Trustees of the Texas Medical Association and now president of the host society, Bexar County Medical Society.

Mrs. John C. Parsons of San Antonio, president of the Woman's Auxiliary to the Bexar County Medical Society

and chairman of the Convention Committee for the State Auxiliary.

We had expected to have Mrs. Leo J. Schaefer of Salina, Kan., President of the Woman's Auxiliary to the American Medical Association, with us this morning. Because of the illness of Dr. Schaefer, she could not be present. She asked that the President-Elect of the Auxiliary to the AMA represent her, and I am glad to present Mrs. George Turner.

Mrs. George D. Feldner of New Orleans, President of the Woman's Auxiliary to the Southern Medical Association, has been meeting with the Texas Auxiliary. We had hoped to present her this morning, but she found it necessary to leave San Antonio to meet other engagements.

Dr. L. Bonham Jones of San Antonio, a member of the Council on Scientific Work and chairman of the Committee on General Arrangements for this annual session.

Dr. B. F. Stout of San Antonio, an active member of the Texas Medical Association for thirty-five years and chairman of the Committee on Memorial Services which arranged our services for this morning.

I am happy to be able to present also Mr. C. P. Loranz of Birmingham, Ala., for many years the secretary-manager of the Southern Medical Association. With him is his assistant, Mr. Robert Butts.

Now Mrs. Edward W. Coyle of San Antonio, President of the Woman's Auxiliary to the Texas Medical Association, will tell us of some of the activities of that group.

Address of Auxiliary President

Mrs. Coyle: Like the little boy who fell in the molasses barrel and came up with his favorite "lickings" on the tip of his tongue and then solemnly prayed, "Oh, Lord, give me a tongue equal to my opportunity," I would like to be able to tell you just how much we appreciate your guidance and material assistance, and how great have been the accomplishments throughout Texas as we have served as an Auxiliary to your organization.

With "Knowledge, Judgment, and Action in Health Leadership" as a guiding theme, special emphasis was placed on friendliness as a basis for full acceptance of our privileges and responsibilities as individual citizens as well as doctors' wives.

Dr. Turner suggested, among other program channels, that we encourage attendance at medical society meetings. Larger auxiliaries prepared dinners before meetings, and smaller groups, particularly where several towns are included in a county group, prepared for dinners together and then had separate meetings. In those groups, we know that attendance has increased.

Self education included many excellent programs and surveys. Our bimonthly *News Letter* is probably our most far-reaching medium for information and better relations. We are indebted to our editor for securing, coordinating, and writing; to the Texas Medical staff; and to you, the Texas Medical Association, who make possible its publication and mailing to our 4,731 members. We have encouraged the reading of *The Journal of the American Medical Association* and the TEXAS STATE JOURNAL OF MEDICINE, especially the legislative information, the monthly message from your President, the PR Diagnotes page, and the Auxiliary Section.

"Public Relations in '53 means Community Service for you and for me," proved true in every community. We have emphasized that we are representing you, the medical profession, in all that we do—whether we are answering the telephone, dealing with the grocer or others who serve us, chatting across the bridge table or on the golf course, or working on a specific project or program.

In health education, many of you assisted by giving *Today's Health* to patients and by having it in your reception rooms. We have placed it in libraries and other places and are responsible for its being used as an official textbook in some schools. Programs and community service projects included those on radio and television on such subjects as "Healthy Living" and "Focus on Health" presented in weekly series. There were health booths and exhibits at fairs and stock shows; physical examinations among our members and families numbering more than 9,000; medical journals sent to Korea; maintenance of a "coke" machine in a county hospital which netted sufficient funds for two oxygen tents and other equipment; parentcraft classes for expectant parents; motion picture films shown to many groups, including those detained at juvenile homes. These are but a few of the different interesting and worthwhile endeavors which do not include the thousands of hours cooperating with such agencies as Red Cross, polio, and Community Chest.

We are proud of our new handbook, and again, we are indebted to you, for its cost was taken out of our Special Fund—your gift to us. We are grateful to the Texas Medical Association staff, the Committee on Public Relations, the public relations counsel—Syers, Pickle, and Winn. This book was sent to every officer, committee chairman, council woman, and county president, with instructions that it be passed on with records and suggestions to their successors.

Essays totaling 860 were written in Texas high schools on the subject of "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care." County societies gave $2,800 in awards, and auxiliaries and participants appreciate the increase in those given by you. The first place winner, Milton Copeland of Wichita Falls, plans to be with us today.

Nurse recruitment was promoted through films, speakers, brochures, social affairs complimenting future nurses and their mothers, hospital tours, and contests. One group was responsible for the creating of a community council for nurse recruitment. Thirty-two gift and loan scholarships totaling over $6,000 were made, with 210 new recruits. There are 40 Future Nurses clubs, including one male club. One auxiliary, in cooperation with a camera club and nursing and other organizations, made a color, sound film.

Mental health was stressed, and we cooperated with the Texas Society for Mental Health in making a survey of the facilities, resources, and needs of the handicapped child.

In civil defense, we cooperated with the State Defense and Disaster Relief Headquarters. Our members worked in blood donor programs; gave printed suggestions on "what to do in emergencies"; taught first aid; and presented television programs called "Nurse, Please."

We appreciate the guidance of your Council on Medical Jurisprudence and your legal adviser. Information, including the *Washington Letter,* is sent to our county presidents, and in auxiliaries there were study groups, speakers, open meetings, "poll tax and vote" campaigns, and communications to legislators.

We have three funds. From our Memorial Fund, primarily for needy widows of doctors, we gave $450 as "love gifts." Our Student Loan Fund is for junior and senior medical students, interns, and residents. Our five loans totaled over $1,200. Your building fund was given $1,000 through our Library Committee, and we added $340 to a fund for rare books, transactions, and other materials for the Library.

We placed much emphasis on the importance of the American Medical Education Foundation fund, realizing that we would not want the teaching standards, the num-

ber of teachers, or facilities to be reduced, nor would we want them to receive government aid for operating costs.

When all sized auxiliaries do the magnificent work that has been done this year, collectively and individually, and when a group of three members writes that they are necessarily circumscribed in their activities; that they feel they form a nucleus of informed members who can work on an individual basis for better community health and public relations; that through organization they can keep in touch with other communities over the state and be ready to grow when the opportunity presents itself; that though they do not meet regularly, they did present a cancer film and more films are planned—then we believe that we have lived up to the challenge of working as an *auxiliary*.

Thanks are insufficient for your thoughtfulness and generosity in assigning a member of the staff to work with us. It has meant better planning and better results—in an efficient and gracious association. For this executive secretary, your other gifts, and many courtesies, we are sincerely grateful.

(Dr. Turner concluded the morning session with the President's Address, which is published in the Original Articles section of this JOURNAL. The meeting was concluded shortly before 10 a. m., at which time meetings of various specialty societies and of the Woman's Auxiliary were held.)

Tuesday and Wednesday, May 4 and 5, 1954

GENERAL SCIENTIFIC MEETINGS

(Scientific meetings of the Texas Medical Association were held Tuesday morning and afternoon, May 4, and Wednesday morning, May 5, in two general sections, Section A—Medical and Section B—Surgical, at the Municipal Auditorium, San Antonio. For these meetings the guest speakers were as follows: Dr. Simeon T. Cantril, Seattle, Wash.; Dr. George T. Harrell, Jr., Gainesville, Fla.; Dr. Harold D. Palmer, Denver, Colo.; Mr. William Alan Richardson, Rutherford, N. J.; and Dr. E. Stewart Taylor, Denver, Colo. Dr. Robert L. Sanders, Memphis, Tenn., was unable to be present because of illness.)

Scientific Exhibit Awards

(Announcement was made before each of the two sections of the awards to scientific exhibits as follows:)

A special Committee on Scientific Exhibit Awards appointed by the President inspected all the scientific exhibits and evaluated them on the basis of subject matter, the exhibitor's interpretation of the display, neatness, teaching value, unusualness, simplicity, and self-explanation. The committee agreed that the certificate of merit for the best exhibit by an individual should be awarded to "Kissing Bug Bite; Its Relationship to Chagas' Disease" by Drs. E. N. Walsh and T. L. Shields of Fort Worth and the certificate for the best exhibit by an institution should go to "Diagnosis and Treatment of Leprosy" by the United States Public Health Service Hospital, Carville, La., and the Texas State Department of Health, Dr. Fred C. Kluth, Corpus Christi. It was recommended that honorable mention go to two exhibits, "Tumors of Infants and Children" by Dr. Luke W. Able, Houston, and "Bronchogenic Carcinoma Simulating Benign Pulmonary Disease" by Dr. G. V. Brindley, Jr., Scott and White Clinic, Temple.

Wednesday, May 5, 1954

MINUTES OF THE HOUSE OF DELEGATES

THIRD MEETING

(The House of Delegates reconvened at 8 a. m., Wednesday, May 5, 1954, in the North Terrace of the Gunter Hotel, San Antonio, with the Speaker, Dr. Hobart O. Deaton, Fort Worth, presiding. A quorum was declared present.)

Speaker Deaton: The introduction of new business today requires the unanimous consent of the House unless it is introduced by the Board of Trustees, the Board of Councilors, or a scientific section. Now, we bogged down in Dr. Kerr's report the other night and will have to finish with that. Dr. Kerr, are you ready?

SECOND REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

Resolution: Reclassification of Membership

Dr. Jack G. Kerr, Dallas: Dr. B. E. Pickett submitted, on behalf of the Director of Records and Classification of the American Medical Association, a resolution calling on the House of Delegates to "request the Constitution and By-Laws Committee to study and reevaluate the classifications of membership as set forth in the Constitution and By-Laws of the Texas Medical Association so that, if possible, the classifications for membership in the Texas Medical Association will conform with the classifications as set up by the American Medical Association," and to "consider making the changes in the classification of membership in the Texas Medical Association on the basis of the recommendation of the American Medical Association."

This Reference Committee recommends that this resolution be submitted to the Committee on Revision of the Constitution and By-Laws for its consideration and subsequent report, and I so move. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Supplementary Report of Board of Councilors

Dr. Kerr: The following proposed addition to the By-Laws submitted by the Board of Councilors would be added at the end of Section 2, Chapter IV: "When appointed, the term of office of the Vice-Councilor shall correspond to the current term of office of the Councilor of his district unless previously relieved by action of the Board of Councilors."

The Reference Committee recommends the approval of this addition. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Amendment: Probationary Membership

Dr. Kerr: Dr. Homer E. Prince, Houston, introduced an amendment to Chapter X, Section 4, of the By-Laws to provide for probationary membership.

The Reference Committee recommends approval of this amendment as presented, and I so move. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Negro Medical Facilities

Dr. Kerr: By majority vote the Reference Committee approves the report Dr. Tate Miller gave for the Committee

on Negro Medical Facilities and commends him on the thoroughness of his work through the years.

Speaker Deaton: Dr. Miller made no specific recommendations in his report. You may continue with your report, Dr. Kerr.

Amendment: Deletion of "White" for Membership

Dr. Kerr: Dr. Clement C. Boehler, El Paso, introduced an amendment eliminating the word "white" from Article II, Section 3, of the Constitution as a requisite for membership in the Association.

By majority vote, your Reference Committee approves the intent of this proposed amendment. Inasmuch as this is a change in the Constitution and will need to lay over for a year, the Committee suggests that it be referred to the Committee on Revision of the Constitution and By-Laws, and I so move.

Speaker Deaton: This does not require a motion, and unless there is some question in particular at this time, the Chair will refer this to the Committee on Revision of Constitution and By-Laws. There is no point in discussing it at this time because any action we take will amount to nothing. It will be discussed at the proper time next year when it comes up.

Report of Council on Scientific Work

Dr. Kerr: The Council on Scientific Work of which Dr. May Owen of Fort Worth is chairman, last year presented amendments which would permit the election of officers at a meeting of the House of Delegates other than on the last day of the session. These have been published, pages 407 and 430-431 of the June, 1953, JOURNAL and were called to the attention of the House this year by the Council and also the Committee on Revision of the Constitution and By-Laws. These amendments, subject to final action by the House at this time, would change Article III, Section 3, of the Constitution and Chapter VII, Section 1, of the By-Laws.

The Reference Committee approves the amendments and recommends their adoption. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Address of President

Dr. Kerr: The Reference Committee does not interpret the last paragraph of Dr. George Turner's presidential address as being in conflict with the proposal of the Council on Scientific Work which was approved. The council's proposal does not necessarily preclude the possibility of a meeting of the House of Delegates on the last day of a convention should circumstances as enumerated by Dr. Turner be present. The Committee is sympathetic with the intent of the Council on Scientific Work to increase attendance at the scientific sessions of the last day.

Report of Committee on Revision of Constitution and By-Laws

Dr. Kerr: The Committee on Revision of the Constitution and By-Laws presented an amendment to simplify the seating of alternate delegates as a substitute for an amendment tabled last year. It would amend Section 6, Chapter VI, of the By-Laws.

The Reference Committee approves this amendment, and I recommend its adoption. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

In its report to the House of Delegates in 1952, the special Committee on Blood Banks recommended that a "permanent committee" be established to continue activity in the field of blood banking. The Reference Committee on Scientific Work, to which the report was referred, concurred in the recommendation, which then was adopted by the House of Delegates. To implement these recommendations, the Committee on Revision of the Constitution and By-Laws offered amendments to Chapter II, Section 3, and Chapter VIII of the By-Laws, the latter by the addition of a new Section 17.

The Reference Committee approves this change, and I move its adoption. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Amendment: Committee on Maternal Mortality

Dr. Kerr: Dr. R. R. Ross of Austin submitted a proposed amendment to Chapter VIII, Section 3, Subsection b, to form a standing state committee on maternal mortality.

Also, he would amend Chapter XI, setting up a new Section 3 to provide for district maternal mortality committees.

The Reference Committee thinks that the creation of a standing committee should be considered by the Reference Committee on Scientific Work and suggests that this amendment be referred there for study and subsequent report, and I so move. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Mr. Speaker, that concludes the report of my Committee, and I move the adoption of this report as a whole. (Thereupon said motion was seconded and the same was duly carried, and said report was adopted.)

Speaker Deaton: If Dr. Scott is ready, we will have the supplementary report of the Reference Committee on Scientific Work.

SECOND REPORT OF REFERENCE COMMITTEE ON SCIENTIFIC WORK

Supplementary Report of Committee on Mental Health

Dr. A. C. Scott, Jr., Temple: The Reference Committee on Scientific Work approves the resolution by Dr. Hamilton Ford and his Committee on Mental Health concerning the statewide campaign to help better conditions in the Texas state mental hospitals, special schools, and tuberculosis hospitals and recommends its adoption by the House of Delegates. (Upon motion made, seconded, and carried, the above report was adopted.)

Amendment: Committee on Maternal Mortality

Dr. Scott: This Reference Committee on Scientific Work has considered the resolution referred to it by the Reference Committee on Amendments to the Constitution and By-Laws relative to the establishment of a standing committee on maternal mortality, which resolution was introduced by Dr. R. R. Ross of Austin in the form of a change of the Constitution and By-Laws.

After a discussion and hearing from the sponsor of the resolution and four other delegate advocates of the resolution who appeared, and after much discussion concerning the nature of such a committee, the probable additional and exceptional demands for work that would be placed upon the office force of the Association in carrying on the work of the committee in organizing and setting up machinery for the district maternal mortality committees provided for in the resolution and other mandates of such Constitution and By-Laws changes, and with the approval of those advocates who appeared before this Reference Committee, your Reference Committee on Scientific Work recommends that no change be made in the Constitution and/or By-Laws relative to this matter; but your Reference Committee further recommends:

1. That this House approve the principle of a continuing survey of maternal deaths in the state of Texas in an effort to reduce the preventable deaths in Texas by eliminating all possible hazards in pregnancy and childbirth.

2. That the House approve the establishment of a special committee of the Texas Medical Association on maternal mortality, which committee shall (a) study problems connected with maternal mortality and (b) work with district councilors and county medical society officers in fostering the establishment of similar district maternal mortality committees to carry out efforts of the special committee to reduce maternal mortality.

3. That the House instruct the President to appoint a special Committee on Maternal Mortality consisting of nine members of the Association of which three shall be from the obstetrical departments of each of the three medical schools of this state, and appoint three ex-officio members consisting of a representative from the Texas Association of Obstetricians and Gynecologists, a representative of the Texas Academy of General Practice, and the director of the Division of Child and Maternal Health of the Texas State Department of Health.

4. That the House of Delegates instruct said Committee on Maternal Mortality (a) that it shall not call upon the state office of the Association to set up the proposed district committees or for other detail work, but that such work shall be done by the committee itself in collaboration with the councilors of the various districts and the county society officers in said districts; (b) that the Committee on Maternal Mortality shall investigate maternal deaths in the various districts and make and return to each district committee a report of its findings and constructive recommendations when appropriate.

Speaker Deaton: As I understand, Dr. Scott, you propose no amendment?

Dr. Scott: That is correct. We propose that no change be made in the Constitution and By-Laws and that no standing committee be appointed but instead a special committee be appointed which requires no change of the Constitution and By-Laws. I move the adoption of this portion of the report. (Thereupon said motion was seconded, and the same was duly carried.)

That completes our report, and I move the adoption of the report as a whole. (Thereupon said motion was seconded and carried, and the report was duly adopted.)

SECOND REPORT OF BOARD OF COUNCILORS AS REFERENCE COMMITTEE

Dr. R. G. Baker, Fort Worth: The Board of Councilors has a report as a Reference Committee.

Supplementary Report of Executive Secretary

Dr. Baker: On the morning of the opening session, each of you was furnished with a list of nominations for inactive and honorary membership. This report was held up until now to permit of additions or deletions as they might be called for. It is upon those nominations that the Board of Councilors reports at this time as a Reference Committee.

The Board of Councilors approves for emeritus membership Dr. Oscar M. Marchman, Sr., Dallas, whose nomination must be held over for a year before final action can be taken.

It approves for honorary membership those listed by the Executive Secretary plus the following:

District 5:
Bexar County Medical Society—
Dr. C. W. Taylor, San Antonio.

District 6:
Webb-Zapata-Jim Hogg Counties Medical Society—
Dr. A. T. Cook, Laredo.

District 9:
Harris County Medical Society—
Dr. F. J. Slataper, Houston.

District 15:
Harrison County Medical Society—
Dr. G. P. Rains, Marshall.

Also, Dr. A. L. Thomas of Ennis requested that his name be struck from the list of proposed honorary members, and the Board of Councilors followed his wishes.

The nominations for inactive membership are approved as presented with two additions:

District 2:
Andrews-Ector-Midland Counties Medical Society—
Dr. James H. Chapple, Odessa.

District 7:
Travis County Medical Society—
Dr. Scott T. McGuire, Austin.

The Board of Councilors moves the election of these members for inactive, honorary, and emeritus membership as designated. (Thereupon said motion was seconded, and the same was duly carried.)

Speaker Deaton: Dr. Van Goodall of Clifton has an additional report for the Reference Committee on Medical Service and Public Relations.

SECOND REPORT OF REFERENCE COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

Report of Committee on Rural Health

Dr. Goodall: The Reference Committee on Medical Service and Public Relations approved the report of the Committee on Rural Health, and I move that it be adopted. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Delegate to State Rural Health Council

Dr. Goodall: The Reference Committee on Medical Service and Public Relations read and accepted the report of the Delegate to the State Rural Health Council. I move its adoption. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Delegate to Lone Star State Medical Association

Dr. Goodall: The report of the Delegate to the Lone Star State Medical Association was read and approved. I move its adoption. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Report of Committee on Infringements on Private Practice

Dr. Goodall: The Reference Committee read the report submitted by Dr. Terrell and his Committee on Infringements on the Private Practice of Medicine, which committee was appointed by the President, Dr. George Turner, at the suggestion last year of the Reference Committee on Medical Service and Public Relations. This report was submitted to the Executive Council at the meeting in Austin in January, and no additions have been made since that date. The Committee wishes to approve this report and might suggest to the future officers that a committee of this type might be continued. I move the adoption of this report. (Upon motion made, seconded, and carried, the above portion of the report was adopted.)

Mr. Speaker, I move that the entire report be adopted. (The motion was seconded and duly carried.)

Election of Officers

Speaker Deaton: Is there any further business? All right, the Chair will entertain nominations for the election of President-Elect.

PRESIDENT-ELECT

Dr. John L. Matthews, San Antonio: It is my distinct honor to nominate for this highest office in our Association a physician worthy of our confidence, who will reflect credit on himself and on our organization.

His life has been characterized by unselfish and devoted service—to his country, to his church, to his community, and to his profession.

He is a modest man, and it is not from him that one would know of his accomplishments and his honors, as, for example, his enviable war record—five years' distinguished service in responsible assignments, a colonelcy in the Army Medical Corps, and decoration for gallantry before the enemy in the Battle of the Bulge.

Not alone have his professional colleagues looked to him for leadership. His church, one of the larger congregations in the state, has relied heavily on him, in his post as chairman of its board and for several years its lay leader.

With all the demands of his busy general practice, he has served faithfully the indigent of his community as staff member and chief of gynecology in the county hospital, which he has headed as its president.

In the organized activities of our profession, he has also been a leader. His years of conscientious service were recognized, on his return from war, by election to the presidency of his county medical society. The respect and confidence which he earned there inevitably led to his election as councilor of his district, which he has represented with distinction these past five years. He is president-elect of his chapter of the Texas Academy of General Practice and a past president of the International Medical Assembly of Southwest Texas.

Mr. Speaker, on behalf of the Bexar County Medical Society, I take great pleasure in nominating for President-Elect, Dr. J. Layton Cochran of San Antonio.

(Thereupon said nomination was seconded by several, and upon motion by Dr. R. G. Baker, Fort Worth, duly seconded and carried, Dr. Cochran was unanimously elected by acclamation.)

(Upon nominations duly made and seconded and motions made, seconded, and carried the following officers were elected by acclamation:

VICE-PRESIDENT

Dr. J. C. Terrell, Stephenville.

SPEAKER OF THE HOUSE OF DELEGATES

Dr. Hobart O. Deaton, Fort Worth, succeeding himself.

VICE-SPEAKER OF THE HOUSE OF DELEGATES

Dr. Charles P. Hardwicke, Austin, succeeding himself.

TRUSTEE

Dr. Troy A. Shafer, Harlingen, succeeding Dr. E. A. Rowley, Amarillo.

COUNCILORS

District 2, Dr. R. B. G. Cowper, Big Spring, succeeding himself.

District 5, Dr. John J. Hinchey, San Antonio, to fill the unexpired term of Dr. J. L. Cochran, San Antonio, the newly elected President-Elect.

District 7, Dr. David Wade, Austin, succeeding Dr. J. M. Coleman, Austin.

District 8, Dr. James H. Wooten, Jr., Columbus, succeeding himself.

District 9, Dr. J. T. Billups, Houston, succeeding himself.

DELEGATES TO AMERICAN MEDICAL ASSOCIATION

Dr. A. C. Scott, Jr., Temple, succeeding himself.

Dr. John K. Glen, Houston, succeeding himself.)

(The next position to be filled was Delegate to the American Medical Association succeeding Dr. Robert B. Homan, Jr., El Paso.)

Dr. A. C. Scott, Jr., Temple: As you all know, our beloved Bob Homan is sick in El Paso and has been unable to attend this meeting. This is the first meeting I know of he has ever failed to attend. I am sure he would have been here if it had been humanly possible.

Bob Homan has done not only an outstanding job in this House, but since you elected him as a Delegate to the AMA, he has done an outstanding job up there. He is held in the highest esteem by the House of Delegates of the American Medical Association, and his voice carries well and far on all things that are good and everybody listens to him.

He has had much opportunity in the House of Delegates up there to serve on various important committees, reference committees and other committees, and he is actually a valuable man in the House of Delegates of the American Medical Association. I think you have done yourselves honor in the past by electing him as a delegate.

I would certainly like to see Dr. Robert Homan go back to the House of Delegates of the American Medical Association. I am equally convinced that it is our duty as members of this House at all times to abide by our Constitution and By-Laws. Therefore, since our By-Laws specifically state that no person shall be elected to office who is not in attendance on the annual session at which the election is held, I am first going to place in nomination the name of our Bob Homan to succeed himself and immediately withdraw his name from nomination and in his place nominate one of our outstanding members who has served us so well and excellently on our Board of Trustees and who this year retires from the Board of Trustees. I nominate Dr. E. A. Rowley of Amarillo as Delegate to the American Medical Association.

Dr. B. E. Pickett, Carrizo Springs: I cannot pass this opportunity without paying tribute to Bob Homan. When I was chairman of the Texas Delegation, he worked with me for many years. It is not known to you, but it is known to me and to others who worked in the House of Delegates of the AMA that twice he has been selected for the office of Vice-Speaker of the House and because of unfortunate circumstances, it was not possible for him to be elected, which would have meant that ultimately he would be Speaker of the House of Delegates of the American Medical Association.

Bob Homan carries with him an influence at the national level that few men have been able to develop in the years that he has been there serving. It grieves us, of course, to know of his illness, but in view of that, I want to second the nomination of Dr. Rowley. I assure you in doing that, that while my heart is with Bob, I am paying this tribute in seconding the nomination of his friend, Dr. Rowley.

Dr. E. A. Rowley, Amarillo: I regret very much that Dr. Homan cannot be here. It is unusual for a fellow to electioneer for himself, but I will assure you that if I am elected, I will resign and the President will appoint Dr. Bob Homan delegate to the AMA.

(Thereupon, upon motion duly made, seconded, and unanimously carried, Dr. Rowley was elected as Delegate to the AMA.) *

(Upon nomination and second and motion duly made, seconded, and carried, the following officials were elected by acclamation:

DELEGATE DESIGNATE TO AMERICAN MEDICAL ASSOCIATION

Dr. James H. Wooten, Jr., Columbus, succeeding himself.

ALTERNATE DELEGATES TO AMERICAN MEDICAL ASSOCIATION

Dr. John L. Otto, Galveston, succeeding himself.

Dr. Robert W. Kimbro, Cleburne, succeeding himself.

Dr. L. C. Heare, Port Arthur, succeeding himself.)

Dr. R. G. Baker, Fort Worth: Mr. Speaker, we do not provide an Alternate Designate to Dr. James Wooten, Jr. Are we due to provide an Alternate Delegate Designate, or does that just stand open?

Speaker Deaton: I don't know that I am an authority to answer that question.

Dr. B. E. Pickett, Carrizo Springs: It is not necessary for Dr. Wooten to have an alternate, although he may if it is the wish of this House. Formerly if a man was a delegate to the AMA, his alternate must serve in his place in the event it was impossible for him to serve. The Constitution and By-Laws of the AMA has been so changed that at this time any alternate delegate attending the session of the AMA may be selected by the delegation from Texas to sit instead of the one that cannot be present.

Dr. James D. Murphy, Fort Worth: I move that one be elected.

Dr. James H. Wooten, Jr., Columbus: I would like to move that an alternate delegate be elected, and I would further move that that fine young gentleman from Fort Worth, Dr. L. H. Reeves, be placed in nomination as my alternate. (Upon motion duly seconded and carried, Dr. Reeves was unanimously elected as Alternate Delegate Designate to the American Medical Association.)

Speaker Deaton: The chair now recognizes Dr. Blasingame.

Dr. F. J. L. Blasingame, Wharton: Initially I should like to pledge to the House that when Dr. Rowley has been disposed of one way or another, I shall nominate Bob Homan to the office of Delegate to the American Medical Association, if that vacancy occurs during my term of office. I can assure that everything that has been said about Bob Homan can be underlined and italicized. He has done a great job for us.

It now falls to my pleasure and responsibility to place in nomination the names of men to fill certain vacancies that occur on the councils and to announce appointments to the standing committees. (Thereupon, the following nominations were confirmed:

Election of Council Members

Dr. John H. Wootters, Houston, Council on Medical Defense, succeeding himself.

Dr. Sam Key, Jr., Austin, Council on Medical Jurisprudence, succeeding Dr. G. W. Cleveland, Austin.†

Dr. Charles D. Reece, Houston, Council on Scientific Work, succeeding Dr. George W. Waldron, Houston.‡

Dr. Gail Medford, Lufkin, Council on Medical Economics, succeeding Dr. H. H. Cartwright, Breckenridge.

Dr. John L. Matthews, San Antonio, already a member, chairman of the Council on Medical Education and Hospitals, succeeding Dr. M. O. Rouse, Dallas, resigned.

Dr. S. W. Thorn, Houston, Council on Medical Education and Hospitals, succeeding Dr. R. Lee Clark, Jr., Houston.

Dr. John S. Chapman, Dallas, Council on Medical Education and Hospitals, succeeding Dr. M. O. Rouse, Dallas, resigned.§

Appointment of Standing Committee Members

Dr. Charles Phillips, Temple, Committee on Cancer, succeeding himself.

Dr. R. Lee Clark, Jr., Houston, Committee on Cancer, succeeding Dr. John H. Wootters, Houston, resigned.

Dr. Felix P. Miller, El Paso, Committee on Medical History, succeeding himself.

Dr. William D. Seybold, Houston, Committee on Tuberculosis, succeeding Dr. Ernest E. Holt, College Station.

Dr. Jack G. Kerr, Dallas, Committee on Library Endowment, succeeding Dr. August J. Streit, Amarillo.

Dr. Andrew S. Tomb, Victoria, Committee on Mental Health, succeeding Dr. Edgar S. Ezell, Fort Worth.

Dr. M. O. Rouse, Dallas, Committee on Public Health, succeeding Dr. Guy A. Tittle, Dallas.

Dr. H. H. Latson, Amarillo, Committee on Public Health, succeeding himself.)

Appointment of Section Secretaries

Dr. Blasingame: While it is not necessary that the House take any action on these, there are certain scientific section vacancies which must be filled. To serve as secretaries, I would like to make these appointments: Section on General Practice, Dr. John M. Smith, San Antonio; Section on Internal Medicine, Dr. Mavis P. Kelsey, Houston; Section on Surgery, Dr. Norman Duren, Beaumont; Section on Obstetrics and Gynecology, Dr. Dennis M. Voulgaris, Wharton; Section on Eye, Ear, Nose, and Throat, Dr. Robert Marion Johnson, Houston; Section on Radiology, Dr. David H. Allen, Wichita Falls; Section on Public Health, Dr. Luther P. Walter, Austin; Section on Clinical Pathology, Dr. John H. Childers, Galveston; Section on Pediatrics, Dr. B. H. Williams, Temple.

Presentation of General Practitioner

Speaker Deaton: At this time the House of Delegates would be delighted to present the General Practitioner of the Year. I will ask Dr. Tenery to do this for us.

Dr. R. Mayo Tenery, Waxahachie: I present to you Dr. A. L. Thomas of Ennis, whom you have elected General Practitioner of the Year.

Dr. Thomas: Last July my county society gave me a big party at the Country Club in Ennis and presented me with a fifty-year pin which I am very proud to wear. Now, you have done me this honor.

I heard of a fellow in Ennis who was somewhat of a wag and he said that people talked about the Lord smiling on them, but he said, He just laughed out loud on me. That's the way I feel about this. I thank you all very much for this honor.

*EDITOR'S NOTE: *Dr. Rowley resigned as Delegate to the American Medical Association on May 7, 1954, and Dr. Robert B. Homan, Jr., El Paso, was appointed to succeed him.*

†EDITOR'S NOTE: *Dr. Key resigned as a member of the Council on Medical Jurisprudence on May 28, 1954, and Dr. G. W. Cleveland, Austin, was appointed to succeed him.*

‡EDITOR'S NOTE: *Dr. Reece resigned as a member of the Council on Scientific Work on May 11, 1954, and Dr. John C. Kennedy, Houston, was appointed his successor.*

§EDITOR'S NOTE: *Dr. Chapman resigned as a member of the Council on Medical Education and Hospitals and Dr. G. N. Aagaard, Dallas, was appointed May 13, 1954, to succeed him.*

Selection of Place for 1956 Annual Session

Speaker Deaton: The next item of business is the selection of the time and place of the 1956 annual session. Gentlemen, we are receptive to invitations.

Dr. John L. Otto, Galveston: On behalf of the Galveston County Medical Society, I would like to invite this group to meet in Galveston at the 1956 annual session. I might add that since your last visit there, Galveston has expanded its facilities somewhat, and I think we have sufficient facilities to accommodate the whole group this year.

Dr. J. T. Billups, Houston: I move we accept the invitation and that the 1956 session be held at Galveston. (Thereupon said motion was seconded and duly carried.)

Dr. Truman Terrell, Fort Worth: I think this body owes the members of the Bexar County Medical Society and the committees in Bexar County a vote of thanks for putting on the meeting that they have, and also we should extend our thanks to the hotels and others for the fine hospitality extended to us. I make that as a motion. (Thereupon said motion was duly seconded and carried.)

Dr. Van D. Goodall, Clifton: I move we adjourn. (The motion was seconded and carried, and the meeting adjourned at 10 a. m.)

Wednesday, May 5, 1954

MINUTES OF GENERAL MEETING LUNCHEON

(The General Meeting Luncheon of the Texas Medical Association was held Wednesday, May 5, 1954, at 12:30 p. m., in the Grand Ballroom of the Gunter Hotel, San Antonio, with Dr. George Turner, El Paso, President, presiding.

(Dr. Turner presented Dr. A. L. Thomas of Ennis, General Practitioner of the Year, who made a few brief remarks, and introduced distinguished guests. Then Dr. S. W. Thorn, Houston, chairman for Texas of the American Medical Education Foundation, announced awards on behalf of the board of trustees of the foundation to the Woman's Auxiliary to the Texas Medical Association, to Mrs. George Turner of El Paso, and to Dr. Stuart Wallace of Houston. Dr. Turner then presented Dr. Hobart O. Deaton, Fort Worth, Speaker of the House of Delegates.)

Address of Speaker of House

Speaker Deaton: The grand total registration for this meeting was 2,114. That includes doctors, Auxiliary, visitors, and exhibitors.

Now, for the House of Delegates. The House of Delegates, as you know, is the legislative body of the Texas Medical Association. It is composed of your elected representatives. We have had three sessions. The first was held Sunday morning, the second Sunday evening, and the final session this morning.

As many of you already know, all reports of officers and the various councils and committees, as well as resolutions and new business, are referred to reference committees for detailed consideration and study. Before these reference committees the proponents and opponents of any given measure may appear and plead their cause. Except in some controversial matters, the recommendations of the committees are usually accepted.

Some of these committees have a terrific amount of work to do. I wish to express my personal gratitude and also the appreciation of the House of Delegates for the wonderful work of these reference committees.

I also wish to commend the central office at Austin for the valuable assistance and cooperation in preparing for these sessions, and especially the young ladies of the headquarters staff who worked many hours of the day and night, typing countless pages of reports and recommendations. I would not forget the faithful reporter, Mr. Henry Beck, who records blow-by-blow all that takes place during the sessions. This account is usually found in the Organization Section of the June JOURNAL. Take some time out and read it and see what your officers and delegates are doing for you. I believe you will see that the profession of medicine today has many grave concerns besides the reporting of interesting cases and the further use of new antibiotics.

To give you a few high spots of our sessions, almost everything was discussed from the extension of social security to the fluoridation of water in Fort Worth and Marshall. There appears to be unified opposition to the extension of social security, and resolutions were enacted to implement this opposition and instruct the delegates to the AMA.

Dr. J. B. Copeland of San Antonio, who is chairman of the Council on Medical Jurisprudence, is doing a fine work, and you would do well to keep up with what his committee is doing and support them.

The problem of veterans' care came up. The stand of the American Medical Association was endorsed, and the House of Delegates recommends that material for the education of physicians and the public be brought forcibly to the attention of each county society.

The House also instructed its delegates to the AMA to request that the national policies relating to the distribution of gamma globulin be reevaluated and that gamma globulin be released for normal use.

The report of the Board of Trustees indicated that your State Association is in a sound financial condition.

The constitutional amendment introduced last year providing for a division of the state into seven trustee districts and increasing the number of Trustees from five to seven was voted down by your House of Delegates. Various other amendments to the Constitution and By-Laws were acted upon, but nothing particularly controversial was involved

A resolution was introduced by Dr. Hamilton Ford, chairman of the Committee on Mental Health, urging that we give our efforts to the statewide campaign to help better conditions in our state tuberculosis hospitals and in the Texas mental hospitals and special schools. This resolution was adopted.

After the completion of some unfinished business this morning, the House of Delegates took up the business of electing officers. No candidate had opposition, and every officer was unanimously elected by acclamation.

Your President-Elect has already been introduced, Dr. J. Layton Cochran of San Antonio. The Vice-President, Dr. J. C. Terrell of Stephenville. For Speaker of the House, your humble servant was reelected to succeed himself. For Vice-Speaker of the House, Dr. Charles P. Hardwicke of Austin was reelected.

One Trustee was to be elected this year, and Dr. Troy Shafer of Harlingen was elected to that post. Some councilors were elected. From the Second District, Dr. R. B. G. Cowper of Big Spring was reelected. From the Fifth District, Dr. John J. Hinchey of San Antonio was elected to replace Dr. Cochran, who can't hold so many offices at one time. For the Seventh District, Dr. David Wade of Austin was elected. For the Eighth District, Dr. James H. Wooten Jr., of Columbus was reelected. For the Ninth District, Dr.

J. T. Billups of Houston was reelected. For the Tenth District, Dr. L. C. Heare of Port Arthur was reelected.

For your AMA Delegates, Dr. A. C. Scott, Jr., of Temple and Dr. John K. Glen of Houston were reelected. Then the House of Delegates came to a knotty problem. As some of you know, to be elected to an office, you have to be present at the meeting. My friend Dr. Robert B. Homan of El Paso was not able to be here. So Dr. E. A. Rowley was elected in Dr. Homan's place, and your Speaker was instructed to liquidate Dr. Rowley in the morning at sun-up so the President can appoint Dr. Homan in his usual job when he recovers from his illness.

AMA Delegate Designate Dr. James H. Wooten, Jr., was reelected. An Alternate Delegate Designate was Dr. L. H. Reeves of Fort Worth. Three Alternate Delegates to the AMA were reelected: Dr. John L. Otto of Galveston, Dr. R. W. Kimbro of Cleburne, and Dr. L. C. Heare.

The selection of a place for the 1956 meeting was taken up, and the invitation of Galveston was accepted. As you know, the 1955 session will be held in Fort Worth. The dates are starting Saturday, April 23, and continuing through Wednesday, April 27.

(The incoming President, Dr. F. J. L. Blasingame, Wharton, then presented an address on "Medical Leadership," which appears in the Original Articles section of this JOURNAL.)

(Mr. Roger Fleming, Washington, D. C., secretary-treasurer of the American Farm Bureau Federation and guest of the Association, then delivered an address, "Let's Get Together," which is published as an Original Article in this JOURNAL.)

Presentation of Gavel

Dr. Turner: Dr. Blasingame, it is a great pleasure to present to you this gavel, representing the authority of the Texas Medical Association. I know that you will make an outstanding President and that the Texas Medical Association will accomplish much under your regime. With the cooperation of your officers, the county medical societies, and every individual member, I am sure great accomplishments will be yours in 1954-1955. I congratulate you and wish for you the very best for your year.

Dr. Blasingame: Thank you, Dr. Turner. I accept this gavel in humility but with courage and in the hope that we shall come through this year with an effective program.

One of the first duties that comes to a President of the Texas Medical Association is to congratulate a President just past, who is now a past president, and to congratulate him on joining that distinguished group. I so do, Dr. Turner, now congratulate you on a job well done and express again on behalf of all our membership our appreciation for the many efforts which you have extended in our behalf. I should like also to give you tangible evidence in the form of a past president's certificate, which I hope you will frame and study and appreciate for many, many years to come. In addition, I want to present to you, as is customary, a medallion which on occasions is worn about the neck of our past presidents. Again it gives me a great deal of pleasure to present this to you in behalf of our Association. May you wear it proudly for many years.

Dr. Turner: Thank you, Dr. Blasingame.

Dr. Blasingame: May I again express to the members of the Bexar County Medical Society our appreciation for the innumerable courtesies extended to us. You have made us feel welcome here, and we are grateful to you. To those of you here, may I as your President wish you a safe trip home, a productive year in the efforts of the Texas Medical Association as well as in your personal affairs, and now I declare the 1954 session of the Texas Medical Association adjourned.

(Thereupon said session was adjourned at 3 p. m.)

TECHNICAL EXHIBITS AT ANNUAL SESSION

Listed below are the technical exhibitors and their representatives at the recent annual session in San Antonio.

Abbott Laboratories, North Chicago—Clifton C. Bowen, Cecil Cain, William C. Wright, R. G. Boothman, William M. Lacy.

Alcon Laboratories, Inc., Fort Worth—Harold C. Johnson.

A. S. Aloe Company, St. Louis—Charlie C. Haynie, M. Charles Smith, Ralph Williams.

American Medical Education Foundation, Chicago—Mrs. J. L. Pettis.

Audio-Digest Foundation, Glendale, Calif.—Dr. Edward C. Rosenow, Jr.

Baby Development Clinic, Chicago—Mrs. Cline, Paul D. LaHue.

Baker Laboratories, Inc., Cleveland—Harry Dahl.

Ballard Surgical Supply Company, San Antonio—John S. Ballard, Charles Thompson.

Borden Company, New York—E. J. Bryant, Carroll W. Shoaf.

George A. Breon and Company, New York—C. W. Vogelsang, Martin White, Harry T. Moseley.

Brown Schools for Exceptional Children, Austin and San Marcos—Lyndon L. Brown, Nova Lee Dearing, H. R. Gipson.

Carnation Company, Los Angeles—Don C. Earnest, James J. Ortasic.

Charles Pharmacy, San Antonio—B. Allen Anderson, Charles Herrara, M. G. Ortega, Eva Cruz.

Ciba Pharmaceutical Products, Inc., Summit, N. J.—Royce H. Bates, L. C. Scheh, H. W. Seay, Jr.

Coca-Cola Bottling Company—Mrs. Dorothy Coggeshall.

Curtis Surgical Supply Company, Waco—Tom Curtis, Henry Lachele.

Cutter Laboratories, Berkeley, Calif.—Tom Bloomer, Jack Downing, Jay Hamilton, Farley B. Hornbeak.

Eaton Laboratories, Inc., Norwich, N. Y.—J. C. Payne, H. B. Walton.

First Texas Chemical Manufacturing Company, Dallas—Gordon Cunningham, Bob Foster.

C. B. Fleet Company, Inc., Lynchburg, Va.—Mike Hill, S. J. Reynolds.

General Electric Company, X-Ray Department, Dallas—T. M. Devine, T. P. Dunn, H. O. McKenzie, Lewis Shook, Raymond W. Crawford.

Gilbert X-Ray Company of Texas, Dallas—G. O. Clason, H. L. Lair, Pen Dell Pittman, Jr., Raymond W. Crawford, Pen Dell Pittman.

Graham Laboratories, Dallas—Paula Whitten.

Group Hospital Service, Inc., and Group Medical and Surgical Service, Dallas—Bob Hawthorne, W. R. McBee, Ralph Webb, Roy Wilmesmeier, Dick Post.

Harrower Laboratory, Inc., Jersey City—J. A. Castille, Jr., J. S. Lathrop.

Hedgecock Artificial Limb Company, Dallas—Ed Latimer.

H. J. Heinz Company, Pittsburgh—C. O. Denham, S. A. Wyatt, Mrs. C. O. Denham, V. W. Blackburn.

Karmac Company, Dallas—D. S. McCrary, Pat Neff.

R. P. Kincheloe Company, Dallas—J. E. Heath, I. B. Schaefer, Mrs. I. B. Schaefer.

Eli Lilly and Company, Indianapolis—E. G. Burchfiel, E. T. McDaniel, C. L. Munford, D. P. Ward, Woodfin Ray.

J. B. Lippincott Company, Philadelphia—J. L. Rosecrants.

P. Lorillard Company, New York—A. J. Bass, Jr., J. M. Vaughn, L. A. Wernert, T. E. Zoda.

J. A. Majors Company, Dallas—Jack McClendon, L. B. Shaver.

Mead Johnson and Company, Evansville, Ind.—Fred Bowles.

Medcalf and Thomas, Fort Worth—Jack McCarty.

Medical Plastics Laboratory, Gatesville—A. C. Hays.

Medical Protective Company, Fort Wayne, Ind.—L. Gayle Nelson, R. F. Reiman.

Miles Reproducer Company, Inc., New York—Dr. J. M. Kuhlik, Mrs. H. B. Kuhlik.

Mission Pharmacal Company, San Antonio—Bailey Adams, Jr., Ted Chapin, Wally Walsdorf.

Murray Agency, Corpus Christi—Don Murray.

C. V. Mosby Company, St. Louis—Mrs. S. G. Cooke.

Pendleton and Arto, Inc., Houston—M. Pat Daley.

Pfizer Laboratories, Brooklyn—H. J. Dahl, Robert Tucker, Dave Walker.

Physicians and Surgeons Supply Company, San Antonio—J. M. Guerrero, B. B. Hunter, Mrs. C. W. Naftzger, A. G. Pierce, E. W. Bickett.

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.—H. H. Koch, C. W. Lewis, F. W. Uzzell, Judith Myerson.

Richards Manufacturing Company, Memphis—Clint G. Johnson.

A. H. Robins Company, Inc., Richmond, Va.—Pete Moses, A. F. Sexton, C. D. Wheeler.

Schering Corporation, Bloomfield, N. J.—Frank Hopwood, Harold L. Sturman.

G. D. Searle and Company, Chicago—J. S. Garrett, Frank McPherson, George R. Stannus.

Sommer Drug Stores Company, San Antonio—John C. Burkholder, Dorothy A. Flowers, L. A. Saldana, Bea Tomlison, W. C. Vaughn, C. W. White.

SoundScriber of San Antonio, Inc., San Antonio—C. S. Hunt, Ted Shields, B. Woodard.

Noa Spears Company, San Antonio—Hugh Cheek, Charles S. Dupont, Noa Spears, Jr., Ray Thompson, Lloyd L. Stryker, Noa Spears.

Taylor Laboratories, Inc., Houston—Tom H. Coulter, Chip Taylor, Bob Watson.

Terrell Supply Company, Fort Worth—Dan Bodiford, O. Coffman, H. M. Land.

Texas Pharmacal Company, San Antonio—A. R. Clark, Ray C. Council, John Cummins.

United Medical Equipment Company, Kansas City—H. C. Culli, Gene Lipsky, Murray Roth.

U. S. Vitamin Corporation, New York—Bill Hasewinkle, Bill Patterson.

VanPelt and Brown, Richmond, Va.—George F. Schindler.

Varick Pharmacal Company, Inc., New York—R. J. Bose.

Walden Industries, Inc., New York—Harold Sobelman, Emanuel Gassman.

William A. Webster Company, Memphis, Tenn.—J. R. Renner, William A. Webster, Jr.

Westinghouse Electric Corporation, Baltimore—L. W. Kent, J. F. Pirozzolo, W. A. Ross.

Westwood Pharmaceuticals, Buffalo, N. Y.—J. Smiser Davis, R. R. Johnson.

Wilson X-Ray and Surgical Company, Austin—R. T. Wilson, Jr., Dick Roberts, Mrs. R. T. Wilson, Jr., Ray Reid.

Winthrop-Stearns, Inc., New York—R. J. P. Foitik, M. E. Moodie.

EXECUTIVE COUNCIL TO MEET SEPTEMBER 5

September 5 has been designated as the date for the next meeting of the Executive Council of the Texas Medical Association by the President, Dr. F. J. L. Blasingame of Wharton. The meeting will be held at the Association building in Austin and will be preceded on September 4 by meetings of such councils and committees as may be called. Members are urged to make their own hotel reservations in Austin at their earliest convenience.

AMERICAN MEDICAL ASSOCIATION

WAIVER OF 1950 DUES DEADLINE NEAR

July 1 is the last date by which payment of 1954 American Medical Association dues will permit reinstatement of members who failed to pay dues in 1950 and were suspended for such delinquency. It will be remembered that former active members of the AMA have been expected to pay dues for 1950 before being accepted for membership in good standing. A resolution adopted by the House of Delegates in St. Louis last December permitted waiver of the 1950 dues for physicians paying their 1954 annual dues by July 1 this year. The dues should be paid through the county medical society secretary and forwarded through the state organization to the AMA, reaching Chicago by the July 1 deadline.

COUNTY SOCIETIES

Baylor-Knox-Haskell Counties Society

March 9, 1954

Baylor-Knox-Haskell Counties Society met in Munday on March 9. R. G. Baker, Fort Worth, Thirteenth District Councilor, spoke to members before they heard "Diet in Disease," a telephone broadcast from the Texas Medical Association headquarters, Austin,

Cherokee County Society

March 23, 1954

Cherokee County Medical Society was honored by the Woman's Auxiliary with a dinner and program on Doctor's Day, March 23, at Jacksonville.

Hardy Kemp, Baylor University College of Medicine, Houston, was principal speaker. Lewis Waters, Ph.D., Southwestern Medical School of the University of Texas, Dallas, was a special guest.

J. M. Travis, Jacksonville; T. H. Cobble, Rusk; C. L. Newburn, Jacksonville; and J. N. Bone, Jacksonville, were given special mention for having practiced medicine in Cherokee County for the longest number of years.

DeWitt County Society

March 17, 1954

DeWitt County Medical Society heard Sam J. Greer, San Antonio, speak on chest conditions at the March 17 meeting in Cuero.

Eastland-Callahan-Stephen-Shackelford-Throckmorton Counties Society

March 16, 1954

Eastland-Callahan-Stephens-Shackelford-Throckmorton Counties Medical Society held a dinner meeting March 16 in Ranger.

R. G. Baker, Fort Worth, Thirteenth District Councilor, spoke to the society, and William B. Sealey and John A. Wiggins, Fort Worth, presented the scientific program.

AUXILIARY SECTION

MRS. TURNER NATIONAL PRESIDENT

"Leadership in Community Health" is the emphasis which Mrs. George Turner of El Paso, incoming President of the Woman's Auxiliary to the American Medical Association, expects to encourage during the forthcoming year. Mrs. Turner, President of the Texas Auxiliary in 1946-1947 and charter member and former president of the El Paso County Auxiliary, is being installed in the highest office of the national medical auxiliary in San Francisco, where the medical profession is convening June 21-25.

Only a month ago, Mrs. Turner was with her pathologist-radiologist husband in San Antonio as he presided over the annual session of the Texas Medical Association as its President. Long active in the State Auxiliary, she has been Corresponding Secretary, Historian, Council Woman, and chairman of several committees as well as President. At San Antonio she was named an honorary life president. On the national level she was Secretary two years, Treasurer three years, and First Vice-President before being named President-Elect in 1953.

A native of Iredell, Mrs. Turner specialized in home economics and education at the Southwest Texas Normal School at San Marcos and at George Peabody College for Teachers at Nashville. Prior to her marriage to Dr. Turner in 1918, she taught in public school and college. In El Paso, where she has reared two daughters, Mrs. Turner has been active

MRS. GEORGE TURNER

in Methodist, parent-teacher, PEO, Chamber of Commerce, and Woman's Club programs.

Embarking upon her year as President of the 66,000-member Woman's Auxiliary to the American Medical Association, Mrs. Turner hopes Auxiliary members will be especially active this year in the areas of mental health, safety, and juvenile delinquency. Relative to these topics and to many others, she suggests establishment of speakers bureaus and sponsorship of health forums as tools for making accessible to other groups the information readily available to the Auxiliary. She stresses the necessity of Auxiliary members keeping themselves informed if they hope to be qualified health leaders and urges that they read the official periodicals, literature, and letters sent to them.

"The appreciation of the public is not based on excellent medical care alone, but is in ratio to our devotion to the welfare of the community through health education and community health service," Mrs. Turner points out. "It is in this unobtrusive, daily relationship between the doctor and his patients and the doctor's wife and her contacts that confidence in our sincerity and ability as leaders in community health is established."

That Mrs. Turner has established for herself an enviable record of leadership in community health and worth-while projects of other nature is evident in the list of achievements she has chalked up in her home city. The successive offices she has held in the medical auxiliary at every level is further proof of her ability to envision what can be done, to set about doing it, and to inspire others to join in the doing.

Texas a Part of the Whole

The Woman's Auxiliary to the American Medical Association was organized in 1922 as the outgrowth of state and county auxiliaries then in existence. Through the efforts of Mrs. Samuel Clark Red of Houston, President of the Texas Auxiliary, and the cooperation of Dr. Edward H. Cary of Dallas, a resolution advocating a Woman's Auxiliary to the AMA was adopted May 26, 1922, by the AMA House of Delegates in St. Louis. Twenty-four women from nine states attended the organizational meeting. Ten years later, thirty-eight states and the District of Columbia had auxiliaries with a membership of 13,351. Today there are 66,000 members.

A Texas brag—the first gavel used by the National Auxiliary was made from an oleander branch from a tree in Galveston. The greatest brag for the state is that four Texas women have been elected President of the Auxiliary to the AMA—the fourth being Mrs. George Turner of El Paso, who will serve for the 1954-1955 term.

Texas ranks high in her scale of activities as compared with other states in the nation. For example, Texas ranked first in the nation in subscriptions to the *Bulletin* of the national organization during 1953. In the same year Texas ranked only behind California and Pennsylvania in membership. Texas was second, following Pennsylvania, in subscriptions to *Today's Health*.

From time to time Texas has joined the National Auxiliary in alerting its members and the public to the hazards of some of the currently proposed medical legislation, and doctors' wives joined the American Medical Association in launching a national education campaign to defeat the compulsory health insurance program in Congress. Recently the Auxiliary has been active in fostering the aims of the American Medical Education Foundation, which seeks to raise funds privately for the operation of medical schools to forestall federal subsidization from grants for operating expenses.

Perhaps the most outstanding accomplishment of the Auxiliary nationally has been in connection with health education and the furthering of health measures. Promotion of the distribution of *Today's Health,* the previously mentioned authentic health periodical for the laity; nurse recruitment; giving and applying scholarship funds; annual physical check-ups; civil defense projects; and emphasis on mental

health are playing important roles in Auxiliary activities.

The doctor's wife attempts individually and through her affiliation with the Woman's Auxiliary to fulfill the objectives of assisting the American Medical Association in its program for the advancement of medicine and public health, to serve as a leader in health education, to cultivate friendly relations among physicians' families, and to promote mutual understanding between the public and the doctor.

DEATHS

W. E. WHITFIELD

Dr. Walter Eugene Whitfield, Edna, Texas, died on February 20, 1954, in a Victoria hospital of coronary occlusion.

The son of Daniel and Elizabeth (Prigmore) Whitfield, Dr. Whitfield was born on June 9, 1888, in Dallas County. He attended the Garland and Dallas public schools and old Polytechnic College, Fort Worth. He received his medical education at the Southwestern University Medical College, Dallas, being graduated in 1911, and served an internship at St. Paul's Hospital, Dallas. Dr. Whitfield was associated with Drs. H. G. Wolcott, J. B. Smoot, and W. B. Carroll in Dallas until 1917, when he decided to become a country doctor and moved to Ganado. He moved later to Edna, practicing general medicine and surgery there until a few months before his death, when he became ill.

DR. W. E. WHITFIELD

Dr. Whitfield was a member of the Texas and American Medical Associations through the Dallas and Wharton-Jackson-Matagorda-Fort Bend Counties Medical Societies almost continuously during his career. He had been city health officer for Ganado, and during World War II he was county doctor for Selective Service. He also had served as physician for local construction companies and insurance companies. He was a member of Theta Kappa Psi medical fraternity, the school board at Edna, Masonic Lodge—being a thirty-second degree Mason, Rotary Club, Chamber of Commerce, and the Methodist Church. Dr. Whitfield was a big sportsman, favoring hunting, and for some years he piloted his own airplane. He enjoyed making fine furniture in his spare time.

He and the former Miss Cordelia Magness were married on September 4, 1910, in Lovington, N. Mex. She survives; as do two daughters, Mrs. H. M. Hargrove, Jr., Liberty, and Mrs. Gene C. Traylor, Victoria; one brother, George Whitfield, Plano; four grandchildren; and two great-grandchildren.

E. C. MEAD

Dr. Ernest C. Mead, Gainesville, Texas, died on February 1, 1954, at his home of carcinoma of the parotid gland.

The son of C. S. and Frances Mead, Dr. Mead was born on July 9, 1884, in South Boston, Ind., and he attended public schools there. He was graduated from Valparaiso University, Valparaiso, Ind., and attended the old Chicago College of Medicine and Surgery, now Loyola University School of Medicine. He then taught school in South Boston for three years and served as principal of the Greenfield, Ind., public school for one year. He was graduated from Chicago College of Medicine and Surgery with honors in 1913. Beginning his career in Campbellsburg, Ind., he was a general practitioner until 1919. He then did postgraduate work at Chicago Eye, Ear, Nose and Throat Hospital and came to Gainesville in 1921 as a specialist. He was certified by the American Board of Otolaryngology in 1926. He took additional work at the University of Vienna, Austria, in 1927. He practiced in Gainesville until his retirement in 1945.

A member of the Texas Medical Association and the American Medical Association through Cooke County Society from 1922 until the time of his retirement, Dr. Mead was a fellow of the American College of Surgeons.

Dr. Mead had served as a member of the District Board of Draft Examiners in an advisory capacity and was an examiner for the Civil Aeronautic Authority for twenty years. An ardent sports fan, he did much to promote football at Gainesville High School. He was a Presbyterian and for a number of years a member of the school board.

He and the former Miss Ada Bundy were married on June 23, 1911, in New Philadelphia, Ind. She survives, as do a son, Bruce Mead, Albuquerque; two daughters, Mrs. Dorothy Morgan, Gainesville, and Mrs. Margaret Gilbert, Dallas; and six grandchildren.

E. HARRIS

Dr. Earl Harris, Fort Worth, Texas, died February 17, 1954, of cancer. He had been hospitalized with Parkinson's disease since 1949.

Dr. Harris was born October 6, 1887, in Quitman, the son of Benjamin and Nancy (Peden) Harris. He received a degree in pharmacy from Tulane University, New Orleans, in 1910. He was graduated from Tulane University of Louisiana School of Medicine as a doctor of medicine in 1921 and interned at Charity Hospital, New Orleans. He did his residency at Marine Hospital, Memphis. Dr. Harris practiced in Fort Worth from 1924 until 1949.

A member of the Texas and American Medical Associations through Tarrant County Medical Society continuously since 1924, Dr. Harris was elected an honorary member in 1949. He was a member of Theta Kappa Psi medical fraternity and Alpha Omega Alpha, honorary medical fraternity.

Dr. Harris is survived by his wife, two sisters, and two brothers.

MEMBERSHIP
TEXAS MEDICAL ASSOCIATION
JUNE, 1954

The membership list which follows is compiled from names sent by county society secretaries to the state office. The names are listed by county societies within the fifteen districts. The number after each county listed below indicates the district in which the county is located.

Anderson—11
Andrews—2
Angelina—10
Aransas—6
Archer—13
Armstrong—3
Atascosa—5
Austin—9
Bailey—3
Bandera—5
Bastrop—7
Baylor—13
Bee—6
Bell—12
Bexar—5
Blanco—7
Borden—2
Bosque—12
Bowie—15
Brazoria—8
Brazos—12
Brewster—1
Briscoe—3
Brooks—6
Brown—4
Burleson—9
Burnet—7
Caldwell—7
Calhoun—8
Callahan—13
Cameron—6
Camp—15
Carson—3
Cass—15
Castro—3
Chambers—10
Cherokee—11
Childress—3
Clay—13
Cochran—3
Coke—4
Coleman—4
Collin—14
Collingsworth—3
Colorado—8
Comal—5
Comanche—4
Concho—4
Cooke—14
Coryell—12
Cottle—3
Crane—4
Crockett—4
Crosby—3
Culberson—1
Dallam—3
Dallas—14
Dawson—2
Deaf Smith—3
Delta—14
Denton—14
De Witt—8
Dickens—2
Dimmit—5
Donley—3
Duval—6
Eastland—13
Ector—2
Edwards—5
Ellis—14
El Paso—1
Erath—12
Falls—12
Fannin—14
Fayette—8
Fisher—2
Floyd—3
Foard—3
Fort Bend—8
Franklin—14
Freestone—11
Frio—5
Gaines—2
Galveston—8
Garza—2
Gillespie—5
Glasscock—2
Goliad—8
Gonzales—5
Gray—3
Grayson—14
Gregg—15
Grimes—9
Guadalupe—5
Hale—3
Hall—3
Hamilton—12
Hansford—3
Hardeman—3
Hardin—10
Harris—9
Harrison—15
Hartley—3
Haskell—13
Hays—7
Hemphill—3
Henderson—11
Hidalgo—6
Hill—12
Hockley—3
Hood—12
Hopkins—14
Houston—11
Howard—2
Hudspeth—1
Hunt—14
Hutchinson—3
Irion—4
Jack—13
Jackson—8
Jasper—10
Jeff Davis—1
Jefferson—10
Jim Hogg—6
Jim Wells—6
Johnson—12
Jones—13
Karnes—5
Kaufman—14
Kendall—5
Kenedy—6
Kent—2
Kerr—5
Kimble—4
King—2
Kinney—5
Kleberg—6
Knox—13
Lamar—14
Lamb—3
Lampasas—7
La Salle—5
Lavaca—8
Lee—7
Leon—11
Liberty—10
Limestone—12
Lipscomb—3
Live Oak—6
Llano—7
Loving—1
Lubbock—3
Lynn—2
McCulloch—4
McLennan—12
McMullen—6
Madison—9
Marion—15
Martin—2
Mason—4
Matagorda—8
Maverick—5
Medina—5
Menard—4
Midland—2
Milam—12
Mills—4
Mitchell—2
Montague—13
Montgomery—9
Moore—3
Morris—15
Motley—3
Nacogdoches—10
Navarro—12
Newton—10
Nolan—2
Nueces—6
Ochiltree—3
Oldham—3
Orange—10
Palo Pinto—13
Panola—11
Parker—13
Parmer—3
Pecos—1
Polk—9
Potter—3
Presidio—1
Rains—14
Randall—3
Reagan—4
Real—5
Red River—15
Reeves—1
Refugio—6
Roberts—3
Robertson—12
Rockwall—14
Runnels—4
Rusk—11
Sabine—10
San Augustine—10
San Jacinto—9
San Patricio—6
San Saba—4
Schleicher—4
Scurry—2
Shackelford—13
Shelby—10
Sherman—3
Smith—11
Somervell—12
Starr—6
Stephens—13
Sterling—4
Stonewall—2
Sutton—4
Swisher—3
Tarrant—13
Taylor—13
Terrell—5
Terry—2
Throckmorton—13
Titus—15
Tom Green—4
Travis—7
Trinity—9
Tyler—10
Upshur—15
Upton—4
Uvalde—5
Val Verde—5
Van Zandt—14
Victoria—8
Walker—9
Waller—9
Ward—1
Washington—9
Webb—6
Wharton—8
Wheeler—3
Wichita—13
Wilbarger—13
Willacy—6
Williamson—7
Wilson—5
Winkler—1
Wise—13
Wood—11
Yoakum—2
Young—13
Zapata—6
Zavala—5

*The asterisk (*) indicates registration at the San Antonio annual session. (In.) indicates Intern Membership. (Hon.) indicates Honorary Membership. (Emer.) indicates Membership Emeritus. (Ina.) indicates Inactive Membership. (Mil.) indicates Military Membership.

FIRST DISTRICT

J. Leighton Green, El Paso, Councilor

EL PASO

Alexander, M. L. (Hon.), Canutillo, Texas.
Arguelles, F. L. (Hon.)
401 S. Stanton, El Paso.
Awe, Chester D.,
4430 Trolbridge, El Paso.
Ayub, Pablo (Mil.), El Paso.
*Barrett, Frank O.,
626 Mills Building, El Paso.
Basom, W. Compere,
520 Montana, El Paso.
Bell, Herbert J.,
503 Roberts Banner Bldg., El Paso.
Bennett, Jacob T.,
415 E. Yandell Blvd., El Paso.
Bennett, Raymond J.,
Medical Center, 1501 Arizona St., El Paso.
Bernard, Jack A., 415 E. Yandell, El Paso.
Bernell, Edward C.,
1015 First National Bldg., El Paso.
Black, Arthur P., 525 Montana, El Paso.
Black, Gordon L., 215 N. Mesa, El Paso.
*Boehler, Clement C.,
Bldg. 8, 1501 Arizona St., El Paso.
Bornstein, Frederick P.,
Providence Mem. Hosp., El Paso.
Boverie, Robert F.,
Roberts Banner Building, El Paso.
Bozzell, James D.,
Suite 3B, 1501 Arizona St., El Paso.
*Breck, Louis W., 520 Montana, El Paso.
Britton, W. W. (Hon.),
2704 Fort Blvd., El Paso.
Brunner, George, 1208 Mills Bldg., El Paso.
Bryan, John N. (Mil.).
Budwig, Ira A., 415 E. Yandell, El Paso.
Byrne, Basil K., 800 Montana, El Paso.
Cameron, David M.,
First National Bldg., El Paso.
Cardwell, Robert J.,
416 Roberts Banner Bldg,. El Paso.
Carnes, David M., Ysleta.
Carpenter, Gray E., 2323 Montana, El Paso.
Carter, Joe C., Roberts-Banner Bldg., El Paso.
Casavantes, Luis, 512 Los Angeles St., El Paso.
Causey, Oscar M., 3313 Fort Blvd., El Paso.
Caylor, Robt. N., 415 E. Yandell, El Paso.
Center, Wm. B., May, Texas.
Cohen, Manley B., 417 E. Yandell, El Paso.
*Coldwell, William I.,
5004 Guido Dr., El Paso.
Cooley, Ben H., 800 Montana, El Paso.
Cooper, Arlin B., 415 E. Yandell, El Paso.
Cornell, Robert C. (Mil.).
Craige, Branch,
Suite 5B, 1501 Arizona St., El Paso.
Cummins, Erwin J., 1018 Mills Bldg., El Paso.
Curtis, Wickliffe R.,
Suite 3B, 1501 Arizona St., El Paso.
Davis, W. J. (Hon.), Anthony, N. Mex.
Demarest, Harry W., 1600 Howze, El Paso.
Deter, Russell L., 214 Banner Bldg., El Paso.
Dietrich, Hervey W., 415 E. Yandell, El Paso.
Dow, Antonio, 4622 Alameda, El Paso.
Dunne, Geo. M., Fort Hancock.
Dutton, Loraine O., 616 Mills Bldg., El Paso.
Eck, Andrew J., 5970 Alameda Ave., El Paso.
Edwards, Geo. M. (Hon.),
3020 Federal, El Paso.
Egbert, Orville E., 1501 Arizona St., El Paso.
Eidinoff, Harold, 2701 N. Kansas, El Paso.
*Ellis, Jack R., 2922 Copper, El Paso.
Elsberg, Charles P., 800 Montana, El Paso.
Emmett, John E., 520 Montana, El Paso.
Epstein, I. M., 525 Montana, El Paso.
Evans, Fred G., 415 E. Yandell, El Paso.
Evans, Ward,
414 Roberts-Banner Bldg., El Paso.
Ewalt, Donald H.,
1415 First National Bldg., El Paso.
Feener, Lester C.,
Roberts-Banner Bldg., El Paso.
Fernandez, Carlos A.,
5980 Alameda Ave., El Paso.
Floyd, Joe R., Roberts-Banner Bldg., El Paso.
Gaddis, Leo R., 1218 Mills Bldg., El Paso.
Gaddis, Wm. R., 1218 Mills Bldg., El Paso.
Gaddy, S. J., Roberts-Banner Bldg., El Paso.
Galatzan, Joseph S., 520 Cincinnati, El Paso.
Gallagher, Paul, 415 E. Yandell, El Paso.
*Garrett, Henry D.,
Medical Center, 1501 Arizona, El Paso.
Gibson, H. M., Jr.,
209 Medical Arts Bldg., El Paso.
Golding, Frank C., 507 Banner Bldg., El Paso.
Goodloe, B. Lynn, 4209 Hastings, El Paso.
*Gorman, James J.,
701 First National Bldg., El Paso.
*Green, J. Leighton,
Bldg. 3, 1501 Arizona St., El Paso.
Hart, Maynard S.,
Roberts-Banner Bldg., El Paso
*Hatfield, Haskell D.,
1805 N. Stanton, El Paso.
Heslington, H. F. (Mil.).
Higdon, Donald A., Fabens.
Hinton, Joseph H., 800 Montana, El Paso.
*Holt, Russell, 415 E. Yandell, El Paso.
Homan, Ralph H.,
Medical Center, 1501 Arizona St., El Paso.
*Homan, Robert B., Jr. (Pres.),
Medical Center, 1501 Arizona St., El Paso.
Hornedo, Manuel D.,
3000 Magoffin, El Paso.
Hunter, C. D., 800 Montana, El Paso.
Ingram, William L., Fabens
Jamieson, Wm. R. (Hon.),
109 N. Oregon St., El Paso.
Jenness, Burt F.,
Texas College of Mines, El Paso.
Johnstone, John H., Ysleta.
Jones, Edmund P.,
214 Roberts-Banner Bldg., El Paso.
Jones, W. A., 415 E. Yandell, El Paso.
Jordan, Gerald H., 109 N. Oregon, El Paso.
*Jumper, Carl E.,
1511 N. Virginia St., El Paso.
Kearney, William W.,
1218 Mills Bldg., El Paso.
Keller, Nathan H.,
El Paso National Bank Bldg., El Paso.
King, Sam R.,
216 El Paso National Bank Bldg., El Paso.

MEMBERSHIP LIST, 1954—*continued*

Kurita, Kenneth S.,
466 S. Glenwood, El Paso.
Laws, James W. (Hon.), Mills Bldg., El Paso.
Leigh, Harry,
411 Roberts-Banner Bldg., El Paso.
Leonard, Morton H., 520 Montana, El Paso.
Licon, Francisco, 2918 Mansana St., El Paso.
Liddell, Thos. C., 109 N. Oregon, El Paso.
Logsdon, Chas. P. C.,
Medical Arts Bldg., El Paso.
Lombard, Julian H.,
Rt. 56, Box 319, El Paso.
*Luckett, Alfred E.,
1311 First National Bldg., El Paso.
*Marshall, Howard J. H.,
Suite 8E, 1501 Arizona St., El Paso.
Martin, John D.,
405 Mills Bldg., El Paso.
Mason, Claude H.,
311 Roberts-Banner Bldg., El Paso.
McCamant, T. J. (Hon.),
1200 First National Bldg., El Paso.
McNeil, Irving (Hon.),
1917 Mesa Avenue, El Paso.
McVaugh, Charles C.,
616 Mills Bldg., El Paso.
Milchen, Carl, 7505 N. Loop Road, El Paso.
*Miller, Felix P. (Emer.),
1331 First National Bldg., El Paso.
Miskimins, J. Harry, Mills Bldg., El Paso.
Molinar y Rey, Jose, 306 S. Stanton, El Paso.
Molinar Z., Ramon, 306 S. Stanton, El Paso.
Molloy, Maxwell S., 502 Cincinnati, El Paso.
Morgan, James R., 3313 Fort Blvd., El Paso.
Morrison, John E., Mills Bldg., El Paso.
*Morrow, Walter G., Jr.,
1001 First National Bldg., El Paso.
Moses, Lyndon D., 221 West Nevada, El Paso.
Multhauf, A. W.,
1315 First National Bldg., El Paso.
Mutnick, Reuben, 112 S. Concepcion, El Paso.
Nering, A. Robert,
First National Bldg., El Paso.
Palafox, Mario, 520 Montana St., El Paso.
Perry, Alvin L.,
209 Medical Arts Bldg., El Paso.
Peticolas, John D.,
204 Roberts-Banner Bldg., El Paso.
Phillips, Richard J. (Mil.).
Pierce, Wendell L.,
El Paso General Hospital, El Paso.
Postlewaite, Jack C.,
507 Banner Bldg., El Paso.
Price, Elwyn D., 1101 Upson Ave., El Paso.
*Prieto, Philip M.,
3710 Alameda Avenue, El Paso.
Randel, Brown W. (Hon.),
1006 Mills Bldg., El Paso.
Ravel, Vincent M., 616 Mills Bldg., El Paso.
Rennick, Charles F., 1218 Mills Bldg., El Paso.
Reynolds, George A. (Mil.).
Rheinheimer, E. W., 415 E. Yandell, El Paso.
Rigney, Paul, 821 E. Yandell, El Paso.
Rissler, Ross W., 2001 Grant Ave., El Paso.
Robbins, Jacob B., 408 Blocker, El Paso.
Rodarte, Ruben B., 401 S. Stanton, El Paso.
Rogde, Jacob, 315 Mills Bldg., El Paso.
*Rogers, S. Perry,
Suite 2B, 1501 Arizona St., El Paso.
Rogers, Will P. (Hon.),
314 Roberts-Banner Bldg., El Paso.
Rush, Jack T., First National Bldg., El Paso.
Schuessler, Willard W.,
First National Bldg., El Paso.
Schuster, Frank P.,
First National Bldg., El Paso.
Schuster, Stephen A.,
First National Bldg., El Paso.
Shanley, Thos. J. B.,
8903 Old Country Road, Ysleta.
Sher, Benjamin, Fabens.
Smith, Leslie M.,
Medical Center, 1501 Arizona St., El Paso.
Snidow, Francis A., 2323 Montana, El Paso.
Sorensen, Alfred, Mills Bldg., El Paso.
Soto, Raul C., 522 Caples Bldg., El Paso.
Spearman, Maurice P.,
1315 First National Bldg., El Paso.
Spier, Erich, 415 E. Yandell, El Paso.
Stanfill, Charles M., 415 E. Yandell, El Paso.
Stapp, Celso C., 800 Montana, El Paso.
Stern, J. Edward, 425 Mills Bldg., El Paso.
Stevens, B. F. (Hon.),
505 Martin Bldg., El Paso.
Stowe, Jesson L., 2323 Montana, El Paso.
Stratemeyer, W. P., 415 E. Yandell, El Paso.
*Thomas, Merle D. (Sec'y),
612 Mills Bldg., El Paso.
Thompson, Robt. F., Mills Bldg., El Paso.
Treece, Angus A., Fabens.
Tubbs, Wm. M., 3031 Altura, El Paso.
*Turner, George,
Suite 6-A, 1501 Arizona St., El Paso.
Turner, Steve F., 403 Bassett Tower, El Paso.
Vance, James (Hon.),
3492 Highway 80A, El Paso.
Vandevere, Wm. E.,
1001 First National Bldg., El Paso.
Varner, Harry H., 125 N. Stanton, El Paso.
Villareal, Leopoldo, Caples Bldg., El Paso.
Vinikoff, Maurice R., 318 Mills Bldg., El Paso.
Von Briesen, Delphin,
Suite 6-A, 1501 Arizona St., El Paso.
*Walker, Newton F.,
First National Bldg., El Paso.
Webb, Charles E.,
First National Bldg., El Paso.
Wilcox, Leigh E.,
214 Banner Bldg., El Paso.
Wollmann, Walter W., 2001 Grant, El Paso.

PECOS-JEFF DAVIS-PRESIDIO-BREWSTER

Blackwell, James H. (Hon.), Marfa.
Carter, John E., Sanderson.
Gipson, James F., Ft. Stockton.
Hill, Malone V., Alpine.
Hoffman, Geo. A., Ft. Stockton.
Kelley, Wm. N. (Hon.), Balmorhea.
Lockhart, Wm. E., Jr., Alpine.
O'Donnell, John W. (Pres.), Alpine.
*Oswalt, Charles E., Jr., Ft. Stockton.
Pate, John W., Sanderson.
Petit, William D. (Hon.), Presidio.
Searls, John P., Marfa.
*Sherrod, Vincent A., Iraan.
Sibley, D. J., Jr. (Sec'y), Ft. Stockton.
Stover, Walter H., Marfa.
Swanson, John D., Iraan.
Wright, Joel E., Alpine.

REEVES-WARD-WINKLER-LOVING-CULBERSON-HUDSPETH

Applegate, Frederic M., Monahans.
Avery, Harlow F., Pecos.
Barnett, Arthur J., Monahans.
Black, Wilmer D. (Hon.), Barstow.
Breeden, L. G., Wink.
Camp, Jim, Pecos.
Dampeer, John O., Jr., Kermit.
Gibson, Joseph V., Jr., Kermit.
Hay, Bruce H. H., Pecos.
Heath, Joe D., Kermit.
Jones, H. Wayne, Monahans.
Kunstadt, Paul, Monahans.
Lindley, Harold, Pecos.
Martin, Hugh W., Pecos.
McClure, Wayne H., Kermit.
Munk, Otto, Monahans.
Nelson, Ernest J., Pecos.
Peddicord, Harper, II (Sec'y), Kermit.
Peddicord, Orene W., Kermit.
Prout, Fred J., Monahans.
Roberts, Rufus A., Pecos.
*Robinson, Cecil A., Kermit.
*Robinson, Lila Rose, Kermit.
Wight, Bennett A. (Pres.), Kermit.

SECOND DISTRICT

Dr. R. B. G. Cowper, Big Spring, Councilor

ANDREWS-ECTOR-MIDLAND

Autry, Paul G., 2010 W. Illinois, Midland.
Barganier, John H.,
3003 East Over Drive, Odessa.
Bauman, John E., Headlee Clinic, Odessa.
Bobo, Thomas C., Box 1488, Midland.
Boles, Truett C., 900 W. Indiana, Midland.
Boone, Martin H. Jr.,
911 W. Illinois, Midland.
*Buck, Roger, 2310 W. Ohio, Midland.
Bugg, Robert N., 208 N. Garfield, Midland.
Carson, Willis T., 1200 N. Texas, Odessa.
Chapple, James H. (Inac.),
Box 2566, Midland.
Colquitt, Landon A.,
310 N. Alleghaney, Odessa.
Connelly, William E., 1600 N. Texas, Odessa.
Connery, David B., 2010 W. Illinois, Midland.
Cooper, Randall E.,
2010 W. Illinois, Midland.
Dickerson, Melford S.,
610 W. Missouri, Midland.
*Driscoll, Edward T.,
2010 W. Illinois, Midland.
Elliott, Vance J., Medical Arts Clinic, Odessa.
Finch, Albert B., 1200 N. Texas Ave., Odessa.
Fulcher, Oliver A., 514 W. 4th St., Odessa.
Gooch, James Oliver, Box 2615, Midland.
Green, Wilbur K.,
404 N. Washington, Odessa.
Greenlees, David L., 516 W. 4th St., Odessa.
Hays, Alan L., Headlee Hosp., Odessa.
Headlee, Emmet V., Box 3112, Odessa.
Hestand, Haskell E.,
421 N. Golder, Odessa.
Holt, William D., 2310 W. Ohio, Midland.
Horne, Albert M., 2200 W. Illinois, Midland.
*Horton, George W., 413 N. Lincoln, Odessa.
Hubbard, Prevost, Jr.,
500 N. Alleghaney, Odessa.
Hunt, H. Lynn, Jr., 421 N. Golder, Odessa.
Hunt, Jackie Hansen,
116 W. 10th, Odessa.
Hutcheson, Zenas W., Jr., Box 218, Andrews.
Johnson, Homer B.,
306 N. Colorado, Midland.
Lang, Garland H., 108 N. Garfield, Midland.
Leggett, Lloyd Waldo,
609 Leggett Bldg., Midland.
Leigh, Henry T., Jr.,
911 W. Illinois, Midland.
Lekisch, Kurt, Box 852, Midland.
*Loring, Milton J., 304 North N, Midland.
Lunn, Wm. W., 408 N. Alleghaney, Odessa.
Madsen, Martha E.,
2200 W. Illinois, Midland.
Marinis, Thos. P., 210 N. Garfield, Midland.
*Mast, Clarence S. (Sec'y),
Mast Clinic, Midland.
Mast, Henrie E. (Pres.),
2203 W. Illinois, Midland.
Mast, John R., 2203 W. Illinois, Midland.
McCrimmon, Herman P.,
604 W. 5th St., Odessa.
McCullough, Edison W.,
1415 N. Big Spring, Midland.
Melton, Thos. J., 308 N. Colorado, Midland.
Nichols, Myron McCall,
2203 W. Illinois, Midland.
Novak, Theodore W., 407 N. Lincoln, Odessa.
Oehlschlager, F. Keith,
1208 W. Tenth, Odessa.
Parks, Walter S., Jr.,
108 N. Garfield, Midland.
Penn, Rhesa L., Jr., 706 W. Ohio, Midland.
Rader, John Paul, 313 N. Alleghaney, Odessa.
*Rainer, James W.,
1200 N. Texas St., Odessa.
Ramsey, Richard R., Andrews.
Rankin, Hattie Love,
309 N. Alleghaney, Odessa.
Roden, J. S., 108 N. Garfield, Midland.
Shapira, Jake, 308 Colorado, Midland.
Thornton, Elbert H. E.,
500 N. Dotsy, Odessa.
Turner, Jack L., 601 W. 4th, Odessa.
Walker, H. Glenn, 1501 W. Wall, Midland.
Walton, Jack R., 2011 W. Ohio, Midland.
*Wiesner, Wm. A.,
406 N. Washington, Odessa.
Wood, John K., 601 W. 4th, Odessa.
Wyvell, Dorothy B., 309 N. M, Midland.
Zang, Louis C. 601 W. 4th, Odessa.

BORDEN-DICKENS-GARZA-KENT-KING-SCURRY-STONEWALL

Alexander, Arthur B., Spur.
Battenfield, John Y., Snyder.
Broaddus, John O., Snyder.
*Cockrell, C. Ray, Snyder.
Dillaha, Carl A., Jr., Snyder.
Hartley, Thomas F., Snyder.
Jones, Wilton N. (Sec'y), Snyder.
Merritt, Sherman H., Snyder.
Middlebrook, F. M., Snyder.
Nichols, Pike C., Spur.
Ward, Harry W., Snyder.
*Wasson, Robert F. (Pres.), Snyder.

DAWSON-LYNN-TERRY-GAINES-YOAKUM

Black, Douglas B., Lamesa.
*Cowgill, David M., Brownfield.
Daniell, Alfred H., Brownfield.
Dow, Harold D., Seminole.
Frazier, Sam Z., Lamesa.
Hill, Wayne C., Brownfield.
Koberg, Frederick J., Seminole.
Lehman, Joe M. (Sec'y), O'Donnell.
Loveless, Jas. C., Lamesa.
McKay, J. Vernon (Pres.), Lamesa.
Price, Noble H., Lamesa.
Prideaux, Thos. M., Lamesa.
Prohl, Emil H., Tahoka.
Seale, Francis E., Lamesa.
Smith, Alfred H., Lamesa.
Thomas, C. Skiles, Tahoka.
Treadaway, Thos. L., Brownfield.

MEMBERSHIP LIST, 1954—*continued*

HOWARD-MARTIN-GLASSCOCK

Bennett, Marion H., 411 E. 9th, Big Spring.
Broadrick, Broadway, 411 E. 9th, Big Spring.
Caldwell, Joe Buck, State Hosp., Big Spring.
Carson, Arch D., 1500 Gregg, Big Spring.
Coffey, John H., Athens.
*Cowper, Roscoe B. G., Box 1127, Big Spring.
Dillon, George F., 811 Main, Big Spring.
Fish, John H., Box 1191, Big Spring.
Friedewald, Vincent E.,
811 Main, Big Spring.
Gaddis, Don A., Fort Davis.
Hall, Granville T.,
P. O. Box 991, Big Spring.
Harrison, Preston E., State Hosp., Big Spring.
Hogan, John E., Box 1029, Big Spring.
Howser, John P., Box 1181, Las Vegas, N. M.
Kirkpatrick, Marjorie,
710 Gregg St., Big Spring.
Lurting, Frederick W.,
811 Main St., Big Spring.
Malone, Phocian W., Box 1029, Big Spring.
*Marcum, Carl B. (Pres.),
811 Main, Big Spring.
Mays, Floyd R., Box 191, Big Spring.
Peacock, George E., 811 Main, Big Spring.
Race, Charles G., Jr., 411 E. 9th, Big Spring.
Sanders, J. Virgil, Box 191, Big Spring.
Sanders, Nell W.,
Petroleum Bldg., Big Spring.
Shaw, Chester A., Huntsville.
Sloan, Roy C., State Hosp., Big Spring.
*Swift, Edward V., 811 Main, Big Spring.
*Talbot, Milton W. (Sec'y),
811 Main, Big Spring.
Thomas, Clyde E., Jr.,
Big Spring Clinic, Big Spring.
Williamson, Thos. J., 411 E. 9th, Big Spring.
Wood, George Hardin,
Petroleum Bldg., Big Spring.
Woodall, Jack M., Box 1029, Big Spring.

NOLAN-FISHER-MITCHELL

Barker, Frank R., Sweetwater.
*Callan, Chester U., Rotan.
Cowan, William K., Colorado City.
Crymes, J. Melvin, Colorado City.
Dinkler, Fred, Whitewright.
Fortner, Amos H., Sweetwater.
Hanna, Jefferson A., Roscoe.
Hood, Francis T. N., Jr., Sweetwater.
Johnson, Bruce H. (Pres.), Loraine.
Johnson, Clark A. (Mil.).
Johnson, J. Frank, Rotan.
Loeb, Sam A. (Sec'y), Sweetwater.
Logsdon, Harry A., Colorado City.
*Peavy, J. E., 1215 Norwood, Austin.
*Peters, Roland O., Sweetwater.
Price, Robert L., Sweetwater.
Raines, John W., Roby.
Rhode, Oscar E., Colorado City.
Rhode, William S., Colorado City.
Richardson, James K., Sweetwater.
Rosebrough, Charles A., Sweetwater.
Rudd, Lawrence H., Colorado City.
*Stennis, Hugh J., Sweetwater.
Supowit, S. F., Sweetwater.
Terry, Joseph C., Loraine.
Wilkinson, Robert T., Rotan.
Young, James W., Sweetwater.
Young, Tom D., Sweetwater.

THIRD DISTRICT

Dr. Frank B. Malone, Lubbock, Councilor

ARMSTRONG-DONLEY-CHILDRESS-COLLINGSWORTH-HALL

Bubblis, John L., Huttig, Ark.
Butler, Robert G., Jr., Childress.
Cariker, Fred H., Childress.
Carroll, Wm. A. (Hon.),
1615 Monroe St., Amarillo.
Dryden, Charles B., Jr., Memphis.
Fox, Grover C., Childress.
*Fox, Jack F., Childress.
Goodall, O. R., Memphis.
Headlee, Robert E., Childress.
Holcomb, Carter (Sec'y), Wellington.
Humphrey, Ben K., Clarendon
Hunt, Thurman A., Memphis.
Hunter, Darlene L., Wellington.
Hunter, Thos. R., Jr., Wellington.
Jenkins, B. L. (Hon.) (dead), Clarendon.
Jenkins, Oscar L. (Hon.),
9330 Forest Hills Blvd., Dallas.
Jernigan, James H. (Hon.), Childress.
Jeter, Perry R. (Hon.), Childress.
Jones, Elmer K., Wellington.
*Jones, Elmer W., Wellington.
Martindale, Evelyn G., Clarendon.
Odom, James A. (Hon.), Memphis.
Stevenson, Harold R. (Mil.).
Townsend, Shell H., Childress.
Vardy, P. L. (Hon.), Estelline.
Watkins, Dale V., Wellington.

DALLAM-HARTLEY-SHERMAN-MOORE

Askins, John R., Jr., Dumas.
Blascbke, John A. (Sec'y), Dalhart.
Brown, Thomas G., Dumas.
Coventry, Wm. V., Dumas.
Cowin, Abe W., Dalhart.
Cunningham, John H., Dalhart.
Glenn, James C., Dalhart.
Meredith, Duane W., Dumas.
Moore, Victor R., Dalhart.
Pearson, Huston, Stratford.
Pieratt, Karl W. (Pres.), Dumas.
Pronko, Michael J., 407 Fisk Bldg., Amarillo.
Richardson, O. J., Dumas.
*Wright, Byron W., Dumas.
Wright, Norman E. (Mil.), Dumas.

GRAY-WHEELER-HANSFORD-HEMPHILL-LIPSCOMB-ROBERTS-OCHILTREE-HUTCHINSON-CARSON

Ashby, Charles H., Pampa.
Bagwell, R. Wayne, Borger.
Barksdale, Wm. C., Borger.
Beach, Wm. W. (Hon.),
2215 E. Yandell, El Paso.
Bellamy, Russell M., Pampa.
*Brindley, C. G., Borger.
Brooks, Wm. W., Borger.
Brothers, Joe F., Borger.
Brown, Richard Malcolm, Pampa.
Chaffin, Curtis R., Shamrock.
Daugherty, Roy, Borger.
Davis, Jesse J. (Hon.), Higgins.
Dils, Grover C., Lockney.
*Donaldson, Joe R., Pampa.
Elder, John F., Pampa.
*Falkenstein, Richard D., Pampa.
Gates, Philip A. (Sec'y),
313 Rose Bldg., Pampa.
Gooch, James W., Shamrock.
Hampton, Dan E., Borger.
*Hampton, Raymond M. (Pres.), Pampa.
Hamra, Henry M., Borger.
Hansen, Arthur F., Borger.
High, Clifton E., Pampa.
Hollingsworth, Harry W., Phillips.
Hrdlicka, George R., Pampa.
Huff, Oscar (Hon.), Pampa.
James, Frank M. (Mil.).
Jermyn, John W., Pampa.
Johnson, James Bluford, Perryton.
Jones, W. Calvin, Pampa.
Kelley, Frank W., Pampa.
Kengle, George L., Perryton.
Key, Julian M., Pampa.
Kimball, Melvin C., Borger.
Kleeberger, Roland L., Spearman.
Lang, Carl M., Pampa.
Laycock, Raymond W., Pampa.
Massad, Woodrow W., Borger.
McDaniel, MacField, Pampa.
Morris, Ernest H., Canadian.
*Nicholson, Harold E., Jr., Wheeler.
Nicholson, Harold E., Sr., Wheeler.
Overton, Marvin C., Jr., Pampa.
Pearson, D. B., Jr., Perryton.
Pennal, Hugh A., Borger.
*Petty, Lester E. (Hon.), Borger.
Purviance, Walter, Pampa.
Sanford, Roy K., Perryton.
Smith, Willard H., Borger.
Snyder, Edward H. (Hon.), Canadian.
Snyder, Rush A., Canadian.
Spiller, Gerald R., Thermopolis, Wyo.
Stephens, Milton M., Borger.
Stephens, Walton G., Borger.
Vendrell, Doris Deal, Pampa.
Vendrell, Felix J., Pampa.
Voet, Henriette H., Borger.
Walker, Glenn R., Wheeler.
Williams, Edward S., Pampa.
Wyatt, George W. (Mil.).
Wyatt, Malcolm H., Pampa.

HALE-FLOYD-BRISCOE-SWISHER

Burk, H. Maurice, Tulia.
Childress, Wm. B., Tulia.
Crum, Kenneth O., Lockney.
Davis, Jeff H., Plainview.
Donnell, Ralph E., Jr., Plainview.
Dye, Everette L., Jr., Plainview.
Dye, Mary R., Plainview.
Foster, Dee R., Hale Center.
Freeman, Ray W., Hale Center.
Greer, Neil E. (Hon.), Lockney.
Hansen, John H., Plainview.
Harvis, Herman J., Plainview.
Heye, Randall G., Plainview.
Howell, McKinley, Plainview.
Jackson, Carl C., Plainview.
Johnson, Gilmer B., Jr., Plainview.
Jones, Don P., Plainview.
Long, Dorothy C., Plainview.
Long, John C. (Sec'y), Plainview.
Mangold, W. J., Lockney.
McCarthy, Eugene G., Plainview.
McClelland, Gene A., Lockney.
Moore, Robert W.,
98 Sherman Road, Chestnut Hill, Mass.
Nichols, E. O., Sr., Plainview.
Nichols, E. O., Jr., Plainview.
Powers, Northern L., Jr., Silverton.
Richards, Fred V., Tulia.
Roberts, Roy R., Plainview.
*Schlecte, Marvin C., Plainview.
Smith, Landria C., Plainview.
*Snyderman, Henry, Plainview.
Stewart, Evans P., Tulia.
Storrs, Loyd A., Plainview.
Wagner, Gerald W., Plainview.
Wayland, Levi C., Plainview.
Williams, Russell K., Plainview.

HARDEMAN-COTTLE-FOARD-MOTLEY

Denney, Ernest D., Matador.
George, Joseph M. (Pres.), Quanah.
Hughes, John F., Spur.
*McDaniel, Robt. R., Quanah.
Powell, Burrell E., Chillicothe.
Salkeld, Phil L., Quanah.
Sitta, Raymond E., Chillicothe.
Stanley, James S., Matador.
Taylor, John M. (Sec'y), Quanah.
Vestal, Earl A., Quanah.

LAMB-BAILEY-HOCKLEY-COCHRAN

*Barnes, Elbert D., Levelland.
Brown, Dan M., Morton.
Campbell, Dale P., Levelland.
Davis, Glenn B., Conroe.
Dupre, John D., Levelland.
*Edgar, George V., Levelland.
Green, L. T., Jr., Muleshoe.
Green, Marion F., Muleshoe.
Janes, Fred W., Littlefield.
Maurer, R. E., Littlefield.
Monk, Norman A., Morton.
*Nowlin, Wm. Carl (Pres.), Littlefield.
Phillips, C. M., Levelland.
Reid, Raymond A. (Sec'y), Levelland.
Renegar, Jas. G., Levelland.
Sharp, Wm. David, Levelland.
Shotwell, Jra T., Jr., Littlefield.
Still, Oscar W., Littlefield.
Straub, G. L., Littlefield.

LUBBOCK-CROSBY

Anderson, Wm. F., 1312 Main, Lubbock.
Arnett, Sam C., Jr., 2609 19th St., Lubbock.
*Barsh, Albert G., 2010 Broadway, Lubbock.
Batson, Carey B., 1315 Tenth St., Lubbock.
*Baugh, Wm. L. (Hon.),
1302 Main St., Lubbock.
Bess, Howard H., Jr., 2613 34th St., Lubbock.
Birdsong, William F., Amherst.
Black, Crawford H., 2504 23rd St., Lubbock.
Blake, Emerson M.,
Lubbock General Hospital, Lubbock.
Bronwell, Alvin W. (Mil.), Lubbock.
Canon, Robert T., 1312 Main St., Lubbock.
Carnrick, Millard, Jr.,
701 College Ave., Lubbock.
Cashion, William R.,
2010 Broadway, Lubbock.
Chalk, John R., 1220 Main, Lubbock.
Clark, Vester V. (Hon.),
2617 19th St., Lubbock.
Cobb, John L., 4412 W. 17th, Lubbock.
Croom, William S., 1910 Knoxville, Lubbock.
Cross, Denzil D., 1312 Main St., Lubbock.
Daniel, Arthur L., 2613 34th St., Lubbock.
Delaney, Robert M., Abernathy.
Donaldson, J. D., Jr., 1318 Main St., Lubbock
Douglas, Richard C., 1312 Main St., Lubbock.
Dunn, Sam G., 1302 Main St., Lubbock.
Duran C, Armando, Box 601, Lubbock.
Elkins, Clyde F., Jr., 1803 13th St., Lubbock.
Ellis, Noel A., 1211 Avenue O, Lubbock.
Elston, Frederick A., Sunray.
English, Otis W., 1312 Main St., Lubbock.
Ewing, Mahon M., 2609 19th St., Lubbock.
Fiel, Chas. A., 3701 19th, Lubbock
Goodwin, Frank C. (Pres.),
701 College, Lubbock.

MEMBERSHIP LIST, 1954—*continued*

*Gordon, William H., 2022 Broadway, Lubbock.
Griffin, Harold B., 1318 Main, Lubbock.
Hale, Lee E., 1902 28th St., Lubbock.
Hall, James T., 511 College Ave., Lubbock.
Hancock, Howard R., 1301 Broadway, Lubbock.
Hand, Orra R., 1301 Broadway, Lubbock.
Haney, Edward L., Ralls.
Harris, Joseph R., Jr., 1211 Avenue O, Lubbock.
Haynes, Henry M., Jr., 2615 19th St., Lubbock.
Hays, Harvey, Jr., 1312 Main St., Lubbock.
Healy, Maurice J., 1214-A Broadway, Lubbock.
Hess, Wallace I., 2611 23rd St., Lubbock.
Hewitt, Archie L., 1910 Knoxville, Lubbock.
Holmes, T. H., Jr., Ralls.
Hudgins, Frank W., 1301 Broadway, Lubbock.
Hull, O. Brandon, 1301 Broadway, Lubbock.
Hunt, Ewell L., 1312 Main St., Lubbock.
Hutchinson, Ben B., 1301 Broadway, Lubbock.
Hutchinson, James T. (Hon.), 1301 Broadway, Lubbock.
Jaynes, Stanley H., Slaton.
Jenkios, Byroo Arthur, 1301 Broadway, Lubbock.
Kallina, Frederick P., Tech. Infirmary, Lubbock.
Key, Olan, 2609 19th St., Lubbock.
Krueger, Julius T., 1301 Broadway, Lubbock.
Lane, Ralph, 1312 Main St., Lubbock.
Lewis, Richard Q., 1210 Avenue R, Lubbock.
Loveless, J. Elbert, Box 28, Rt. 3, Lubbock.
Loveless, Roy G., Plains Clinic, 2609 19th St., Lubbock.
Lunceford, Tennie M., 1301 Broadway, Lubbock.
*Malone, Frank B., 2609 19th St., Lubbock.
Manseli, Chris C., 1302 Main St., Lubbock.
*Mantooth, Walter B., Jr., 2615 19th St., Lubbock.
Mattison, Myron D. (Mil.).
Mayfield, Ivan G., 1312 Main St., Lubbock.
McCarty, Robert H., c/o Lubbock Sanitarium & Clinic, Lubbock.
McClure, Edwin E., 701 College, Lubbock.
McDaniel, Bennie O., Amherst.
McSween, M. Jay, Jr., Slaton.
Miller, Pauline A., 2609 19th St., Lubbock.
Moore, Robert (Mil.).
Morris, James G., 1312 Main St., Lubbock.
Moss, Charles B., 1318 Main, Lubbock.
Moss, Ennis E., Jr. (Mil.).
Nalle, Ernest, Jr. (Mil.).
Nash, Charles H., Jr., 1910 Knoxville, Lubbock.
O'Loughlin, Richard K. (Sec'y), 1910 Kooxville, Lubbock.
Overton, Marvin C. (Hon.), 1301 Broadway, Lubbock.
Payne, Clifford E., 511 College, Lubbock.
Payne, Glen B., Slaton.
Payne, William E. (Hon.), Slaton.
Pennington, Hugh A., 2613 34th St., Lubbock.
Pigford, Charles A., Fort Pierce, Fla.
Poole, Warren B., 3020 34th St., Lubbock.
Ratcliff, Charles E., 1910 Knoxville, Lubbock.
Rhoades, Dale R., Crosbyton.
Riddel, Roy L., Jr., 1318 Main, Lubbock.
Rountree, John B., Jr., 2615 19th St., Lubbock.
Rountree, John R., Post.
Sauer, David E., 2615 19th St., Lubbock.
Selby, John H., 1301 Broadway, Lubbock.
Shannon, Emmet (Int.), V. A. Hosp., Houston.
Shaw, Marie L., 1301 Broadway, Lubbock.
*Sheffield, Roy S., 2022 Broadway, Lubbock.
Slemmons, Theodore M., Amherst.
Smith, Gerald S., 1301 Broadway, Lubbock.
Smith, Lynwood B., 1910 Knoxville, Lubbock.
Smith, Roy L., 2615 19th St., Lubbock.
Smith, William C., 1301 Broadway, Lubbock.
Snodgrass, M. R., Crosbyton.
Snow, Wister C., 3315 39th St., Lubbock.
Spikes, Lowell W., Ralls.
Stewart, Allen T., 1318 Main St., Lubbock.
Stiles, James H., c/o Lubbock Sanitarium, Lubbock.
Surman, Arnold C. (Hon.), Post.
Talbert, Thos. L., Slaton.
Taylor, Otis, Jr., 511 College, Lubbock.
Tubbs, Harry A., Post.
Upshaw, Leon R., 1312 Main St., Lubbock.
Wagner, Charles J. (Hon.), 1302 Main St., Lubbock.
Wallace, Grady M., 1020 Avenue N, Lubbock.
Walsh, Andrew L., Jr., Lorenzo.
Warshaw, Harold, 3801 31st, Lubbock.
Waters, William A., 1910 Knoxville, Lubbock.
Watkins, Mina D., 1312 Main St., Lubbock.
Williams, David C. (Hon.), Post.
*Woods, Limmie B., 2402 Main St., Lubbock.

POTTER

Archer, John R., 3310 Lynette, Amarillo.
Aronson, Sam J. R., Amarillo Bldg., Amarillo.
Askew, Wesley L., 104 N.E. 7th St., Amarillo.
Black, Ross P. (Mil.).
*Blackwell, Ben T. (Pres.), 705 Fisk Bldg., Amarillo.
Bordelon, Howard M., 2204 W. 6th Ave., Amarillo.
Broyles, Sam K., 616 N. Polk St., Amarillo.
Budd, Wilbur Q., 804 Fisk Bldg., Amarillo.
Campbell, Wm. J., 1217 W. 10th St., Amarillo.
Carroll, James Ralph, 703 Harrison St., Amarillo.
Chase, Gaylord R., 201 Doctors Bldg., Amarillo.
Churchill, Thomas P., Box 710, Amarillo.
Citron, Ralph (Mil.).
Claybourn, Norman L., P. O. Box 647, Amarillo.
Cole, Marion W., V. A. Hospital, Amarillo.
Crume, John J. (Hon.), Fisk Bldg., Amarillo.
Crumley, Fred J., Fisk Bldg., Amarillo.
Davis, Margaret M., 705 Fisk Bldg., Amarillo.
Dine, William C., Fisk Bldg., Amarillo.
Dravin, Isadore, Veterans Hosp., Amarillo.
Duncan, Frank B., Amarillo Bldg., Amarillo.
Duncan, Robert A., 339 Amarillo Bldg., Amarillo.
Ellis, John V., 315 Fisk Bldg., Amarillo.
Flamm, Kenneth R., 205 Amarillo Bldg., Amarillo.
Gallagher, Robt. P. (Hon.), 701 Adams, Amarillo.
Garre, Peter R., 906 Oliver Bldg., Amarillo.
*Gilkerson, Nan L., Fisk Bldg., Amarillo.
Gist, Robert D., 611 Fisk Bldg., Amarillo.
Gleason, Robert L., 2019 Jackson St., Amarillo.
Goldston, Alton B., 1501 W. 10th St., Amarillo.
Greer, Rex E., Medical Prof. Bldg., Amarillo.
Harkleroad, Frank S., 616 N. Polk, Amarillo.
Harchett, Capres S., Jr., 213 Amarillo Bldg., Amarillo.
Hegedus, W. J., 2007 W. 7th St., Amarillo.
Hyde, Robert F. (Mil.).
Intress, Robt. H., 2237 Peachtree St., Amarillo.
Jackson, Harvey K., P. O. Box 3275, Amarillo.
Jacobson, Merlin E., 2710 W. 10th, Amarillo.
*Johnson, H. Fred., 2308 W. 8th St., Amarillo.
*Johnson, James L. (Sec'y), 904 W. 7th St., Amarillo.
Johnson, Jeremiah B., 1501 W. 10th St., Amarillo.
Jordaan, John D., 201 Fisk Bldg., Amarillo.
Kelly, Francis J., 1606 Julian Blvd., Amarillo.
Keys, Richard, 611 Fisk Bldg., Amarillo.
Klingensmith, Wm. R., Jr., 215 Fisk Bldg., Amarillo.
Latson, Harvey H., 324 Amarillo Bldg., Amarillo.
*Laur, Wm. E., 906 W. 7th St., Amarillo.
Lemmon, Jefferson R., 211-12-13 Fisk Bldg., Amarillo.
Lipscomb, Joe L., 825 W. 7th St., Amarillo.
Livengood, Gerald S., 2710 W. 10th, Amarillo.
Lokey, Early B., 906 W. 7th St., Amarillo.
Loving, Dan H., 611 Fisk Bldg., Amarillo.
Marcley, David M., 1815 Washington, Amarillo.
Marsalis, Don S., 806 Oliver Eakle Bldg., Amarillo.
McKay, Edward D., 812 Fisk Bldg., Amarillo.
Mok, Wa T., 1817 Washington St., Amarillo.
Mullins, Wm. B., 602 Fisk Bldg., Amarillo.
Murphy, Weldon O., Fisk Bldg., Amarillo.
Owens, Guy, Amarillo Bldg., Amarillo.
Patton, David M., 703 Harrison St., Amarillo.
Patton, Louis K., 705 Harrison St., Amarillo.
Payne, Ralph B., Fisk Bldg., Amarillo.
Pickett, John M., 2710 W. 10th St., Amarillo.
Potter, Wilkes A., 2007 W. 7th, Amarillo.
Powers, Evelyn G., Fisk Bldg., Amarillo.
Powers, George L., Fisk Bldg., Amarillo.
Puckett, Bascom M., 205 Amarillo Bldg., Amarillo.
Puckett, Howard E., 205 Amarillo Bldg., Amarillo.
Rasco, Isaac (Hon.), 611 Fisk Bldg., Amarillo.
Reed, Emil P., 1200 Bowie, Amarillo.
Reed, Holley W., 825 W. 7th St., Amarillo.
Reid, Howard C., 315 Fisk Bldg., Amarillo.
Robberson, Jason H., 301 Polk St., Amarillo.
Rook, Rex L., 1501 W. 10th, Amarillo.
*Rowley, Elmer A., Amarillo Bldg., Amarillo.
Royse, George T., 225 Amarillo Bldg., Amarillo.
Russell, Woolworth, 1019 Van Bureo, Amarillo.
*Sadler, Charles B., 915 W. 8th, Amarillo.
*Scott, Wilbert E., Jr., 1501 W. 10th Ave., Amarillo.
Shelton, James L., 723 W. 7th St., Amarillo.
Smith, G. Ernestine, 705 Fisk Bldg., Amarillo.
Stout, William W., 703 Harrison, Amarillo.
*Streit, August J., Fisk Bldg., Amarillo.
Swindell, Raymon R., 2400 Line Ave., Amarillo.
Thomas, Edward F., 900 W. 7th St., Amarillo.
Van Sweringen, Walter, Box 1227, Amarillo.
Vaughan, John H., Fisk Bldg., Amarillo.
*Vineyard, Roy L., 901 Oliver Eakle Bldg., Amarillo.
Vinyard, George T. (Hon.), Box 1385, Amarillo.
Waddill, George M., Jr., Fisk Bldg., Amarillo.
Walkes, Ernest E., V. A. Hospital, Amarillo.
Watkins, Walter C., 1217 W. 10th, Amarillo.
Werner, Jan H. R., 2307 W. 7th, Amarillo.
*Wertz, Royal F., Amarillo Bldg., Amarillo.
Wheir, Wm. H., 2400 Line Ave., Amarillo.
*White, Jesse B., 518 Amarillo Bldg., Amarillo.
*Winsett, Amos E., 611 Fisk Bldg., Amarillo.
Winsett, E. Merrill, Box 430, Amarillo.
Witcher, Jones E., 902 W. 7th St., Amarillo.
Witt, John E., 1501 W. 10th, Amarillo.
Wolf, Horace L., 4507 W. 3rd, Amarillo.
*Wolfson, Charles, 2718 W. 10th, Amarillo.
Wrather, James R. (Hon.), 301 Polk St., Amarillo.
Yeakel, S. Victor, 2400 Line Ave., Amarillo.

RANDALL-DEAF SMITH-PARMER-CASTRO-OLDHAM

Barnett, Lewis B., Hereford.
Boswell, Leta N., Canyon.
Cogswell, Ronald E., Dimmitt.
Glendenniog, Fletcher C., Hereford.
Jarrett, Robert P., Canyon.
Lawrence, William D., Hereford.
Masters, Bert A., Canyon.
Metzner, W. R. T. (Mil.).
Mims, Arthur T. (Pres.), Hereford.
Moore, G. Dudley, Jr., Canyon.
Neblett, Robert A., Canyon.
Nester, Charles R., Canyon.
Nobles, Millard W., Hereford.
Smith, Thomas B. (Sec'y), Friona.
Spring, Paul L., Friona.
Wills, Ralph R., Hereford.

FOURTH DISTRICT

Dr. H. L. Locker, Brownwood, Councilor

BROWN-COMANCHE-MILLS-SAN SABA

Allen, Homer B., Jr., McGregor.
Allen, Homer B., Sr., Brownwood.
Ballard, Claude J., Comanche.
Benson, William F., Brownwood.
Bullard, Chester C., Brownwood.
Cadenhead, Ernest F., Brownwood.
Childress, Marvin A., Goldthwaite.
Cooke, Mildred L., Brownwood.
Farley, Frederick W., San Saba.
Felts, Richard C., San Saba.
Galbreath, John C., Brownwood.
Gold, Philip S., Brownwood.
Gray, Chas. W., Comanche.
Hallum, Roy G., Brownwood.
Hughes, Sidney W., Brownwood.
Jensen, Andrew O., Brownwood.
Lobstein, Henry L., Brownwood.
*Locker, Harry L., Brownwood.
*Locker, S. Braswell, Brownwood.
*Mayo, Oscar N., Brownwood.
Nyvall, Harry O., Gustine.
Ory, Lee K., Comanche.
Pence, Winfield S., San Saba.
*Pope, Fielding M. (Pres.), Brownwood.
Snyder, Ned A., Jr. (Sec'y), Brownwood.
*Spencer, Fred D., Jr., Brownwood.

MEMBERSHIP LIST, 1954—*continued*

Stephens, Joe B., Bangs.
Walker, James B. N., Brownwood.
Wheelis, Paul M., Brownwood.
*Wilson, Francis W., Brownwood.

COLEMAN

Bailey, Robert (Hon.), Coleman.
Burke, Francis M., Coleman.
Henner, Charles M. (Pres.), Santa Anna.
Jennings, William L., Coleman.
Lovelady, Roy R., Coleman.
Mann, Morris D., Coleman.
Moody, Chas. O. (Sec'y), Coleman.
Weaver, Manly E., Coleman.
Yarbrough, Cecil G., Coleman.
Young, Josephus C., Coleman.

CRANE-UPTON-REAGAN

Daves, Elizabeth Ann, Big Lake.
Daves, James A., Big Lake.
Gossett, James D., Rankin.
*Maynard, Billy J., Crane.
Terry, John E. (Sec'y), Crane.
Wright, John L., Jr. (Pres.), Big Lake.

KIMBLE-MASON-MENARD-McCULLOUGH

Anderson, James P. (Sec'y), Brady.
*Anderson, James S., Brady.
Baze, Perry A., Mason.
Bodenhamer, James G., Mason.
*Breckenridge, Elmer O., Mason.
Coleman, Jesse L., 2606 Marianna, Midland.
Hallum, B. A., Brady.
Hanus, Joseph J.,
Austin State Hospital, Austin.
Hartgraves, Hallie (Hon.), Kenosha, Wisc.
Hays, Aaron R., Brady.
Hays, Robert D., Brady.
Hinchman, Alda W. (Pres.), Brady.
Hyman, Maurice, Menard.
Jordon, Dowdell W., Brady.
Land, W. M. (Hon.), Lohn.
McCall, John G. (Hon.), Brady.
Moss, Eli Bruce, Junction.
Ricks, Glenn H., Brady.

RUNNELS

*Bailey, Charles F., Ballinger.
*Chandler, Oren H., Ballinger.
Downing, Lloyd L., Ballinger.
Green, John E., Jr. (Pres.), Ballinger.
Jones, Glenn M. (Sec'y), Ballinger.
Jones, Murrell D., Ballinger.
Rives, C. T., Winters.
Shiller, John J., Rowena.

TOM GREEN-COKE-CROCKETT-CONCHO-IRION-STERLING-SUTTON-SCHLEICHER

Alexander, Eugene P.,
1516 W. Beauregard, San Angelo.
Allison, Richard F., Sanatorium.
*Anderson, Hiram M.,
119 E. Harris, San Angelo.
*Anderson, Wilson D.,
123 W. Harris, San Angelo.
Arledge, Robt M. (Pres.),
203 E. Harris, San Angelo.
*Ballard, John E.,
Shannon Mem. Hosp., San Angelo.
Barry, Douglas J.,
119 E. Beauregard, San Angelo.
Boster, Ray G.,
219 S. Magdalen, San Angelo.
*Brask, H. Kermit,
111 E. Harris Ave., San Angelo.
Brauns, Wilhelm H.,
234 W. Beauregard, San Angelo.
*Browne, Charles F., Sonora.
*Bunyard, Joseph A.,
San Angelo Natl. Bank Bldg., San Angelo.
Butner, Wendell B,
201 E. Beauregard, San Angelo.
*Byars, Perry J. C.,
19 S. Park, San Angelo.
Chase, Ralph R., Jr.,
234 W. Beauregard, San Angelo.
*Cohen, Milton R.,
814 McBurnett Bldg., San Angelo.
Coleman, T. Gabe,
510 W. Beauregard, San Angelo.
Cornelison, Joe L. (Sec'y),
510 W. Beauregard, San Angelo.
Curtis, Ward C., Wichita Falls.
Eckhardt, Gus F.,
510 W. Beauregard, San Angelo.
*Engelking, Charles F.,
Clinic Hospital, San Angelo.
Everhart, Merrill W.,
2704 Douglas Drive, San Angelo.
Finks, Robert M., Clinic Hosp., San Angelo.
Fowler, David D. (Hon.), Paint Rock.
*French, Cecil M.,
Central Natl. Bank Bldg., San Angelo.
Gainer, Marthalyn J.,
612 E. Parkway, San Angelo.
Gainer, Sam H.,
110 S. Magdalen, San Angelo.
Grafa, Barney G., 1509 Bedford, Midland.
*Harris, John R., Bronte.
*Hershberger, Lloyd R.,
Shannon Hospital, San Angelo.
Hickman, H. E.,
123 E. Beauregard, San Angelo.
Hollister, W. L. (Ina.),
202 E. Ave. J, San Angelo.
Howell, John F., Sonora.
Hutchins, F. Leon,
McBurnett Bldg., San Angelo.
Irvine, George N., Jr.,
112 Hobbs St., San Angelo.
Johnson, Clay H.,
203 E. Beauregard, San Angelo.
Jones, Robert R.,
1705 W. Beauregard, San Angelo.
Knight, Maynard D.,
234 W. Beauregard, San Angelo.
*Kunath, Carl A.,
111 E. Harris Ave., San Angelo.
Landy, Aaron E.,
309 McBurnett Bldg., San Angelo.
Lewis, Aubry L.,
123 E. Beauregard, San Angelo.
Lindsey, William H., Eldorado, Tex.
Madding, Gordon F.,
111 E. Harris Ave., San Angelo.
Martin, Scott H., 115 South Park, San Angelo.
*McCaw, Blanche M.,
114 S. Magdalen, San Angelo.
*McCaw, William H.,
114 S. Magdalen, San Angelo.
McDaniel, John D., Robert Lee.
McIntire, Floyd T., Box 1472, San Angelo.
McKnight, Joseph B. (Hon.),
2206 Dallas St., San Angelo.
Mee, Edmond L.,
McBurnett Bldg., San Angelo.
Moon, Roy E.,
234 W. Beauregard, San Angelo.
*Morse, Robert A.,
234 W. Beauregard, San Angelo.
Mowrey, Jack I., Eldorado.
Nesrsta, George L., Box 1390, San Angelo.
Nibling, George W. (Hon.),
1416 W. Harris, San Angelo.
Pilmer, Gordon A.,
1401 W. Beauregard, San Angelo.
Porter, William L.,
111 E. Harris Ave., San Angelo.
Powers, Rufus L.,
203 E. Harris Ave., San Angelo.
Rape, J. Marvin,
22 S. Magdalen, San Angelo.
Reilly, Daniel R., City Hall, San Angelo.
Ricci, Henry N.,
McBurnett Bldg., San Angelo.
Ricketts, Harry M., Jr. (In.),
Shannon Hosp., San Angelo.
Round, Harry F., 201 E. Harris, San Angelo.
Round, Kye B.,
201 E. Harris Ave., San Angelo.
Sattenspiel, Edward.
114 S. Magdalen, San Angelo.
Schulkey, Wm. E.,
234 W. Beauregard, San Angelo.
Schulze, Victor E.,
219 S. Magdalen, San Angelo.
Sessums, John R. (Hon.),
1324 W. Ave. D, San Angelo.
Sessums, J. Valton, 635 S. Bishop, San Angelo.
Simpson, Fredric E.,
234 W. Beauregard, San Angelo.
Smith, Jerome H. (dead), San Angelo.
*Smith, Wm. Lacey,
111 E. Harris, San Angelo.
Swann, Wm. J., Sterling City.
Tandy, Hugh B., Ozona.
Tester, Lewis K.,
Central Natl. Bank Bldg., San Angelo.
*Thompson, Chase S.,
111 E. Harris Ave., San Angelo.
Wall, D. D., 234 W. Beauregard, San Angelo.
Walley, Cecil Rhodes, Ozona.
*White, James N.,
206 E. Harris Ave., San Angelo.
Williams, Harvey M.,
McBurnett Bldg., San Angelo.
*Windham, Robert E. (Hon.),
Christoval Rd., San Angelo.
Winkelmann, Eugene C.,
1606 W. Beauregard, San Angelo.
*Womack, Clifford T.,
401 Central Natl. Bank Bldg., San Angelo.
Wood, Marion L., 119 E. Harris, San Angelo.

FIFTH DISTRICT

Dr. J. J. Hinchey, San Antonio, Councilor

ATASCOSA

Austin, John D. (Sec'y), Pleasanton.
Faggard, John M. (Pres.), Poteet.
*Joyce, Walter H., Lytle.
*Mann, Robert E., Pleasanton.
Ogden, U. B., Pleasanton.
Ward, Jeremiah, Jr. (Hon.), Poteet.
*Ware, Thomas P., Poteet.

BEXAR

*Adelman, Jack A.,
221 Donaldson Ave., San Antonio.
*Aderhold, James P.,
1122 Medical Arts Bldg., San Antonio.
Adler, Harry F.,
133 Handley St., San Antonio.
Albert, Arnold.
2714 S. Presa St., San Antonio.
Albert, Monroe,
2714 S. Presa St., San Antonio.
*Alexander, Charles B.,
1716 Nix Prof. Bldg., San Antonio.
*Allen, Sovern W.,
1022 Medical Arts Bldg., San Antonio.
Allin, Frederick A.,
1150 Highland, San Antonio.
*Allin, Willis W.,
1105 E. Commerce, San Antonio.
*Altgelt, Daniel D.,
219 W. Gramercy, San Antonio.
*Altgelt, James E.,
510 W. Lynwood, San Antonio.
Alvis, Milton E.,
422 Medical Arts Bldg., San Antonio.
*Arendt, Erich J.,
625 Shook Ave., San Antonio.
Atkinson, Donald T.,
827 Medical Arts Bldg., San Antonio.
*Atmar, Robert C.,
205 Camden, San Antonio.
*Barnett, John L.,
1206 Nix Prof. Bldg., San Antonio.
Barton, Julian C.,
909 Nix Prof. Bldg., San Antonio.
*Bates, LeRoy E.,
717 E. Houston, San Antonio.
*Beach, Asa, 205 Camden, San Antonio.
*Beal, Albert R.,
Rt. 2, Box 339G, San Antonio.
Beck, Emma (Ina.), Fredericksburg.
*Berchelmann, Adolph,
901 W. Mistletoe, San Antonio.
*Berchelmann, August G.,
802 S. Laredo St., San Antonio.
*Berchelmann, David A.,
809 S. Laredo, San Antonio.
Bernard, George E.,
107 Eads Ave., San Antonio.
Berry, Lloyd E., Jr.,
5148 Broadway, San Antonio.
*Biggar, Jas. H. (Hon.),
242 Rockwood St., San Antonio.
*Bishop, Elmer W.,
5307 S. Flores, San Antonio.
*Blair, Jas. R., Jr.,
211 Richmond Ave., San Antonio.
*Block, William J., Jr.,
1216 Nix Prof. Bldg., San Antonio.
*Bloom, Bernard H.,
243 Stanford Dr., San Antonio.
Blumer, Max A.,
1108 Nix Prof. Bldg., San Antonio.
*Boccelato, Salvador L.,
3304 W. Commerce, San Antonio.
*Boehs, Charles J.,
1126 Medical Arts Bldg., San Antonio.
*Bohmfalk, John H,.
207 E. Hildebrand, San Antonio.
*Bondurant, Wm. W., Jr.,
909 Nix Prof. Bldg., San Antonio.
Bonnet, Edith M.,
404 Medical Arts Bldg., San Antonio.
*Borsheim, Raymond S.,
1702 Nix Prof. Bldg., San Antonio.
Bose, Edda von,
914 Kayton Ave., San Antonio.
*Boso, Fred M., 308 Dallas St., San Antonio.
*Bosshardt, Carl E.,
200 W. Rosenwood, San Antonio.
*Bowen, Robert E. (Ina.),
205 Camden, San Antonio.
*Bowen, Robert E., Jr.,
205 Camden, San Antonio.
*Boyd, G. D.,
1411 N. Main Ave., San Antonio.

MEMBERSHIP LIST, 1954—*continued*

*Boysen, Arthur E.,
1520 McCullough, San Antonio.
*Breath, Marshall B.,
929 Manor Dr., San Antonio.
Brendel, William B.,
647 Moore Bldg., San Antonio.
Breuer, Alfred, 731 E. Houston, San Antonio.
*Brewer, Dorothy, 205 Camden, San Antonio.
*Brown, A. A. (Hon.),
233 Linda Dr., San Antonio.
Brunner, George Harmon.
303 Contour Dr., San Antonio.
Brunner, Robbie Neeley,
1208 S. Texas Bldg., San Antonio.
*Burg, Edward M.,
2167 W. Summit, San Antonio.
*Burk, Joseph E.,
3202 San Pedro, San Antonio.
Burk, William E.,
1030 Medical Arts Bldg., San Antonio.
*Burkhardt, William L.,
1100 Austin Hwy., San Antonio.
*Burleson, Jno. H. (Emer.),
1034 Nix Prof. Bldg., San Antonio.
*Bush, Howard M.,
1629 Nix Prof. Bldg., San Antonio.
*Buttery, Harold D.,
902 Nix Prof. Bldg., San Antonio.
Calder, Royall M.,
Medical Arts Bldg., San Antonio.
Callan, John R.,
110 E. Hermosa Dr., San Antonio.
Calvert, Hulon E.,
506 Medical Arts Bldg., San Antonio.
*Canter, Joseph M.,
532 Moore Bldg., San Antonio.
Carter, James W., Jr.,
619 New Moore Bldg., San Antonio.
*Case, John B.,
625 Medical Arts Bldg., San Antonio.
Cayo, Edward A.,
923 Medical Arts Bldg., San Antonio.
Cayo, Ernest P.,
Santa Rosa Hospital, San Antonio.
Celaya, Albert,
205 Camden St., San Antonio.
Celaya, Henry,
1211 Medical Arts Bldg., San Antonio.
*Center, Wm. M.,
511 W. French Place, San Antonio.
Cerha, Harry T.,
537 Moore Bldg., San Antonio.
Chaffin, W. T. Cadman, Benson, Arizona.
*Champion, Albert N.,
1223 Medical Arts Bldg., San Antonio.
*Chandler, Jack R. (In.),
2503 W. Woodlawn, San Antonio.
*Chankin, Edgar D.,
1525 Nix Prof. Bldg., San Antonio.
Childers, Herschel N. (Mil.).
Childers, M. A.,
Alamo Natl. Bank Bldg., San Antonio.
Christian, Thos. E.,
810 Medical Arts Bldg., San Antonio.
*Clark, A. Fletcher,
827 Medical Arts Bldg., San Antonio.
*Clark, A. F., Jr.,
827 Medical Arts Bldg., San Antonio.
Clifton, Collis B.,
303 Maverick Bldg., San Antonio.
*Coates, Elmer T.,
401 W. Summit, San Antonio.
*Cochran, Joel L.,
1220 Medical Arts Bldg., San Antonio.
*Coffman, Graham M.,
1134 Garrity Rd., San Antonio.
*Coleman, Frederick C.,
914 Nix Prof. Bldg., San Antonio.
*Collins, George P. (In.),
Santa Rosa Hosp., San Antonio.
*Cook, Clara G.,
706 Gibbs Bldg., San Antonio.
Cook, Walter R.,
123 Ogden Lane, San Antonio.
Cooper, Elmer E., 505 Howard, San Antonio.
Cooper, Fred B.,
827 Medical Arts Bldg., San Antonio.
*Cooper, Jean H.,
211 Richmond Ave., San Antonio.
*Cooper, Melbourne J.,
211 Richmond Ave., San Antonio.
*Copeland, Joseph B.,
1014 Medical Arts Bldg., San Antonio.
Cotham, Christian M.,
414 Medical Arts Bldg., San Antonio.
*Cover, Ellen C.,
San Antonio State Hosp., San Antonio.
Cowles, Andrew G. (Hon.),
202 W. Kings Highway, San Antonio.
*Coyle, Edward W.,
1030 Nix Prof. Bldg., San Antonio.
*Crews, Eli R., 434 Beverly Dr., San Antonio.
*Curtis, Margaret S.,
622 Funston Place, San Antonio.
Darwin, Lloyd K., Jr. (In.),
236 Pamela Dr., San Antonio.
Davis, David F. (Mil.).
*Davis, F. Milton,
1502 Nix Prof. Bldg., San Antonio.
*Davis, Herman L.,
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DePew, Evarts V. (Hon.),
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*Diseker, Thos. H.,
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Dodge, Donald T.,
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San Antonio.
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608 Commerce Bldg., San Antonio.
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*Rabel, John E.,
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*Ramsey, Wayne V., Jr. (In.).
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Hinman, Alexander J., New Braunfels.
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*Heinen, Allen I., Seguin.
Knolle, Robert L., Jr., Seguin.
Moore, Melba McNeil, Seguin.
Moore, Raymond T., Seguin.
Randolph, Vivien P., Schertz.
*Williams, Jesse B. (Pres.), Seguin.

KARNES-WILSON

Blake, John V., Jr., Floresville.
Bonstetter, Harold J., Kenedy.
Boykin, Solomon R., Floresville.
Edwards, Thos. P., Runge.
Jones, Ernest W., Kenedy.
McKinney, William C. (Sec'y), Runge.
Mills, William C., Jr., Kenedy.
Osoba, William G. (Pres.), Stockdale.
*Oxford, Jerry W., Floresville.
*Quillian, Causey C., Kenedy.
Shannon, Shelby E., Karnes City.

KERR-KENDALL-GILLESPIE-BANDERA

Bell, W. E., Kerrville.
Birt, John B., Harper.
Blackstock, Mathis W. (Sec'y), Kerrville.
Brandenstein, Luise C., Kerrville.
*Brown, Dor W., Jr., Fredericksburg.
Day, Harold C. (Pres.), Boerne.
Diamond, Jack R., Boerne.
Drane, Hugh A., Kerrville.
Dyer, Edward L., Kerrville.
Eley, Julia S., Kerrville.
*Feller, Lorence W., Fredericksburg.
Gregg, Wm. E., Kerrville.
Guill, Russell E., Kerrville.
Harzke, Otto F., Comfort.
*Jones, C. C., Sr., Comfort.
Jones, C. C., Jr., Kerrville.
*Keyser, Lester L., Fredericksburg.
*Knapp, Dwight R., Kerrville.
Mares, Charles F., Kerrville.
Matthews, Choice B., Kerrville.
*McClellan, C. L. (Hon.), Kerrville.
*McCullough, David, Kerrville.
Meador, George D., Bandera.
Packard, Duan E., Kerrville.
Perry, J. Hardin, Fredericksburg.
Ross, Luther W., Kerrville.
Sarwold, Albert N.,
410 Merimax Prof. Bldg., Galveston.
Seidel, Joshua, Legion.
*Simpson, Robert K., Kerrville.
*Springall, W. H., Fredericksburg.
Thompson, Sam E. (Emer.), Kerrville.
Thorne, Frederic H., Kerrville.
*Wiedeman, John E., Junction.

LA SALLE-FRIO-DIMMIT

Cook, John A., Cotulla.
Crawford, John M., Carrizo Springs.
Lindley, C. D. (Hon.), Cartizo Springs.
McKinley, Robert L., Pearsall.
Myers, Clyde P., Cotulla.
O'Connor, Timothy D. (Pres.), Pearsall.
*Pickett, B. E., Sr., Carrizo Springs.
*Pickett, B. E., Jr., Carrizo Springs.
Primomo, John S., Dilley.
*Primomo, Marion P. (Sec'y), Dilley.
Wilson, Wm. S., Jr., Carrizo Springs.

MEMBERSHIP LIST, 1954—*continued*

MEDINA-UVALDE-MAVERICK-VAL VERDE-EDWARDS-REAL-KINNEY-TERRELL-ZAVALA

Burditt, Bucky L., Del Rio.
*Cartall, Louis M., Del Rio.
*Cox, George W., 1512 Forrest Trail, Austin.
Crossley, S. W. (Hon.), Del Rio.
Cunningham, George B., Uvalde.
Dimmitt, Dean P., Uvalde.
Donaldson, Elizabeth, Del Rio.
Eads, Ray A., Uvalde.
Fly, Sterling H., Jr. (Mil.).
Gates, Ellis F., Eagle Pass.
Gentry, Thomas C., Leakey.
Graham, Robert N., Del Rio.
Guice, LeRoy E., Uvalde.
Horton, Joseph J., Buda.
*Howard, Woods A. (Sec'y), Uvalde.
Hyslop, Henry R., Del Rio.
Hyslop, James R., Del Rio.
Johnson, Thos. M., Del Rio.
Kaback, Harry, Eagle Pass.
LaForge, Hershall, Uvalde.
*Lewis, B. O., Eagle Pass.
McWilliams, W. R., Del Rio.
*Meredith, W. P., Del Rio.
*Merritt, Geo. H., Uvalde.
*Montemayor, Raul, Eagle Pass.
Peters, Leo E., Devine.
Poindexter, Cary A., Crystal City.
Pratt, Frank H. (Pres.), Rocksprings.
Rodriguez, Simon, Del Rio.
Ross, Horace B. (Hon.), Del Rio.
Samsel, Theodore B., Jr., Crystal City.
*Spencer, John C., Crystal City.
Sutton, C. R., Jr. (Mil.).
*Williamson, James D., Castroville.
Wood, Sterling C., Uvalde.
York, D. Alonzo (Hon.), Del Rio.

SIXTH DISTRICT

Franklin W. Yeager, Corpus Christi, Councilor

BEE-LIVE OAK-McMULLEN

*Davis, David W., Three Rivers.
Edmondson, John W., Beeville.
Gipson, Carie D., Three Rivers.
Kirkland, Luman W. (Pres.), Beeville.
Lancaster, Howard E., Beeville.
McNeill, Scott E., Beeville.
Miller, Ernest E., Beeville.
Poff, Claude M., Tuleta.
Reagan, James L. (Sec'y), Beeville.
Reagan, John W., Beeville.
Reagan, Tom B., Beeville.
Sansom, George W., George West.

BROOKS-DUVAL-JIM WELLS

Allison, Albert M., Alice.
Bartlett, Glenn E., Jr., Falfurrias.
Buck, Haldor R. (Sec'y), Premont.
Gonzalez, Juan C., Benavides.
Howard, Glenn T., Alice.
*Moet, John A., Orange Grove.
Newkirk, Wm. H., Alice.
O'Neil, Andrew W., Falfurrias.
Penly, Richard S., Falfurrias.
Virgin, Edwin P., Alice.
Wilder, Lowell E., Falfurrias.
Williams, J. Harold, Alice.
Winfield, C. F., Alice.
Wyche, Geo. G., Jr. (Pres.), Alice.
Wyche, Geo. G., Sr., Alice.

CAMERON-WILLACY

Allen, Geo. Earl (Mil.).
Amidon, Vivien M., Harlingen.
Ashcraft, E. Jeff, Jr., Harlingen.
Atchison, Martin V., Harlingen.
Baden, Ervin E., Raymondville.
Baden, Wayne F., Raymondville.
Bedri, Marcel R., Harlingen.
Benavides, Simon I., Jr., Raymondville.
Bennack, Geo. E., Raymondville.
Bernard, Richard C., Harlingen.
Berrey, Bedford H. (Mil.).
Bleakney, Phil A., Harlingen.
*Boice, Edward H., San Benito.
Bowyer, Chas. H., Los Fresnos.
Breyer, Amy, Brownsville.
Brown, John F., Jr., San Benito.
Caldeira, Frederick D., Harlingen.
Calderoni, Francisco F., Brownsville.
*Cannon, Geo. M., Brownsville.
Carranza, Enrique M., Brownsville.
Casey, James D., San Benito.
*Cash, Clarence M. (Hon.), San Benito.
Chase, Ned B., Jr., San Benito.
*Clarke, James Y., Harlingen.
Cox, Walter E. (Hon.), Brownsville.
Davis, J. Walker, Harlingen.
Davis, Lum M., Harlingen.
de la Garza, Enrique, Brownsville.
DeStefano, Frederick W., Brownsville.
Drake, John S., Raymondville.
*Duckworth, Frederick L., San Benito.
Duncan, George W., Harlingen.
Eisaman, Ralph H., Brownsville.
Englerth, Fred L., Harlingen.
Fox, Roy E., San Benito.
*Gallaher, George L., Harlingen.
George, James C., II (Pres.), Brownsville.
Goerger, Verne F., Raymondville.
Grimm, John H., Harlingen.
Guerrero, Emilio, Brownsville.
Guilbeau, Joseph A., Jr., San Benito.
Haas, Nelson W., San Benito.
*Hamilton, Oscar A., Harlingen.
Harrop, L. Louis, Harlingen.
Hartman, John T., Harlingen.
Hawkins, Beatrice, Brownville.
Hawkins, W. W., Brownsville.
Heins, Otto H., Raymondville.
*Higgs, Paul C., Harlingen.
Hockaday, James A., Port Isabel.
Hume, Evan B., Brownsville.
Jondahl, Willis H., Harlingen.
Kinder, Thurman A., Jr., Brownsville.
*Krishna, Ikbal, Brownsville.
Kuppinger, John C. (Mil.).
Lamm, Annie T., La Feria.
Lamm, Heinrich, La Feria.
LaMotte, Thos. J., Harlingen.
*Lancaster, David D., Harlingen.
Longoria, Vidal, Brownsville.
Lyle, Chas. F., San Benito.
McLean, Edwin P., Brownsville.
Miller, Harry A. (Sec'y), Brownsville.
Miller, John B., Brownsville.
Moet, Joe L., La Feria.
Nickell, David F., Harlingen.
Olcott, Cornelius, Jr., Harlingen.
Packard, John P., Harlingen.
Para, Andrew W., Brownsville.
Parker, S. Mitchell, San Benito.
Pearson, Bernard S., Harlingen.
Petta, George H., Harlingen.
Pollard, A. J. (Hon.), Harlingen.
*Poole, Pierre P., Brownsville.
Pope, Andrew J. (Hon.), La Feria.
Rodriguez, Hesiquio, Rio Hondo.
Roth, Karl A., Brownsville.
Salinger, Leland M., Brownsville.
*Scales, Hunter L., Jr., San Benito.
*Scanlan, Nestor, Brownsville.
*Shafer, Troy A., Harlingen.
Sherman, K. C., Harlingen.
Smith, Dudley W., Harlingen.
Smith, Robert N., Jr., Harlingen.
Spence, Chas. H., Jr., Raymondville.
Stephens, John M., Brownsville.
Strass, Herbert W., Harlingen.
Tewell, Howard E., Jr., Harlingen.
*Vinsant, Wm. J., San Benito.
Walsworth, Frank D., Harlingen.
Watkins, John C., Harlingen.
*Welty, John A., Harlingen.
Wharram, Kenneth J., Harlingen.
*Willeford, George, Harlingen.
Withers, John C. (Mil.).
Works, Bynum M., Brownsville.
Works, Lee, Brownsville.

HIDALGO-STARR

Bazan, Carlos, Jr., Mission.
Bennett, Frank W., McAllen.
*Blocker, W. P., Donna.
*Bohmfalk, Stanley W., Weslaco.
Booth, Earnest, East Dallas Clinic, Dallas.
Booth, James, V. A. Hosp., Little Rock, Ark.
Burgess, George A., McAllen.
Burnett, Thomas R., Mission.
Caldeira, Antonio D., Mercedes.
Caton, McKee, McAllen.
*Clark, Richard G., McAllen.
*Coulter, W. W., Jr. (Ina.), McAllen.
Dewitt, Joseph L., Elsa.
Dick, Delfred L., Pharr.
Dowlen, Joseph A., Mission.
Duncan, W. H., McAllen.
Edwards, T. G., Mercedes.
Ellis, Jack R., Weslaco.
Evans, Sheridan S. (Sec'y), McAllen.
Fitch, James F., McAllen.
Forcher, Henry, Edinburg.
*Frenzel, Paul H. (Pres.), Donna.
*Frink, Berton F., McAllen.
Fry, Wilburn S., Jr., Donna.
Garcia, Octavio, McAllen.
Gilliam, Hilburn D., McAllen.
Glass, Thomas W. (Hon.), Weslaco.
Graham, Ronald A., Pharr.
Guerra, Gilbert A., Edinburg.
Hall, Allon K., Mission.
Hamme, Curtis J., Edinburg.
Hamme, Ralph E., Edinburg.
Hatfield, Walter H., McAllen.
Heidrick, Daniel L., Mercedes.
Ice, Noel V. (Mil.).
Ivy, J. Bryan, Weslaco.
Johnston, Robert H., Mercedes.
Katribe, Paul, McAllen.
Kellar, Robert J., Weslaco.
Lancaster, George M., Weslaco.
*Lawler, Marion R., Mercedes.
Long, William H., Pharr.
Lubben, John F., Jr., McAllen.
Marsh, Elinor E., McAllen.
Martin, A. G. M., III (Mil.).
Martin, James C., Jr., Mission.
Matthews, John W., Edinburg.
*Maxwell, W. J., Jr., McAllen.
McCalip, Edwin L., Weslaco.
*McKinsey, S. Joe, McAllen.
Mims, Charles H., Mission.
Mock, Duane V., San Juan.
Montague, Laurence J. (Hon.), Austin.
Moore, Loyal H., McAllen.
Nevarez, Miguel A., McAllen.
North, Norman T., Mission.
Osborn, Alfred S., McAllen.
Osborn, Frank E. (Hon.), McAllen.
Osborn, Robt. W., McAllen.
Palisano, Philip A., McAllen.
Panzer, Ralph P., Weslaco.
Parker, Samuel T., Pharr.
Rabinowitz, Geo. E., McAllen.
Ramirez, Mario E., Roma.
Reed, Walter Earl, San Juan.
Riley, Pat, Mission.
Rodriguez, M. J., Rio Grande City.
Schutz, Joe D., McAllen.
Scott, Kincy J., Pharr.
Shamburger, W. H., Pharr.
Smith, E. G. (Hon.), Mercedes.
Southwick, Lloyd, Edinburg.
*Sybilrud, Hjalmar, McAllen.
Terrell, Pruitt D., McAllen.
Walker, Ottis (In.), Glendale, Calif.
Westphal, Herbert M., Weslaco.
Wharton, James O., McAllen.
Whigham, Herschel E., McAllen.
*Whigham, William E., McAllen.

KLEBERG-KENEDY

Barnett, Lawrence M., Bishop.
Boyd, Newell D., Kingsville.
Dunn, S. Chester (Pres.), Kingsville.
Ewert, William A., Kingsville.
Gaston, Earl, Kingsville.
Ginther, Clarke E., Bishop.
Greif, Emmett W., Kingsville.
Higgins, Frank B., Kingsville.
Jones, A. C., Kingsville.
Peace, Dewey W., Bishop.
Peace, Dewey W., Jr., Bishop.
Ramey, Lindell E., Kingsville.
Ruchelman, H. Harry, Kingsville.
Scales, James R., Kingsville.
Sublett, Collier M., Kingsville.
Walling, Bert H., Jr., Kingsville.
Wiles, William T. (Hon.), Riviera.
Woods, Helen H., Kingsville.
Woods, Richard R. (Sec'y), Kingsville.

NUECES

Abbey, Joseph A.,
429 Palmero, Corpus Christi.
*Ahern, Gerald S. (Sec'y),
1017 Santa Fe, Corpus Christi.
Aldis, William (Mil.).
Alsop, Joseph F.,
1813 S. Alameda, Corpus Christi.
Appel, Myron H.,
1200 Santa Fe, Corpus Christi.
Arnim, Landon C.,
701 Medical Prof. Bldg., Corpus Christi.
Ashmore, Alvin J.,
225 Med. Dental Bldg., Corpus Christi.
Barnard, James L.,
1240 3rd St., Corpus Christi.
Barnard, William C.,
1240 3rd St., Corpus Christi.
Barnes, George B.,
617 McCall, Corpus Christi.
Bernwanger, Damon C.,
2935 Norton, Corpus Christi.
Bickley, Estel T.,
Medical Prof. Bldg., Corpus Christi.

MEMBERSHIP LIST, 1954—*continued*

Blair, John V.,
Nixon Bldg., Corpus Christi.
Bounds, Lloyd D.,
719 Jones Bldg., Corpus Christi.
Brown, Walter C.,
1733 S. Brownlee, Corpus Christi.
Bryson, J. Gordon.
1220 S. Staples, Corpus Christi.
Burns, Herbert V.,
Medical-Dental Bldg., Corpus Christi.
Cameron, James M. (dead), Corpus Christi.
Cameron, Ralph H.,
211 Med. Prof. Bldg., Corpus Christi.
Carlson, O. Sherman,
1755 Santa Fe, Corpus Christi.
Chriss, John W.,
2933 Norton, Corpus Christi.
Clark, Charles S.,
220 Med.-Dental Bldg., Corpus Christi.
Clark, Dan H.,
1012 Annapolis, Corpus Christi.
Cline, William B., Jr.,
1238 Fifth St., Corpus Christi.
Collins, C. B. (Hon.),
338 Louise Bldg., Corpus Christi.
Colyer, George E.,
312 Medical Prof. Bldg., Corpus Christi.
Concklin, C. Lewis,
2201 16th St., Corpus Christi.
Connolly, Sidney M.,
1300 3rd St., Corpus Christi.
Cope, Solomon F.,
Medical-Dental Bldg., Corpus Christi.
Crain, Carroll F.,
1214 Santa Fe, Corpus Christi.
Danford, Edwin A.,
712 Booty, Corpus Christi.
Davis, Walter T.,
517 Clifford St., Corpus Christi.
Dixon, Chalmer D.,
207 Nixon Bldg., Corpus Christi.
Dolch, Stanley F. N., Jr.,
2935 Norton, Corpus Christi.
Draper, L. M.,
Nixon Bldg., Corpus Christi.
Dunham, Richard B.,
712 Booty, Corpus Christi.
Eberle, Howard J. (In.),
Boston City Hosp., Boston, Mass.
Eckhardt, Kleberg,
3832 Denver, Corpus Christi.
Edwards, Thomas W.,
244 Oleander, Corpus Christi.
Ellis, Frank A.,
611 Blucher, Corpus Christi.
Fitzgerald, Thos. F.,
509 Clifford, Corpus Christi.
Frank, Thelma E.,
1314 16th St., Corpus Christi.
Fraser, David B.,
1611 Fifth St., Corpus Christi.
Frashuer, William E., Robstown.
Frich, Michael C.,
525 Everhart Rd., Corpus Christi.
Friedman, Bernard B.,
916 Jones Bldg., Corpus Christi.
*Furman, McIver,
Furman Bldg., Corpus Christi.
Gaddis, Herman W.,
Cowling Bldg., Corpus Christi.
Garcia, Hector P.,
3024 Morgan St., Corpus Christi.
Garcia, Jose A.,
1101 19th St., Corpus Christi.
Gardner, Jos. E.,
1214 Santa Fe, Corpus Christi.
Garrett, Leslie M.,
2850 Topeka, Corpus Christi.
Gentry, W. H. (Hon.),
Box 963, Corpus Christi.
Ghormley, Mary O.,
615 Oliver Courts, Corpus Christi.
Ghormley, Wm. C.,
615 Oliver Courts, Corpus Christi.
Giles, E. Jackson,
Medical Prof. Bldg., Corpus Christi.
*Gill, E. King,
Medical Prof. Bldg., Corpus Christi.
*Glanz, Sanford,
506 Med.-Prof. Bldg., Corpus Christi.
Gray, Paul M.,
1014 Ohio St., Corpus Christi.
Griffin, Harold E.,
305 Med. Prof. Bldg., Corpus Christi.
*Groner, Edwin B.,
1234 5th St., Corpus Christi.
Grossman, Bernard B.,
Jones Bldg., Corpus Christi.
Grossman, Dave N.,
Med. Prof. Bldg., Corpus Christi.
Grossman, Saul,
911 Jones Bldg., Corpus Christi.
Guttman, L. Paul.
206 Med.-Dental Bldg., Corpus Christi.
Guttman, Paul B.,
328 Jackson Pl., Corpus Christi.
Hamilton, Doyne B., Robstown.
Hartwick, Fred W.,
623 Sorrell, Corpus Christi.
Heaney, H. Gordon,
1300 3rd St., Corpus Christi.
Heaney, Harry G. (Hon.),
P. O. Box 930, Corpus Christi.
Heaney, Kathryn,
2709 Swantner, Corpus Christi.
Hearne, Charles A. (Hon.),
1425 Ocean Drive, Corpus Christi.
Heymann, Hans E.,
1246 Annapolis, Corpus Christi.
Hoffpauir, A. C.,
Medical Prof. Bldg., Corpus Christi.
Holt, Everett L.,
1200 Santa Fe, Corpus Christi.
Horbaly, William (Mil.).
House, Rex C.,
509 Med. Prof. Bldg., Corpus Christi.
Howze, Jo W., Robstown.
Hubler, Winthrope R. (Mil.).
Hudson, George C.,
2914 David St., Corpus Christi.
Hudson, Richard L.,
908 Ayers, Corpus Christi.
Hyder, Prentiss L.,
Nixon Bldg., Corpus Christi.
Janssen, L. W. O., Jr.,
503 Medical Prof. Bldg., Corpus Christi.
Jasperson, Clarence P.,
621 Oliver Courts, Corpus Christi.
Jimenez, Prospero, Jr.,
216 Ocean View Pl., Corpus Christi.
*Johnson, Robt. W.,
1236 5th St., Corpus Christi.
Kemp, Kenneth J.,
Medical Prof. Bldg., Corpus Christi.
Kendrick, Michael C.,
1317 3rd St., Corpus Christi.
*Kennedy, Hugh A. (Pres.),
220 Med.-Dental Bldg., Corpus Christi.
Kiel, Alois F.,
1813 Alameda, Corpus Christi.
Klotz, Joseph G.,
518 Med. Prof. Bldg., Corpus Christi.
*Kluth, Fred C.,
Box 49, Corpus Christi.
Knapp, Roger S.,
621 Ohio, Corpus Christi.
Koepsel, Orlando S.,
Medical Prof. Bldg., Corpus Christi.
Kurzner, Meyer,
712 Booty, Corpus Christi.
Landesman, Joseph D.,
1230 Third St., Corpus Christi.
*Lane, Alfred L.,
1733 Brownlee Blvd., Corpus Christi.
Lang, Rudolph R.,
220 Med.-Dental Bldg., Corpus Christi.
Lemke, Walter M.,
901 Med. Prof. Bldg., Corpus Christi.
Lingenfelder, John,
1920 S. Staples, Corpus Christi.
Little, C. R.,
521 Medical Prof. Bldg., Corpus Christi.
Mann, Nathan, Murray Bldg.,
1733 Brownlee Blvd., Corpus Christi.
Marler, Otis E.,
Med.-Dental Bldg., Corpus Christi.
Martin, Sterling B.,
1713 S. Brownlee Blvd., Corpus Christi.
McCaskey, Gregory M.,
2935 Norton, Corpus Christi.
McKemie, Jack F.,
1611 Fifth, Corpus Christi.
*McKenzie, Charles E.,
P. O. Box 3151, Corpus Christi.
Mella, Charles A.,
230 Med.-Dental Bldg., Corpus Christi.
Metzger, William R.,
2840 S. Alameda, Corpus Christi.
Moller, G. Turner,
601 Medical Prof. Bldg., Corpus Christi.
Moody, Foy H.,
1611 Fifth St., Corpus Christi.
Moon, Orville B., Jr.,
1546 S. Brownlee, Corpus Christi.
Morgan, Charles G.,
156 Santa Barbara St., Corpus Christi.
*Morphew, Raymond L.,
1116 Morgan, Corpus Christi.
Morris, William E.,
1546 S. Brownlee, Corpus Christi.
Nast, Jerome,
1126 Third St., Corpus Christi.
Nast, Maurice D.,
1126 Third St., Corpus Christi.
Neubauer, Dorothea E.,
Rt. 4, Box 78, Corpus Christi.
O'Brien, Thos. P.,
309 Wilson Bldg., Corpus Christi.
O'Byrne, George T.,
1227 Third St., Corpus Christi.
Oshman, Joseph,
201 Med.-Dental Bldg., Corpus Christi.
*Pace, Karl B., Jr.,
1510 S. Brownlee, Corpus Christi.
Padilla, Arthur,
Medical Prof. Bldg., Corpus Christi.
Pasternack, Joseph G.,
216 Wilshire Place, Corpus Christi.
Perkins, Maury J.,
719 Jones Bldg., Corpus Christi.
*Pilcher, John F.,
Medical Prof. Bldg., Corpus Christi.
Posner, Sidney, Robstown.
Powell, Sam M.,
301 Palmero, Corpus Christi.
Priday, Cedric, 506 Vaky, Corpus Christi.
Pruessner, Harold T.,
3308 Ayers, Corpus Christi.
Riley, James R.,
Medical Prof. Bldg., Corpus Christi.
Riley, Winston E.,
612 Med. Prof. Bldg., Corpus Christi.
Rinehart, Archie B. (Hon.),
509½ S. Port, Corpus Christi.
*Rogers, Frederick F.,
1733 S. Brownlee, Corpus Christi.
Rosenheim, Philipp,
Medical Prof. Bldg., Corpus Christi.
Russo, G. Martin,
310 Jones Bldg., Corpus Christi.
Schuster, George, III,
Medical Prof. Bldg., Corpus Christi.
Segrest, John B., 711 King, Corpus Christi.
Sharp, James C.,
Medical Prof. Bldg., Corpus Christi.
Sigler, Robert J.,
1126 Third St., Corpus Christi.
Slabaugh, Carlyle B.,
1731 S. Brownlee, Corpus Christi.
*Sloan, John J.,
904 Med. Prof. Bldg., Corpus Christi.
Sloan, Joseph M.,
1010 Ohio, Corpus Christi.
Smith, Youel C., Sr.,
1813 Alameda, Corpus Christi.
Sory, Crysup,
1546 S. Brownlee, Corpus Christi.
Spann, R. Gayle, Thomas-Spann Clinic,
1546 Brownlee, Corpus Christi.
*St. John, Ralph V.,
416 Chaparral St., Corpus Christi.
*Stephen, J. J., Robstown.
*Stewart, Chas. Duncan,
614 Medical Prof. Bldg., Corpus Christi.
*Stone, Belo, Robstown.
Stroud, S. K.,
Medical-Dental Bldg., Corpus Christi.
Swearingen, Robert G.,
1002 Ohio St., Corpus Christi.
Tabler, J. Walton,
1002 Ohio St., Corpus Christi.
Talley, Oran H.,
3701 S. Saxet Dr., Corpus Christi.
Thomas, James H.,
1546 S. Brownlee Blvd., Corpus Christi.
Thomas, John R.,
722 Morgan, Corpus Christi.
*Thomas, Rex E.,
1546 S. Brownlee, Corpus Christi.
Thomason, Elizabeth C.,
3364 Manitou, Corpus Christi.
Thomason, Robert H.,
1611 Fifth St., Corpus Christi.
Triplett, W. C.,
234 Med.-Dental Bldg., Corpus Christi.
Tyree, James I.,
1232 5th St., Corpus Christi.
Upshaw, Bette Y.,
430 Catalina, Corpus Christi.
Upshaw, Jackson E.,
1017 Santa Fe, Corpus Christi.
Watson, Clyde O.,
Box 839, Corpus Christi.
White, Hosea A.,
711 N. Tancahua, Corpus Christi.
Wilkens, Robert,
219 Med. Prof. Bldg., Corpus Christi.
Williams, M. L. (Hon.), Robstown.
Williams, Stephen A.,
319 Furman Bldg., Corpus Christi.
Williford, E. A.,
1546 So. Brownlee, Corpus Christi.

MEMBERSHIP LIST, 1954—*continued*

Woods, Haddon B.,
1335 Third St., Corpus Christi.
Woody, Hannah,
515 Elizabeth, Corpus Christi.
Woody, Norman C.,
515 Elizabeth, Corpus Christi.
Wright, Levon David,
1546 S. Brownlee Blvd., Corpus Christi.
*Yates, June,
Medical Prof. Bldg., Corpus Christi.
*Yeager, Charles P.,
Nixon Bldg., Corpus Christi.
*Yeager, Franklin W.,
408 Nixon Bldg., Corpus Christi.
Youngberg, Stephen A.,
509 S. Port Ave., Corpus Christi.

SAN PATRICIO-ARANSAS-REFUGIO

*Baen, Daniel R., Mathis.
Bull, John H. B., Aransas Pass.
Deitcb, Ernest R., Sinton.
Ewing, F. Stanley, Sinton.
Finn, John H., Refugio.
Guynes, Wm. A., Mathis.
Horine, Maurice S. (Sec'y), Ingleside.
Jenkins, Young S., Taft.
*Koontz, Arch C., Woodsboro.
Love, Albert J., Mathis.
McConchie, Richard D., Aransas Pass.
Meitzen, Travis C., Refugio.
Miller, Harry A., Refugio.
Pierce, Jas. L., Jr., Sinton.
Rittiman, Melross C., Sinton.
*Selby, Claude A., Sinton.
Shelton, Josephine (Pres.), Refugio.
*Simpson, Chas. H., Sinton.
Tasch, A. F., Taft.
Tunnell, John W., Taft.
Tunnell, Rose N., Taft.
Voss, Alpheus H., Odem.
Wood, Lloyd G., Rockport.
Zarsky, Emil P., Refugio.

WEBB-ZAPATA-JIM HOGG

Baker, Julia,
Apertado Postal 28561-Tacuba,
Mexico City 17, D. F., Mexico.
Canales, Gregorio M., Laredo.
*Canseco, Francisco M., Laredo.
Chapa-Badillo, Jesus, Laredo.
Cigarroa, Joaquin G., Laredo.
Cigarroa, L. Gonzalez, Laredo.
Cigarroa, Margaret G., Laredo.
Cook, Albert T. (Hon.), Laredo.
Crawford, James L., Laredo.
de la Garza, Raul, Laredo.
Emerson, William J., Laredo.
*Fuller, Martin L., Laredo.
Graham, Stephen H., Jr., Laredo.
Guerra, M. Barrera, Hebbronville.
*King, Albert C., Laredo.
Koenig, Robt. Louis, Laredo.
Longoria, Enrique M., Laredo.
Lowry, John T., Laredo.
Lowry, Ruby S., Laredo.
Malakoff, Morris E., Laredo.
*McGee, Aubrey S., Laredo.
Montalvo, Lauro, Laredo.
*Penny, George E., Laredo.
*Powell, Paul H., Jr. (Sec'y), Laredo.
Powell, William R., Laredo.
Puig, Valentine L., Jr. (Pres.), Laredo.
Reitman, James S., Laredo.
*Rottenstein, Max, Laredo.
Trevino, Enrique G., Laredo.
Valls, Miguel, Laredo.
Wright, Ray B. (Hon.), Laredo.

SEVENTH DISTRICT

Dr. David Wade, Austin, Councilor

BASTROP-LEE

Burns, Robert B., Giddings.
Chapel, James P., Elgin.
Goddard, Chauncey G., Bastrop.
*Hardt, Sterling M., Bastrop.
Hazzard, Alford R. (Sec'y), Giddings.
Kroulik, Frank J. (Hon.), Smithville.
*Loveless, Robert W., Bastrop.
Mantzel, Sherwood W., Giddings.
Morris, Roy H., Jr., Elgin.
Stephens, J. D., Smithville.
*Thomas, James W., Smithville.
Vickers, Albert F. (Pres.), Giddings.

CALDWELL

DuBoise, Otho K., Lockhart.
Fielder, Darwin L., Lockhart.
Gambrell, William M., Jr., Luling.
*Luckett, Francis (Pres.), Fentress.
*Nichols, H. Clay, Jr., Luling.
O'Banion, J. Turner, Luling.
Playfair, James H. (In.), Greensburg, Pa.
Ross, Abner A., Lockhart.
*Ross, Alonzo A. (Emer.), Lockhart.
Wales, Philip A. (Sec'y), Lockhart.

HAYS-BLANCO

*deSteiguer, John R. (Hon.), San Marcos.
Elliott, Benge (Pres.), San Marcos.
Flannery, John J., Blanco.
Heatly, Maurice D. (Sec'y), San Marcos.
*McCormick, T. C., Jr., Buda.
Moore, Wm. L., Jr., San Marcos
Scheib, Chas. W., San Marcos.
*Sladczyk, George, Wimberly.
Sowell, Rugel F., San Marcos.
Teveluwe, William A., Blanco.
Van Ness, J. M. (Hon.), San Marcos.
*Whaley, William C., Johnson City.
White, David L., San Marcos.
*Williams, Milton C. (Hon.), San Marcos.

LAMPASAS-BURNET-LLANO

Allen, George Scott, Burnet.
Black, D. W. (Hon.), Lampasas.
Brook, Winston M., Lampasas.
Dansby, Garland L., Llano.
Duffy, Jack G., Bertram.
Gray, George L., Llano.
Hoerster, Dan J., Llano.
*Hoerster, Henry J., Llano.
*Kern, John C., Burnet.
Landrum, Marvin M., Lampasas.
McMillin, D. Rusb, Lampasas.
Newman, Peggy Jo (Sec'y), Lampasas.
Patteson, M. K. (Pres.), Lampasas.
Shepperd, Joe A., Burnet.
*Shepperd, Ray L., Burnet.
Shepperd, W. Ivan, Marble Falls.
Vaughn, Thos. D., Bertram.

TRAVIS

Adamson, Wm. C.,
412 W. 17th, Austin.
Allison, Bruce (Ina.),
5121 Pershing Ave., Fort Worth.
Archer, John D. (In.),
Univ. of Texas Med. Brancb, Galveston.
Archer, Thomas J., Jr.,
3203 Mereditb, Austin.
Auler, Hugo (Ina.),
4701 Crestway, Austin.
Baggett, Seldon O.,
1519 Mohle Dr., Austin.
Bailey, Charles W.,
Scarbrough Bldg., Austin.
Bailey, Joe W.,
502 W. 15th, Austin.
Bain, Ruth M.,
1805 Nueces, Austin.
Barker, Paul W. (Mil.).
Barkley, Douglas F.,
1702 No. Congress, Austin.
Bates, B. Clary,
403 W. 18th St., Austin.
*Bendel, Henry W. (In.),
Brackenridge Hosp., Austin.
*Bethea, James A.,
Capitol Sta., Box S, Austin.
Black, Walter B.,
211 E. 6th St., Austin.
Blaustone, Henry H.,
Scarbrough Bldg., Austin.
*Blewett, Emerson K.,
408 W. 15th St., Austin.
*Bohls, Sidney W.,
803 E. 32nd St., Austin.
Brady, J. J.,
1705 Colorado, Austin.
Brandes, Gerald E. (In.),
Brackenridge Hosp., Austin.
Brandt, Otto, Jr.,
1506 Guadalupe, Austin.
Bratton, Robert E.,
1606 Poquonack, Austin.
Brown, M. I.,
209 Capital Natl. Bank Bldg., Austin.
Brownlee, Charles H.,
603 W. 14th, Austin.
*Brumage, Wm. S.,
c/o State Health Dept., Austin.
Carter, C. E.,
603 Carolyn, Austin.
Carter, Rexford G.,
1709 San Antonio, Austin.
*Chauvin, E. V., Jr.,
218 Scarbrough Bldg., Austin.
Clark, George E., Jr.,
1709 San Antonio, Austin.
*Cleveland, G. W.,
1209 Parkway, Austin
Cloud, Ralph E (Ina.),
48 Summit View, Austin.
*Coleman, James M.,
108 West 30th St., Austin.
*Colwell, Leslie C.,
1410 Brazos, Austin.
Cooper, R. Allwyn,
106 W. 13th St., Austin.
Covert, Frank M., III,
1103-B Nueces, Austin.
Creel, Wylie F.,
407 W. 15th, Austin.
Cromer, Horace E., Jr.,
605 Capital Natl. Bank Bldg,. Austin.
Crowell, Caroline,
University Health Center, Austin.
Darnall, Charles M.,
Capital National Bank Bldg., Austin.
Davidson, Harry T.,
1403 Rio Grande, Austin.
Davis, Charles E.,
1403-C Guadalupe, Austin.
*Dildy, Charles B.,
801 West Ave., Austin.
*Doles, Emmett A.,
704 Capital Natl. Bank Bldg., Austin.
Douglas, John E.,
1403 San Antonio, Austin.
Dryden, Sam H.,
1302 Sabine, Austin.
Dubilier, Ben,
528 Capital Natl. Bank Bldg., Austin.
Dunlop, Josephine N. (Ina.),
108 West 15th St., Austin.
Eckhardt, James W.,
1312 Capital Natl. Bank Bldg., Austin.
*Edens, Lee E.,
2814 San Pedro St., Austin.
Eppright, Ben R.,
Capital Natl. Bank Bldg., Austin.
Esquivel, Sandi,
1306 Rio Grande St., Austin.
Exline, Albert L.,
505 W. 15th, Austin.
Fatter, Mervin E.,
500 W. 15th St., Austin.
Faubion, Darrell B.,
1403-C, Guadalupe St., Austin.
*Forbes, M. Allen, Jr.,
607 W. 14th, Austin.
Fox, Kermit W.,
409 W. 15th St., Austin.
Franken, Robert, Princeton, W. Va.
Garcia, Albert G.,
209½ East 6th St., Austin.
Garcia, John A.,
209½ East 6th St., Austin.
Gauntt, Wm. C.,
403 W. 18th, Austin.
*Gentry, M. Elizabeth,
2209 Quarry Rd., Austin.
*Gilbert, Joe T.,
Capital Natl. Bank Bldg., Austin.
*Glynn, James D.,
1213-B Parkway, Austin.
Goddard, Walter C.,
1410 Brazos, Austin.
*Graham, James M.,
1504 Guadalupe, Austin.
Granberry, Howard. Jr.,
906 W. 6th, Austin.
Gregg, F. Banner,
700 Brazos, Austin.
Griffin, Lawrence L.,
409 W. 15th St., Austin.
Haan, George W.,
3001 Perry Lane, Austin.
Hahn, Wm. B.,
1506 Guadalupe St., Austin.
Hamer, James G.,
4207 Guadalupe St., Austin.
Hanes, Lisburn C., Jr. (Mil.).
Hanna, Ralph,
108 W. 30th, Austin.
*Hardwicke, C. P.,
120 W. 7th St., Austin.
Harris, Woodson W.,
1410 Nickerson, Austin.
Hayes, Sigman W.,
4708 Burnet Rd., Austin.
Heitzman, Celine I. C.,
2600 E. 19th St., Austin.
*Helm, Fred P.,
Texas State Dept. of Health, Austin.
*Henry, Harvey B.,
1205 Nueces, Austin.
Herrod, James H.,
405 W. 15th St., Austin.
Hilgartner, H. L., Jr.,
202 W. 13th St., Austin.

MEMBERSHIP LIST, 1954—*continued*

Hoetster, Samuel A., Jr.,
Capitol Sta., Austin.
*Holland, Lang F.,
505 W. 13th St., Austin.
*Holle, Henry A.,
State Health Dept., Austin.
Holtz, Harvey E.,
421 Scarbrough Bldg., Austin.
*Hunter, Richard O.,
1512½ S. Congress, Austin.
*Jackson, J. Warren,
Capital Natl. Bank Bldg., Austin.
Johnson, Billy Frank,
1506 Guadalupe, Austin.
Johnson, David O.,
1403-C Guadalupe, Austin.
*Johnson, J. Edward,
401 Scarbrough Bldg., Austin.
Karn, Willard R. (In.),
2303 Tower Dr., Austin.
Kelly, Alfred J.,
6009-A Burnett Rd., Austin.
Kelton, Wm. W., Jr.,
108 W. 30th St., Austin.
*Key, Sam N., Sr. (Hon.),
Capital Natl. Bank Bldg., Austin.
*Key, Sam N., Jr.,
Capital Natl. Bank Bldg., Austin.
*King, William C.,
607 W. 14th, Austin.
Klint, Hugo A.,
311 W. 13th, Austin.
Klotz, H. L.,
Capital Natl. Bank Bldg., Austin.
Kreisle, James E.,
2317 Longview, Austin.
Kreisle, Matthew F., 2317 Longview, Austin.
Kreisle, Matthew F., Jr.,
2317 Longview, Austin.
LaBrosse, E. H. (Mil.).
LaLonde, Albert A.,
806 Capital Natl. Bank Bldg., Austin.
Lassiter, James W.,
1403-C Guadalupe, Austin.
*Legett, Cary, Jr.,
1707 Colorado, Austin.
*Legett, Georgia F.,
1707 Colorado, Austin.
Legett, Martin P., 3717 East Avenue, Austin.
Lippmann, Otto,
1801 Lavaca, Austin.
Long, Walter K.,
503 W. 15th, Austin.
Lowry, Frederick C.,
312 W. 15th St., Austin.
Lucas, Richard A.,
502 W. 13th, Austin.
Martin, Claud A.,
1301 Rio Grande, Austin.
Martin, Zeno T.,
Austin State Hosp., Box 96, Austin.
McCauley, Morris D.,
1506-A Guadalupe St., Austin.
McCormick, Katharine,
University Health Service, Austin.
McCrummen, Thomas D.,
Capital Natl. Bank Bldg., Austin.
*McCuistion, C. Hal (Sec'y),
609 Capital Natl. Bank Bldg., Austin.
McElhenney, Thomas J.,
1402 Nueces St., Austin.
McGuire, Scott T. (Ina.),
827 Harris Ave., Austin.
*McLean, Wm. F.,
502 W. 13th, Austin.
Miears, Claude H.,
Scarbrough Bldg., Austin.
Milligan, Barth,
4616 Red River, Austin.
Morgan, Wm. P.,
Capital Natl. Bank Bldg., Austin.
Morris, Truman N.,
408 W. 15th St., Austin.
*Morrison, Robert B.,
801 Capital Natl. Bank Bldg., Austin.
Murray, R. Vincent, Jr.,
405 W. 15th, Austin.
Nanney, Audie L.,
406 Capital Natl. Bank Bldg., Austin.
Neighbors, A. H., Jr.,
1801 Lavaca, Austin.
Neighbors, A. H., Sr.,
1801 Lavaca, Austin.
Newman, Henry W.,
Capital Natl. Bank Bldg., Austin.
Paggi, Leonard C.,
404-A W. 15th, Austin.
*Paris, P. J.,
702 Littlefield Bldg., Austin.
Paterson, Elizabeth A.,
2614 Delwood Pl., Austin.
Pattillo, Albert D.,
3200 South First St., Austin.
*Peavy, Charles D.,
806 Littlefield Bldg., Austin.
Pelphrey, Chas. F.,
1709 San Antonio, Austin.
Phillips, Jos. T.,
Univ. Health Center, Austin.
Pohl, Donald E.,
500 W. 15th, Austin.
*Polsky, Morris,
1503 Guadalupe, Austin.
Prewett, J. Edwards,
1000 Lavaca, Austin.
Price, Pinckney C.,
108 W. 30th, Austin.
*Primer, Ben M., Sr.,
2709 Rio Grande, Austin.
Primer, Ben M., Jr. (Mil.).
Rabb, Virgil S., Jr.,
602 W. 12th St., Austin.
Rainey, John R., Jr.,
1709 San Antonio, Austin.
Ravel, Jerome O.,
1705 North Congress, Austin.
Reinarz, Berthold H.,
Capital Natl. Bank Bldg., Austin.
Renfert, Henry, Jr.,
705 Capital Natl. Bank Bldg., Austin.
Roberts, Walter D.,
Univ. Health Center, Austin.
Robinson, Harold L.,
801 West Ave., Austin.
Robison, James T.,
Capital Natl. Bank Bldg., Austin.
*Ross, Raleigh R.,
1309 Nueces St., Austin.
Rothen, Robert M.,
502 W. 13th, Austin.
*Rousos, Anthony P.,
528 Capital Natl. Bank Bldg., Austin.
Rude, Joe C.,
Brackenridge Hosp., Austin.
Runge, Thos. M.,
712 Capital Natl. Bank Bldg., Austin.
Scarborough, Lee F.,
Box 42, Austin.
Schiller, Nelson L.,
515 W. 15th St., Austin.
*Schoch, Eugene P., Jr.,
112 W. 7th St., Austin.
*Scott, H. A.,
1302 Sabine, Austin.
Scott, Z. T. (Hon.),
3700 Windsor Rd., Austin.
Senter, Gerald R.,
209½ E. 6th, Austin.
Sbarpe, Wendell S., Pasadena.
Shepard, Herbert L.,
607-A W. 14th, Austin.
Shurley, J. T. (Mil.).
Simms, Benjamin F.,
507 W. 14th St., Austin.
Smith, Howard E.,
410 E. 5th St., Austin.
Standifer, Charles H. (Ina.),
1601 Preston Ave., Austin.
*Suehs, Oliver W., 120 W. 7th St., Austin.
Swearingen, R. O.,
611 West 15th St., Austin.
Terry, A. A.,
1709 San Antonio St., Austin.
Thomas, John C. (Hon.) (dead), Austin.
*Tbomas, John F.,
120 W. 7th St., Austin.
Tbompson, Burch,
1801 Lavaca, Austin.
Thorne, Geo. C.,
2317 Longview, Austin.
Thorne, Lancing S.,
1405 Rio Grande, Austin.
Thorne, Milner S.,
1403-C Guadalupe, Austin.
Tipton, George W.,
502 W. 15th St., Austin.
*Tisdale, Albert A.,
403-A West 15th St., Austin.
Todaro, Samuel P.,
Box 589, Austin.
*Turner, Milton,
2406 Rio Grande, Austin.
*Wade, David,
Capital Natl. Bank Bldg., Austin.
*Walter, Luther P.,
3212 Meredith, Austin.
Watt, Terrance N.,
1503 Guadalupe St., Austin.
Watt, Will E.,
Norwood Bldg., Austin.
*Weaver, John D.,
600 W. 11th St., Austin.
White, B. O.,
1707 Nueces, Austin.
Wbite, Paul L.,
Health Dept., Univ. of Texas, Austin.
Wilborn, Sam W.,
609 W. 15th St., Austin.
Williams, Harold L.,
1503 Guadalupe St., Austin.
*Williams, Harold M.,
3221 Gilbert, Austin.
*Williams, Harriss,
Capital Natl. Bank Bldg., Austin.
*Wilson, R. T.,
2911 Harris Blvd., Austin.
Wing, Herman, Texas Confederate Home,
P. O. Box 1098, Austin.
Winkler, John J.,
5623 Shoal Creek Blvd., Austin.
*Womack, David R.,
3415 Spanish Oak Dr., Austin.
*Woodson, B. Palmer,
Scarbrough Bldg., Austin.
Wooten, G. S. (Mil.).
Yeakel, Earl L., Jr.,
1403-C Guadalupe, Austin.
Zedler, Garland G.,
603 W. 15th St., Austin.
Zidd, Edward,
403 W. 15th St., Austin.

WILLIAMSON

Alexander, Margaret H., Taylor.
Clark, J. Frank, Georgetown.
*Cooper, Dewey H., Georgetown.
Doak, Edmund (Hon.), Taylor.
Gaddy, Howell R., Jr., Georgetown.
Godbey, John C., Jr., Taylor.
Gregg, Dick B., Round Rock.
Hermann, Robert C. (Pres.), Taylor.
Houghton, James F. (Sec'y), Taylor.
*Johns, Jay J., Taylor.
Kirkpatrick, B. A., Taylor.
Kirkpatrick, Roy H., Taylor.
Lehmberg, Seth W., Taylor.
Leshikar, Marvin J., Taylor.
*Makinson, James T., Granger.
Martin, John R., Georgetown.
*Miller, Charles R., Leander.
*Rice, Albert J., Georgetown.
Stromberg, E. W., Taylor.
Swanson, Wayland R., Taylor.
*Watkins, W. Pruett, Taylor.
Wedemeyer, William C., Walburg.

EIGHTH DISTRICT

Dr. James H. Wooten, Jr., Columbus, Councilor

BRAZORIA

Brown, Greenberry B., Jr., Angleton.
Caldwell, John S., Jr., Velasco.
Carlton, B. Hardy, Jr., Freeport.
Carroll, James A., Alvin.
Fuste, Carlos E., Jr. (Sec'y), Alvin.
Galloway, Wm. T., Freeport.
*Gray, Ralph E., Lake Jackson.
Greenwood, Wm. M., West Columbia.
*Hale, Robert A., Angleton.
*Hardwick, M. Warren, Angleton.
Hayes, Granville J., Alvin.
Heimbigner, Elmer, Lake Jackson.
Holt, Wm. C., Angleton.
Johnson, Oscar L., Jr., Lake Jackson.
Kirkpatrick, Robt. H., Freeport.
*Laugblin, J. Milton, Sweeney.
May, Henry K. (Mil.).
McCary, A. O'Brien, Freeport.
McCary, Roger M., Freeport.
Merz, Herbert E., Alvin.
Miller, Robert C., Lake Jackson.
Montgomery, Joe S., Jr., Angleton.
Moore, John M., Jr., Brazoria.
*Nicholson, Wm. D. (Pres.), Freeport.
O'Leary, John C.,
2815 McCullough St., San Antonio.
Perryman, Gerald F., Freeport.
Steele, Wayne K., Angleton.
Stevens, George M., Lake Jackson.
Stewart, James A., Freeport.
Turner, Frederick C., Freeport.
Woolf, Martin P., Freeport.

COLORADO-FAYETTE

*Boelsche, Leslie D., La Grange.
Damiani, Michel S., Columbus.
*Daniel, Crawford J., Taylor.
Guenther, John C., La Grange.
*Ible, Lyman E., Schulenburg.
Laughlin, John R., Eagle Lake.
Laughlin, Jones C., Eagle Lake.
Luedemann, W. O., Schulenburg.

MEMBERSHIP LIST, 1954—*continued*

Martin, Edward H., Spur.
Miller, Arthur C., Carmine.
Paine, Henry C., La Grange.
Peters, Leo J., Schulenburg.
Ryan, Jas. E., Weimar.
*Shult, Clarence I., Columbus.
Thompson, Robert G. (Mil.).
Watzlavick, August J. A. (Sec'y), Schulenburg.
Williams, Edward T. (Pres.), La Grange.
*Wooten, Jas. H., Jr., Columbus.
Youens, William T., Columbus.
Youens, Willis G., Weimar.
Zatopek, Leland F., La Grange.

DEWITT

Barth, John H. (Sec'y), Yorktown.
*Bohman, Alfred J., Cuero.
Burns, John G., Cuero.
Cross, Geo. W. (Hon.), Yorktown.
Douthit, Walton E., Cuero.
Hall, Oscar E., Jr. (Sec'y), Cuero.
Landry, Luchion B., Cuero.
*Milner, Robert M. (Pres.), Yoakum.
*Nowierski, Leon W., Yorktown.
*Prather, Frank A., Cuero.
Richter, Louis B. S., Yoakum.
Trott, John E., Yoakum.
Westphal, Robert D., U. S. V. A. Hosp., Houston

GALVESTON

*Adriance, Carroll T., 2402 Sealy, Galveston.
Ainsworth, Wm. H., John Sealy Hospital, Galveston.
Allen, Charles R., 928 Strand, Galveston.
*Anderson, Wm. T., LaMarque.
Aves, Fred W., 1728 Market St., Galveston.
*Baird, Elwood E., John Sealy Hospital, Galveston.
Baxter, M. Ruth L. (In.), John Sealy Hospital, Galveston.
Baxter, Virgil C., 2001 Avenue L., Galveston.
Beeler, Geo. W., Texas City.
Binney, Charles II (In.), Harlingen.
Blacklock, David M., LaMarque.
Blocker, Truman G., Jr., U. of Texas Medical Branch, Galveston.
Blocker, Virginia I., U. of Texas Medical Branch, Galveston.
Boelsche, Arr Nell (In.), John Sealy Hospital, Galveston.
Brindley, Paul, State Medical College, Galveston.
Brown, G. Wooten, 2402 Sealy, Galveston.
*Bruce, E. Ivan, Jr., 1014 Strand, Galveston.
Burch, Buford H. (In.), U. of Texas Medical Branch, Galveston.
Caravageli, M. A., 506 U. S. Natl. Bank Bldg., Galveston.
Carmignani, A. E., National Hotel Bldg., Galveston.
*Casey, Robert E., Texas City.
*Childers, John H., U. of Texas Medical Branch, Galveston.
Childress, James L. (In.), 124 Marlin, Galveston.
Cohen, Irvin M., Galveston State Hosp., Galveston.
Cone, Robert E., 706 U. S. Natl. Bank Bldg,. Galveston.
Cooke, Willard R., U. of Texas Medical Branch, Galveston.
Crass, Gwendolyn, U. of Texas Medical Branch, Galveston.
Danforth, Duncan R., Texas City.
Davis, Harry K., League City.
Delany, John J., 22nd and Sealy, Galveston.
DeLoach, Asa W. (In.), U. of Texas Medical Branch, Galveston.
deMesquita, Paul B., 2402 Avenue I, Galveston.
Dernehl, Carl U., Texas City.
Duff, Bedford K., McKinney.
*Duflot, Leo S. M., John Sealy Hospital, Galveston.
Eames, Daniel H., Jr., LaMarque.
Egbert, O. Edward, Jr. (In.), 2612 Avenue N, Galveston.
Eggers, Geo. W. N., 2201 Avenue D, Galveston.
Elizondo, Cesar M. (In.), 107 Tarpon, Galveston.
Engler, Joseph I. (In.), Bethesda, Md.
Ericson, Ruth A. (In.), 1508 Tremont, Apt. 2, Galveston.
Fisher, William C., 215 Merimax Bldg., Galveston.
Fleming, Ben P., Texas City.
Ford, G. David (Sec'y), 2202 Avenue M, Galveston.
Ford, Hamilton F., John Sealy Hospital, Galveston.
Forman, Sol, 2212 Avenue L, Galveston.
*Fowler, Marshall L., 2210 39th St., Galveston.
*Frank, Theodore M., Texas City.
Fuchs, Carl J., Texas City.
Futch, Edward D., 611 U. S. Natl. Bank Bldg., Galveston.
Garbade, Francis A., 22nd & Sealy, Galveston.
Garber, E. Peter, 410 Merimax Bldg., Galveston.
Gibbs, Reagan H., Children's Hospital, Galveston.
*Gingrich, Wendell D., John Sealy Hosp., Galveston.
*Glass, Cecil R. (In.), U. of Texas Medical Branch, Galveston.
Gomillion, J. D., Jr., 820 U. S. Natl. Bank Bldg., Galveston.
Green, Robert Paul, Texas City.
*Gregory, Lloyd J. (Mil.).
*Gregory, Raymond L., Medical College, Galveston.
Gwin, H. Shannon B. (In.), U. of Texas Medical Branch, Galveston.
Haggard, Mary Ellen (In.), John Sealy Hosp., Galveston.
Hander, William W., U. of Texas Medical Branch, Galveston.
Hansen, Arild E., 4319 Caduceus, Galveston.
*Harris, Titus H., Sealy Hospital, Galveston.
Harrison, A. Wilson, U. of Texas Medical Branch, Galveston.
*Hejtmancik, M. R., 118 Marlin, Galveston.
*Herrmann, Geo. R., U. of Texas Medical Branch, Galveston.
Hoffman, George T. (Mil.).
Hooks, Charles A., 816 Strand, Galveston.
*Jackson, Ira J., U. of Texas Medical Branch, Galveston.
Jameson, Grace K., 121 Tarpon, Galveston.
Jarrell, Norman D., Texas City.
Jarvis, Garth L., U. of Texas Medical Branch, Galveston.
Jinkins, A. J., 2402 Sealy, Galveston.
Jinkins, Julius L., 22nd & Sealy, Galveston.
Jinkins, J. L., Jr., 906 22nd St., Galveston.
Jinkins, Wiley J., Jr. (In.), 22nd & Avenue I, Galveston.
Johnson, Jesse B., 2201 Avenue D, Galveston.
Johnson, J. B., Jr., 816 U. S. Natl. Bank Bldg., Galveston.
*Johnson, John E. (In.), John Sealy Hosp., Galveston.
Johnson, Joseph K. (In.), 340 N. Blvd., Apt. D-17, Galveston.
*Jones, Edgar F., 2402 Sealy, Galveston.
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Kemp, Clarence S. (In.), John Sealy Hosp., Galveston.
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Kleiman, Harold (In.), John Sealy Hospital, Galveston.
Kolb, Weldon G., LaMarque.
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*Lewis, Stephen R., John Sealy Hospital, Galveston.
*Longfield, Aaron N., 915 Strand, Galveston.
Magliolo, Albert M., Dickinson.
Magliolo, Amedeo A., Dickinson.
*Magliolo, Andrew J., Dickinson.
Magliolo, Joseph C,. Dickinson.
Malone, James D. (Mil.).
*Manske, Gerhard R., Texas City.
Marr, William L., 611 U. S. Natl. Bank Bldg., Galveston.
Matlage, William T., Texas City.
May, Lawrence Geo., 915 Strand, Galveston.
McDanald, Eugene C., Jr., 112 N. Blvd., Galveston.
McDonald, Richard, LaMarque.
*McGivney, John, 2202 Ave. L, Galveston.
McKibben, J. Warren, Jr., Modesto, Calif.
McLarty, E. S., 22nd & Avenue I, Galveston.
McLarty, E. Sinks, Jr. (In.), 131 San Fernando Dr., Galveston.
*McReynolds, Geo. S., Merimax Bldg., Galveston.
*Meadows, John C., Jr., U. of Texas Medical Branch, Galveston.
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Moore, Robert M., John Sealy Hospital, Galveston.
Moran, John P. (In.), 2501 45th St., Galveston.
Mullen, Brooks W. (In.), John Sealy Hospital, Galveston.
*Mullins, J. Fred, 927 Strand, Galveston.
*Murray, Neville, Kerrville.
*Otto, John L., John Sealy Hospital, Galveston.
Palasota, Pete C., 112 N. Blvd., Galveston.
*Paley, Hyman W. (In.), John Sealy Hospital, Galveston.
Parker, James P., LaMarque.
Perlman, Bernard, 3905 Ave. R., Galveston.
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Rigdon, Raymond H., U. of Texas Medical Branch, Galveston.
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Robertson, Gaynelle, Texas City.
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Rosenblad, Lawrence E., Texas City.
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Rowe, Caroline W., John Sealy Hospital, Galveston.
Rowe, Edward B., John Sealy Hospital, Galveston.
*Ruskin, Arthur, John Sealy Hospital, Galveston.
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*Schneider, Martin, U. of Texas Medical Branch, Galveston.
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Sedberry, Miles E. (In.), Foundation Apts., Apt. 19D, Galveston
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Simpson, Robt. R., Texas City.
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Slocum, Harvey C. (Mil.).
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Smith, Eugene L., 315 Merimax Bldg., Galveston.
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*Spiller, William F., 22nd & Sealy, Galveston.
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Stephen, Weldon W., 22nd & Sealy, Galveston.
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Stiernberg, R. Cam., Texas City.
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Stone, Charles T., Jr.,
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*Thaddeus, Aloysius P. (In.),
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Thiel, John M.,
U. of Texas Medical Branch, Galveston.
Thompson, Edward R.,
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John Sealy Hospital, Galveston.
Townsend, Frank M. (Mil.).
Tree, Herschel G., Texas City.
Twidwell, Leonard, Texas City.
Ulmer, Robert J. (In.),
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Verrett, Richard R., Texas City.
Wall, Dick P.,
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Walton, Ida K., 1702 Ball, Galveston.
Walton, Worth, 1702 Avenue H, Galveston.
Weinert, Herman, Jr.,
U. S. Natl. Bank Bldg., Galveston.
Williams, G. D., LaMarque.
Williams, Warren S. (Mil.).
Wilson, William A., III,
Hotel Galvez, Galveston.
Wolma, F. J., Jr.,
120 Barracuda, Galveston.

LAVACA

Boyle, James W., Jr. (Ina.), Temple.
Buttery, James M.,
1024 Garrity Rd., San Antonio.
Connolly, John V. (Sec'y), Shiner.
*Dufner, Carl T., Hallettsville.
*Marek, Emil H., Yoakum.
*Renger, Harvey, Hallettsville.
Spikes, George A., Hallettsville.
Strieder, Hugo J., Paducah, Ky.
Wagner, Frank M., Shiner.
*Wagner, Robert J., Shiner.
Welles, Edward H., Hallettsville.
Williams, Robert W. (Pres.), Shiner.

VICTORIA-CALHOUN-GOLIAD

Alcorn, Robert S., Victoria.
Allen, Richard C., Jr., Victoria.
Bade, Craig P., Victoria.
Bush, Leonard E., Port Lavaca.
Coleman, Winton L., Victoria.
Constant, George A., Victoria.
*Dodson, Pattie May, Victoria.
Ehlert, Edward A., Victoria.
*Gilliam, Rochell B., Victoria.
*Glover, George E., Jr., Victoria.
Hilderbrand, Harold E., Goliad.
*Hopkins, Joseph V., Victoria.
Lancaster, York, Port Lavaca.
Lander, Roy S., Victoria.
Lester, Stanley W., Port Lavaca.
Logsdon, Francis M., Port Lavaca.
McCollom, C. J. (Pres.), Victoria.
McGlothlen, G. E., Victoria.
Mooney, Ern C. (Sec'y), Victoria.
Paul, Jesse W., Victoria.
Pillsbury, Curtis B., Victoria.
Reed, Roy G., Victoria.
*Sale, Walter W., Victoria.
Seger, Forrest M., Victoria.
Shields, Allan C., Victoria.
Smith, D. Heaton, Victoria.
Smith, William G., Port Lavaca.
Story, Joseph R., Victoria.
*Tomb, Andrew S., Victoria.
Tomme, Jesse Wm., Port Lavaca.
Ward, Rawley W., Victoria.

WHARTON-JACKSON-MATAGORDA-FORT BEND

Amman, Franz E., Rosenberg.
Arbuckle, Bertrand D., El Campo.
Bader, Joseph N., Edna.
*Bauknight, J. M., Ganado.
Black, Vernon A., Wharton.
Blair, Wm. M., Wharton.
*Blasingame, F. J. L., Wharton.
Boswell, Samuel R., Rosenberg.
Brewer, Paul L., Bay City.
*Dye, Fulton E., Bay City.
Emmett, William Bill, Ganado.
Fretz, Howard Z., Wharton.
Halamicek, J. A., El Campo.
Halamicek, John F., El Campo.
Hollomon, John J., Jr., Edna.
*Johnson, Leonard B., El Campo.
Johnson, R. G., New Gulf.
Knolle, Ben E., Rosenberg.
Kolle, Fred W., Wharton.
Kuykendall, Harold D., Sugar Land.
Leslie, Robert E., El Campo.
Little, Raymond D., Wharton.
Mangum, Hugh J., Bay City.
Martin, Don Elbert, Jacksonville.
Matthes, Homer C., Bay City.
McGee, Borden M., Rosenberg.
Mortland, S. Richard, Ganado.
Much, Joe C., Richmond.
*Nichols, C. V., Richmond.
Northington, Harold M., Wharton.
Outlar, L. Bolton, Wharton.
Presley, Walter D., El Campo.
*Reeves, Hiram V. (Hon.), El Campo.
Roll, John W. (Mil.).
Rugeley, Frank R., Wharton.
*Sanford, E. B., Palacios.
Sawyers, James R., Edna.
Schuhmann, J. Daniel (Pres.), East Bernard.
Scott, W. E., Rosenberg.
Shoultz, Charles A., Bay City.
Simons, Bryan E., Bay City.
Simons, Jack H., Bay City.
*Simons, James W., New Gulf.
*Stengl, Lorraine I., El Campo.
Stepan, John D., El Campo.
Thiltgen, Winston S., El Campo.
Thompson, Stanley E., Richmond.
*Voulgaris, Dennis M., Wharton.
Wilcox, Leroy A., Palacios.
Woodson, Clinton E., Wharton.
Yelderman, Gus C., Rosenberg.
Yelderman, Joe C. (Mil.).
*Yelderman, Robert L., Rosenberg.
*Zipp, Raymond D., Edna.

NINTH DISTRICT

Dr. J. T. Billups, Houston, Councilor

AUSTIN-WALLER

Bolton, M. Graham, Hempstead.
Gordon, Virgil, Sealy.
Hackfield, Alfred J., Industry.
Harle, Jas. B. (Sec'y), Bellville.
Hopkins, Jesse J., Brookshire.
*Neely, Jubal A., Bellville.
Neely, Robert A. (Mil.).
Roensch, Herbert E., Bellville.
Smith, Frank T. (Pres.), Sealy.
*Walker, Sidney C., Hempstead.

GRIMES

*Coleman, Solon D. (Pres.), Navasota.
*Hansen, Carl M., Navasota.
Ketchum, Everard T., Navasota.
Parker, Marshall E. (Hon.), Anderson.
Sanders, Guy C., Richards.
Stewart, Homer L. (Sec'y), Navasota.
Thompson, H. E., Navasota.

HARRIS

*Abbott, Jack P.,
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*Able, Luke W.,
905 Hermann Prof. Bldg., Houston.
Adam, George F.,
4828 Caroline, Houston.
Adamo, Dominick C.,
410 W. 20th St., Houston.
*Adams, Granville Q.,
1202 Hermann Prof. Bldg., Houston.
Agnew, James H. (Hon.) (dead), Houston.
Ainsworth, Joseph T.,
7444 Harrisburg Blvd., Houston.
Alexander, Chas. S.,
702 Hermann Prof. Bldg., Houston.
*Alexander, Herbert L.,
904 Holman, Houston.
Alexander, J. C.,
904 Holman, Houston.
Alger, Leon J.,
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Ameen, Ray C. (Mil.).
*Ames, Frederick D.,
2418 Travis, Houston.
Anderson, A. Burton,
804 Hermann Prof. Bldg., Houston.
Anderson, Thos. A., Jr.,
4001 Westheimer, Houston.
Andrews, Tom A., Jr.,
4705 Montrose Blvd., Houston.
Applebe, Edward W. (Hon.),
1806 Holman, Houston.
*Armbrust, Chas. A., Jr.,
4109 Montrose Blvd., Houston.
Armstrong, John W.,
7338 McHenry, Houston.
Armstrong, John T.,
405 Hermann Prof. Bldg., Houston.
*Arnold, Hiram P.,
706 Hermann Prof. Bldg., Houston.
Arnold, Hugh F.,
1603 Medical Arts Bldg., Houston.
Arnold, Jasper H.,
811 Medical Arts Bldg., Houston.
*Arnold, William T.,
1402 Hermann Prof. Bldg., Houston.
Ashkenazy, Moses
2259 W. Holcombe, Houston.
*Ashmore, Chas. M.,
918 Medical Arts Bldg., Houston.
Atkins, Richard D., Jr.,
3229 Wisconsin, Baytown.
Aves, Frederick H.,
4109 Montrose, Houston.
Axelrod, Alexander,
1009 Medical Arts Bldg., Houston.
Axelrod, Harold,
1111 Calumet, Houston.
Axelrod, William,
Medical Arts Bldg., Houston.
Babcock, Darrow S.,
8710½ Humble Road, Houston.
Bachtel, May B.,
5504 La Branch, Houston.
Baird, J. Byron, Box 232, Pasadena.
Baird, Raleigh W., Jr.,
3701 Montrose Blvd., Houston.
Baird, Val C., Box 2180, Houston.
Baker, Lowell B.,
1717 La Branch, Houston.
Ballantyne, Alando J.,
2310 Baldwin, Houston.
Barclay, Sam D.,
300 Hermann Prof. Bldg., Houston.
Barkley, Howard T.,
4109 Montrose Blvd., Houston.
Barnes, J. Peyton,
1704 Crawford, Houston.
Barnhart, Joseph M.,
1201 Hermann Prof. Bldg., Houston.
Barrett, John H.,
1304 Walker, Houston.
Bashour, Sam B.,
5208 Caroline, Houston.
Bayer, Bernard H.,
104 E. 20th, Houston.
Behr, Thomas S.,
2418 Travis, Houston.
Behrens, Chas. A.,
5644 Lawndale, Houston.
Bell, Exter F., Jr.,
4528 Griggs Rd., Houston.
Bell, Justin E.,
2255 W. Holcombe, Houston.
Belleggie, Philip A.,
3203 Fannin, Houston.
Bennett, Hugh D.,
2002 Holcombe Blvd., Houston.
Bennett, Wm. H. (Hon.), Humble.
Bernard, Lynn A. (Mil.).
Berry, Chas. R. (dead), Houston.
Best, Paul W.,
805 Medical Arts Bldg., Houston.
Bettis, C. Moody,
3902 Montrose Blvd., Houston.
Betts, William A., Jr.,
4205 Leeland, Houston.
Bevil, Jack N.,
529 Medical Arts Bldg., Houston.
Beyer, Alvin, Jr.,
1119 Lovett Blvd., Houston.
Bickel, Laura C.,
30 Oakdale, Houston.
*Biles, Ervin W.,
602 Lamar Ave., Houston.
*Billups, J. T.,
605 Hermann Prof. Bldg., Houston.
Bing, Lyndon W., Katy.
Blackburn, Edward A., Jr.,
1304 Walker Ave., Houston.
Blair, Lyman C.,
1212 Rothwell, Houston.
Blair, Robt. K.,
2418 Travis, Houston.
Blattner, Russell J.,
Baylor College of Medicine, Houston.
Blish, M. Eleanor,
4705 Montrose Blvd., Houston.
Bloom, Fred A.,
10 Chelsea Blvd., Houston.
Bloom, Manuel G.,
409 Medical Arts Bldg., Houston.
Bloxsom, Allan P.,
4402 Travis, Houston.
Blundell, J. Reese,
302 Medical Arts Bldg., Houston.
Boardman, Harriet L. (Ina.),
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Bourdon, Lynn L.,
1917 Ashlaod, Houston.
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3529 Montrose Blvd., Houston.
*Bowen, Shirley S.,
1215 Walker, Houston.
Boyd, Adam N.,
2918 Caroline, Houston.
Boylston, Bedford F.,
5215 S. Main, Houston.
Braastad, Frederick W.,
1626 Medical Arts Bldg., Houston.
Braden, Albert H., Jr.,
2014 Crawford, Houston.
*Bradford, F. Keith,
410 Hermann Prof. Bldg., Houston.
Brady, Randle J.,
3317 Binz, Houston.
Bragg, Wm. J., Jr.,
8710 Humble Rd., Houston.
Brandau, Geo. H.,
619 Medical Arts Bldg., Houston.
Brandes, E. B.,
3101 Fannin, Houston.
Brandon, Sylvan,
928 Medical Arts Bldg., Houston.
Brannon, Jack G.,
2715 Fannin, Houston.
Bratteng, Elizabeth H.,
1729 Sunset Blvd., Houston.
Brauer, Raymond O.,
1103 Hermann Prof. Bldg., Houston.
Breckenridge, C. G.,
1200 M. D. Anderson Blvd., Houston.
Brener, Lazard S.,
1200 Bissonet Ave., Houston.
Brener, Zidella S.,
2325 Bluebonnet, Houston.
Bressler, J. L.,
1215 Walker, Houston.
Brewer, Thos. W.,
3103 Fannin, Houston.
Bridges, Wm. H., Baytown.
Brockman, Hiram L. (In.),
Baylor Med. School, Houston.
Brodsky, Alexander E.,
4817 Montrose Blvd., Houston.
Brohn, Alfred J.,
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Brown, Clarence A. (In.),
3315 Belfontaine, Houston.
*Brown, James A.,
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Brown, R. Alec,
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Brumby, Wm. M. (Hon.),
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Bukowski, Lucian M.,
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Burdick, Jesse G.,
Ethyl Corporation, Pasadena.
Burg, Abner D.,
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Burge, Curtis H.,
1205 Hermann Prof. Bldg., Houston.
Burke, Thos. W.,
Esperson Bldg., Houston.
Burnett, Mathew D., Jr.,
208 Hermann Prof. Bldg., Houston.
Burr, Harry B.,
503 Medical Arts Bldg., Houston.
Burrows, John B.,
910 Hermann Prof. Bldg., Houston.
Butera, J. M.,
1814 Crawford, Houston
Butler, Donald B.,
3226 Milburn, Houston.
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V. A. Hospital, Houston.
Caffery, Eldon L.,
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Calaway, F. Otis,
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Calhoun, C. Alsworth,
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1107 Hermann Prof. Bldg., Houston.
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1106 Hermann Prof. Bldg., Houston.
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Caplovitz, Harry,
1207 Eagle, Houston.
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1613 Medical Arts Bldg., Houston.
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Cato, Dorothy A.,
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1304 Walker, Houston
Cody, C. C., III,
1304 Walker, Houston.
Cody, Melville L.,
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Cogburn, Charles C.,
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Cohen, Raymond,
2304 Caroline, Houston.
Cole, Wm. Frank,
2255 W. Holcombe, Houston.
Collette, Allan,
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Collier, James L.,
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Collins, Lois C.,
1200 M. D. Anderson Blvd., Houston.
*Collins, Vincent P.,
1200 M. D. Anderson Blvd., Houston.
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*Connor, Edwin E.,
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*Connor, W. Harris,
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Conte, Raphael J.,
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Cook, Thos E. (In.),
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Cooley, Denton A.,
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Cooper, Jack C.,
2204 Baldwin, Houston.
*Cope, R. Louis,
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Corbett, Louis B.,
3507 Crawford, Houston.
Coulter, W. W., Sr.,
1215 Walker, Houston.
Cowart, Edmund M.,
10 Chelsea Blvd., Houston.
Cowart, O. Hiram.
103 S. Munger, Pasadena.
Cox, DeWitt W., Jr.,
1527 Cheshire, Houston.
Cox, James F., Jr.,
8518 Jensen Drive, Houston.
Cox, John K. (In.),
7 Wooster-Cedar Bayou Rd., Baytown.
Cox, Joseph H.,
617 Tarar, Pasadena.
Crain, Edward L., Jr.,
1005 Hermann Prof. Bldg., Houston.
Crain, Lovell B.,
106 Hermann Prof. Bldg., Houston.
Crank, H. Harlan,
3902 Montrose Blvd., Houston.
Crapitto, Louis A.,
610 Medical Arts Bldg., Houston.
Crawford, Elizabeth S.,
1107 Hermann Prof. Bldg., Houston.
Crigler, Cecil M.,
1504 Hermann Prof. Bldg., Houston.
*Crocker, Edward S.,
2121 San Jacinto, Houston.
*Cromwell, H. A.,
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Cronin, Thomas D.,
6410 Fannin, Houston.
Crossman, Lyman W.,
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Crow, Howard G.,
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Crow, Louise C.,
3843 Aberdeen Way, Houston.
*Cruce, Wm. V., (Mil.)
Cruse, Ray (Mil.)
Cull, Herbert G.,
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Cullen, Aubrey P., Jr.,
4710 Lillian, Houston.
Cullick, Louis,
737 S. 75th, Houston.
*Cummings, Hatch W., Jr.,
203 Hermann Prof. Bldg., Houston.
Cunningham, G. N.,
1033 Mellie Esperson Bldg., Houston.
*Curb, Dolph L.,
3755 Merrick, Houston.
Curbo, James R.,
3820 Fannin, Houston.
Cuttin, James G.,
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Daeschner, Chas. W., Jr.,
Baylor Medical School, Houston.
Dailey, James E.,
4109 Montrose Blvd., Houston.
Daily, Herschel,
4552 Holmes Rd., Houston.
*Daily, Louis, Jr.,
Medical Arts Bldg., Houston.
Daily, Ray K.,
1117 Medical Arts Bldg., Houston.
Dale, Sebron C.,
6723 Bertner Blvd., Houston.
Darden, Paul M.,
203 S. Munger Blvd., Pasadena.
Dargan, Joseph L.,
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Dashiell, Albert M.,
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*Daughety, Jewel D.,
109 Allendale, Bellaire.
David, Solomon D.,
911 Medical Arts Bldg., Houston.
Davidson, Thos. H.,
708 Garden Oaks Blvd., Houston.
Davis, Avolin R. (In.),
Hermann Hospital, Houston.
Davis, Charles Q.,
2407 N. Main., Houston.
Davis, Cornelius C.,
4205 Leeland, Houston.
Davis, Earl D.,
2255 W. Holcombe, Houston.

MEMBERSHIP LIST, 1954—*continued*

Davis, Glenn E.,
5501 Richmond, Bellaire.
Davis, Hamlet I., 9 N. Ashbel, Baytown.
Davis, Rufus C., Jr.,
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Dawes, Raymond (Hon.),
206 Hutcheson St., Houston.
Dawson, Donald C.,
906 E. Southmore, Pasadena.
*Day, George P.,
1011 Medical Arts Bldg., Houston.
Day, William K. (In.),
4220 Byron St., Houston.
Deaton, David Grady, Galena Park.
DeBakey, Michael E.,
1200 M. D. Anderson Blvd., Houston.
*Denman, Frank R.,
5208 Caroline, Houston.
Denman, Peyton R. (Hon.),
5208 Caroline, Houston.
DeVore, Marion S.,
8777 Katy, Houston.
DeVore, Neal M.,
1215 Walker, Houston.
*DeYoung, Richard,
629 Med. Arts Bldg., Houston.
Diamond, Max M., 919 Maple, Pasadena.
Dickson, J. Chas.,
903 Hermann Prof. Bldg., Houston.
Dinges, Malcolm D., Jr. (Mil.).
*Dippel, A. Louis,
309 Hermann Prof. Bldg., Houston.
Dittman, Hyman,
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Geringer, Benjamin,
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215 Milby, Houston.
Giessel, Lotta,
215 Milby, Houston.
Giessel, Wm. U.,
215 Milby, Houston.
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217 Hermann Prof. Bldg., Houston.
Glantzberg, Herman,
403 Herman Prof. Bldg., Houston.
Glass, Willard G.,
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728 Medical Arts Bldg., Houston.
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1914 Travis, Houston.
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1039 Mellie Esperson Bldg., Houston.
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1407 N. Shepherd Dr., Houston.
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Harris, Clarence P.,
1103 Medical Arts Bldg., Houston.
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*Lowe, Percy E.,
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Lumis, Fred R.,
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Maresh, Henry R.,
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Maresh, Rudolph E.,
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Mathis, Robt. L. (Mil.).
Mayes, Lee P.,
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5000 Montrose Blvd., Houston.
Mendell, Jack L.,
5000 Montrose Blvd., Houston.
Merrill, Samuel J. (In.),
4928 Spruce St., Bellaire.
Merriman, Geo. J.,
P. O. Box 14464, Houston.
Messer, Jesse N.,
Medical Arts Bldg., Houston.
Meyer, Henry S.,
1203 Cleburne, Houston.
Meynier, Maurice J., Jr.,
1601 Calhoun, Houston.
Miles, John M.,
3012 Market St. Rd., Baytown.
Miller, Arthur L.,
1245 Yale, Houston.
Miller, G. Maxwell, La Porte.
Miller, George V.,
Hermann Hospital, Houston.
Miller, Howard E. (Mil.).
Miller, Sam L.,
508 Hermann Prof. Bldg., Houston.
Milligan, John J.,
10 Chelsea Blvd., Houston.
Mintz, A. Aaron, (Mil.).
Mitchell, A. Lane,
3820 Fannin, Houston.
Mitchell, Donald D.,
5204 Spruce St., Bellaire.
Mock, Presley J., La Porte.
Moers, Robt. O.,
1325 Medical Arts Bldg., Houston.
Mohle, Flavius D.,
3902 Montrose Blvd., Houston.
Moise, Leonard D.,
509 Indiana, Houston.
Molloy, James P., Jr.,
1516 Medical Arts Bldg., Houston.
Monroe, Myrick L., 211 S. Main, Pasadena.
Montgomery, Chas. F.,
301 Medical Arts Bldg., Houston.
Moody, Irving W.,
2418 Travis, Houston.
Moore, Duncan L.,
300 Hermann Prof. Bldg., Houston.
Moore, Geo. L.,
5501 Old Richmond Rd., Bellaire.
Moore, Jack,
405 Hermann Prof. Bldg., Houston.
Moore, Thos. O., Jr.,
1502 Hermann Prof. Bldg., Houston.
Moorhead, Wm. H.,
5000 Montrose Blvd., Houston.
Moorman, Jesse A., Jr.,
1234 Sheffield Blvd., Houston.
Morgan, Ray M., Jr.,
1202 Hermann Prof. Bldg., Houston.
Morris, Geo. C., Jr., (In.),
4530 Oakshire, Houston.
Morrison, J. Winston,
4528 Griggs Rd., Houston.
Morrow, Edwin J.,
1603 Medical Arts Bldg., Houston.
Morse, Walter S.,
3411 Montrose Blvd., Houston.
Mounce, Stanley H. (Mil.).
*Moursund, W. H. (Emer.),
5625 Jackson, Houston.
Muetz, Walter,
5600 Telephone Rd., Houston.
Myers, Claude D.,
518 Medical Arts Bldg., Houston.
Nance, Jno. O.,
325 W. 20th St., Houston.
Nesselrode, John E.,
3301 Market St., Baytown.
Newton, Berne L.,
Baylor Medical College, Houston.
Nichols, John W. (Mil.).
Nicosia, Ralph V.,
805 Westheimer, Houston.
Norris, Ronald F., (Mil.).
O'Donnell, William W. (In.),
Jefferson Davis Hosp., Houston.
O'Heeron, Michael K.,
901 Medical Arts Bldg., Houston.
Ohlhausen, S. G.,
2710 Renshaw, Houston.
Oldham, Dudley Y.,
1207 Hermann Prof. Bldg., Houston.
*Oliver, J. Stanley,
7444 Harrisburg Blvd., Houston.
Oliver, John T.,
7444 Harrisburg Blvd., Houston.
Oliver, William D., Galena Park.
*Olson, Stanley W.,
1200 M. D. Anderson Blvd., Houston.
O'Neal, Kermit C.,
5701 Jackson, Houston.
Orman, McDonald,
Medical Arts Bldg., Houston.
Orr, Guy H.,
7236 Staffordshire, Houston.
Ory, Edwin M., (Mil.).
Osborne, Clarence F., Box 769, Pasadena.
Overstreet, John W.,
210 Med. Arts Bldg., Houston.
Overton, Robt. C., Jr., (In.),
2002 Holcombe, Houston.
*Owen, A. George,
1805 Banks, Houston.
Owens, John B.,
613 Harold, Houston.
Owsley, William C., Jr.,
Hermann Hosp., Houston.
Page, Jos. Herbert,
5517 Crawford, Houston.
*Palm, William M.,
1625 Main, Houston.
Pannill, F. C., Jr.,
1200 M. D. Anderson Blvd., Houston.
Panzarella, Carlo J., Humble.
Park, David R.,
Hermann Hosp., Houston.
Park, James H., Jr.,
4010 Montrose, Houston.

MEMBERSHIP LIST, 1954—*continued*

Parker, George E.,
4115 Caroline, Houston.
Parr, Luther H.,
825 Med. Arts Bldg., Houston.
Parrish, Frank F.,
507 Hermann Prof. Bldg., Houston.
Paton, Donald M.,
4611 Caroline, Houston.
Patrick, Ralph C.,
908 Medical Arts Bldg., Houston.
Patterson, Robt. T.,
1503 Tuam, Houston.
Patteson, James L.,
4936 Fulton, Houston.
Pawelek, I. L.,
222 Medical Arts Bldg., Houston.
Pawelek, Louis G.,
222 Medical Arts Bldg., Houston.
Peck, T. T., Jr., 1921 W. Main, Baytown.
Perdue, George W.,
1426 Medical Arts Bldg., Houston.
Peek, John S., 10405 Palestine St., Houston.
Perry, John L., Jr., (In.),
M. D. Anderson Hosp., Houston.
Peters, I. D.,
202 Hermann Prof. Bldg., Houston.
Petersen, Henry A.,
820 Medical Arts Bldg., Houston.
Peterson, Carl A.,
4710 Lillian, Houston.
Petri, Karen Aileen,
4119 Montrose Blvd., Houston.
Petway, Aileen,
3302 Cloverdale, Houston.
Petway, Max E.,
8710 Humble Rd., Houston.
Pfeiffer, Eva-Marie,
2905 LaBranch, Houston.
Phelps, Kenton R.,
1108 Hermann Prof. Bldg., Houston.
Phillips, Elliott S.,
1803 Crawford, Houston.
Phillips, John R.,
Medical Arts Bldg., Houston.
Phillips, Leon,
1902 Blodgett, Houston.
Phipps, John,
8262 Park Place Blvd., Houston.
Pipkin, Robt. W.,
Box 3663, Baytown.
Pittman, James E.,
312 Hermann Prof. Bldg., Houston.
Pollard, Claude, Jr.,
411 Hermann Prof. Bldg., Houston.
Pope, James W.,
1401 Hermann Prof. Bldg., Houston.
Porter, John T.,
721 East Texas Ave., Baytown.
Potts, Charles R.,
1304 Walker, Houston.
Powell, Elizabeth B.,
3002 San Felipe Rd., Houston.
Powell, Norborne B.,
801 Hermann Prof. Bldg., Houston.
Poyner, Herbert F.,
1014 Medical Arts Bldg. Houston.
Pratt, Helen L.,
302 S. 7th St., Bellaire.
Pratt, Willard M.,
918 Lovett, Houston.
Price, William P.,
1009 W. Main, Houston.
*Prince, Homer E.,
808 Caroline, Houston.
Pritchett, I. E. (Hon.), Angleton.
Pronin, Arthur,
5307 Cavalcade, Houston.
Pruitt, George J. (In.),
Hermann Hosp, Houston.
Pugsley, Cornelius, Jr.,
807 Hermann Prof. Bldg., Houston.
Pulliam, Lawrence T.,
Medical Arts Bldg., Houston.
Qualtrough, Walter F.,
4716 Montrose Blvd., Houston.
Queen, Dan M.,
1200 M. D. Anderson Blvd., Houston.
Radcliffe, Glen J.,
3334 Palm St., Houston.
Radding, Robt. S.,
702-A Hermann Prof. Bldg., Houston.
Rader, John F.,
7444 Harrisburg Blvd., Houston.
*Ramsay, William E.,
4705 Montrose, Houston.
Rape, Marvin G.,
915 Medical Arts Bldg., Houston.
Raymer, Warren J., (Mil.).
Red, William S., Jr.,
2918 Caroline, Houston.
Rednick, Meyer S.,
104 E. 20th, Houston.
*Reece, Charles D., (Pres.),
1402 Hermann Prof. Bldg., Houston.
Reinke, Robt. T. (In.),
Jefferson Davis Hospital, Houston.
*Renfrow, W. Frank,
1302 Medical Arts Bldg., Houston.
*Richardson, Joe B.,
Medical Arts Bldg., Houston.
Richeson, Rae A.,
1106 Hermann Prof. Bldg., Houston.
Ried, Hubert L.,
4006 Montrose Blvd., Houston.
Rivers, Franklin M.,
4705 Montrose Blvd., Houston.
Robbins, E. Freeman,
1112 Eagle, Houston.
Robertson, Robt. C. L.,
411 Hermann Prof. Bldg., Houston.
Robey, Grace Lucile,
603 Hermann Prof. Bldg., Houston.
*Robinett, James B., Jr.,
3434 Norris, Houston.
Robins, Bill,
1010 Union Nat. Bank Bldg., Houston.
Robinson, Fred W.,
529 Med. Arts Bldg., Houston.
*Robinson, Hampton C.,
109 Hermann Prof. Bldg., Houston.
Robinson, W. Tryon,
920 Westheimer, Houston.
Robison, J. M.,
1304 Walker, Houston.
Rodgers. Lawrence R.,
5000 Montrose Blvd., Houston.
Rogers, Stanley F.,
5124 Old Richmond Rd., Bellaire.
Rohrer, Geo. E.,
1502 Medical Arts Bldg., Houston.
Rollins, Wiley J.,
1217 Calhoun, Houston.
*Rose, Jack M.,
215 Hermann Prof. Bldg., Houston.
Rosenblatt, Henry D.,
1401 Medical Arts Bldg., Houston.
*Rothenberg, Lionel H.,
4528 Griggs Road, Houston.
Roy, Harry L., Jr., (In.),
2002 Holcombe Blvd., Houston.
*Royce, Thos. L.,
402 Hermann Prof. Bldg., Houston.
Ruiz, John J.,
7919 Park Place Blvd., Houston.
Rumph, Quah,
Medical Arts Bldg., Houston.
Rushing, John B.,
1613 Medical Arts Bldg., Houston.
Russell, Thos. G.,
1215 Walker, Houston.
Russell, Wm. O.,
2310 Baldwin, Houston.
Rutledge, Felix N., Jr.,
4828 Caroline, Houston.
Ryan, Bert M.,
1048 Cruse Dr., Pasadena.
Sacco, Allan C.,
1102 Elgin at Fannin, Houston.
Salerno, Joseph P.,
1717 La Branch, Houston.
*Salinger, Alfons,
2212 Calumet Dr., Houston.
Salmeron, Pedro, Jr.,
2502 Canal, Houston.
Salmon, George W.,
3911 Montrose Blvd., Houston.
Salyer, Charles P.,
2815 Reid, Houston.
Sammons, James H., Highlands.
Sammons, Karl T., Highlands.
Sanders, Chas. B.,
1526 Medical Arts Bldg., Houston.
Sanders, Elmer K.,
1002 Hermann Prof. Bldg., Houston.
Sanders, Zal H.,
1300 Telephone Rd., Houston.
Sanderson, Thos. A.,
2320 Southgate, Houston.
Sappington, H. O.,
Box 4128, Baytown.
Scardino, Peter H. (Hon.),
4520 Rossmoyne, Houston.
Schaffer, Elliott N.,
1208 Wayside, Houston.
Schaffer, Helen G., 2905 La Branch, Houston.
Schaffer, Randolph L.,
3102 San Jacinto. Houston.
Schaffer, Samuel S.,
2905 La Branch, Houston.
Schaffner, Harold B.,
3102 San Jacinto, Houston.
Scher, David,
216 Med. Arts Bldg., Houston.
Scheurich, Richard E.,
105 East Texas Ave., Baytown.
Schnur, Howard L.,
5610 H. M. C. St., Houston.
Schnur, Roxana R.,
2002 Holcombe Blvd., Houston.
Schnur, Sidney,
Medical Arts Bldg., Houston.
Schoenvogel, Otto F., Jr.,
1207 Hermann Prof. Bldg., Houston.
Schrum, David I.,
5101 Fannin, Houston.
Schuhmacher, L. F., Jr.,
Hermann Hospital, Houston.
*Schultz, Jacob F.,
1304 Walker, Houston.
Schwartz, Harold R.,
2300 Caroline, Houston.
Schwartz, Max J.,
1204 Wayside, Houston.
Scott, Daniel W.,
1818 Crawford, Houston.
*Seale, Everett R.,
1017 Medical Arts Bldg., Houston.
Sears, Ernest S.,
346 W. 19th, Houston.
Secor, Harold E. (In.),
Methodist Hosp., Houston.
Selders, Raymond E.,
1051 Mellie Esperson Bldg., Houston.
Selke, Oscar O., Jr.,
Hermann Hospital, Houston.
Sengelmann, W. A.,
317 Medical Arts Bldg., Houston.
*Seybold, Wm. D.,
Hermann Prof. Bldg., Houston.
Sharp, William E.,
721 East Texas, Baytown.
Shaw, Edward N.,
1401 Eagle, Houston.
Shearer, Thos. P.,
411 Hermann Prof. Bldg., Houston.
Shelton, Elvin L., Jr.,
Hermann Prof. Bldg., Houston.
Sher, Malcolm F.,
Medical Arts Bldg., Houston.
Sherrill, Douglas B.,
617 Tatar, Pasadena.
Sherrill, E. A., Jr.,
3102 San Jacinto, Houston.
Sherrill, Lloyd H.,
3102 San Jacinto, Houston.
*Sherrill, Wm. M.,
242 S. Post Oak Lane, Houston.
Shindler, Thos. O.,
605 Hermann Prof. Bldg., Houston.
Shirley, Carl W.,
429 Medical Arts Bldg., Houston.
Shoemaker, Roger D.,
325 W. 20th St., Houston.
Shrader, Harold E.,
617 Tatar, Pasadena.
Shullenberger, C. C.,
304 Hermann Prof. Bldg., Houston.
Siegel, Jacob,
7320 Long Point Rd., Houston.
Silverman, Robert A.,
1603 Lorraine, Houston.
Sinclair, Marga H.,
1107 Hermann Prof. Bldg., Houston.
Sinclair, Thos. A.,
410 W. 20th St., Houston.
Singleton, Edward B.,
6621 Fannin St., Houston.
Skaggs, Ray H.,
107 Hermann Prof. Bldg., Houston.
*Skelton, James M.,
4001 Westheimer, Houston.
Skogland, John E.,
521 Medical Arts Bldg., Houston.
*Slataper, Eugene L.,
3702 Turnberry Circle, Houston.
Slataper, Felician J., (Hon.),
1110 Medical Arts Bldg., Houston.
Slaughter, Carlos A., Sugar Land.
*Smith, Benjamin F.,
1704 Crawford, Houston.
Smith, Burt B.,
1008 Hermann Prof. Bldg., Houston.
Smith, Clifford T.,
Medical Arts Bldg., Houston.
*Smith, Edward T.,
906 Hermann Prof. Bldg., Houston.
Smith, Harry S.,
4115 Fannin, Houston.
Smith, Jackson A.,
1020 Holcombe Blvd., Houston.
Smith, J. Murry,
Medical Arts Bldg., Houston.
Smith, Mary Louise,
2202 Arbor St., Houston.
Smolens, Nathan M.,
3012 Market St., Baytown.
Snow, William J.,
718 Medical Arts Bldg., Houston.
Snyder, Hal, 1135 West Gray, Houston.
*Snyder, Harvey B.,
1801 Buffalo Dr., Houston.

MEMBERSHIP LIST, 1954—*continued*

Snyder, John T.,
Box 708, Channelview.
Sonenthal, I. Ronald,
1200 Bissonnet, Houston.
Spankus, Willerd H.,
706 Garden Oaks Blvd., Houston.
Speck, Carlos D., Jr.,
3709 Montrose Blvd., Houston.
Spence, Philip S., Jr.,
1039 Esperson Bldg., Houston.
Spencer, Walter C. E.,
1316 Medical Arts Bldg., Houston.
Spencer, William A.,
1801 Buffalo Dr., Houston.
Spezia, Joseph L., 1102 Elgin, Houston.
Spiller, John B.,
Baylor Univ. College of Med., Houston.
Spiller, Wm. F., Jr.,
5000 Montrose, Houston.
Spurlock, George H. (Hon.),
3240 Del Monte, Houston.
*Spurr, Charles L.,
2002 Holcombe Blvd., Houston.
Stackhouse, Howard, Jr.,
1222 Medical Arts Bldg., Houston.
*Stalnaker, Paul R. (Hon.),
4715 Fannin, Houston.
Stanford, John P., Jr., (In.),
4126 Woodhaven, Houston.
Staub, John D. (In.),
2418 Travis, Houston.
Stent, Paul A.,
4208 Ella Blvd., Houston.
Stephens, Mollie Marie,
307 East Shaw, Pasadena.
Sterling, Russell R., 802 Travis, Houston.
Stevenson, Murphy D.,
807 Hermann Prof. Bldg., Houston.
Stone, Francis E.,
Medical Arts Bldg., Houston.
Stool, Joseph A., 3718 Travis, Houston.
Stork, Walter J., 1117 E. Alabama, Houston.
Stough, John T., 4501 Fannin, Houston.
Strashun, Mat F.,
1500 Hermann Prof. Bldg., Houston.
Strassmann, Erwin O.,
1405 Hermann Prof. Bldg., Houston.
Straw, Kenneth,
7444 Harrisburg, Houston.
Stringer, Chas F., 300 S. 7th St., Bellaire.
Stuermer, Cassie E.,
1324 Federal Rd., Houston.
Surgi, Marie L., 3709 Montrose, Houston.
Sweatingen, Robt E. (In.),
Hermann Hosp., Houston.
Synnott, James D., 1917 Ashland, Houston.
Synnott, Thos. G., 1917 Ashland, Houston.
Tackaberry, A. L. W. (Hon.),
2407 N. Main, Houston.
Talley, A. T., Jr.,
1307 Medical Arts Bldg., Houston.
*Talley, A. T., Sr. (Hon.),
Medical Arts Bldg., Houston.
Talley, Elizabeth D.,
1354 Sue Barnett Dr., Houston.
Talty, Matthew H., Jr.,
1601 Calhoun, Houston.
Tashnek, Arthur B.,
4545 Griggs Rd., Houston.
Tatar, Mervin (Mil.).
Tausend, Harold J., 5012 Travis, Houston.
Tausend, Paul L., 211 S. Main, Pasadena.
Taylor, Fred M.,
Baylor Medical College, Houston.
Taylor, Homer A., Jr.,
1302 Medical Arts Bldg., Houston.
Taylor, Holman, Jr.,
1505 Hermann Prof. Bldg., Houston.
Thoma, Earl W.,
Medical Arts Bldg., Houston.
Thomas, Albert M.,
825 Medical Arts Bldg., Houston.
*Thomas, Fred P.,
Hermann Hospital, Houston.
Thomas, George B.,
5000 Montrose Blvd., Houston.
Thomas, John R.,
Baylor Med. College, Houston.
Thomas, Stephen,
204 Hermann Prof. Bldg., Houston.
Thomason, Edgar M.,
104 E. 20th, Houston.
Thompson, B. D.,
2004 River Oaks Blvd., Houston.
Thompson, Walker,
3902 Montrose Blvd., Houston.
*Thorn, S. Wesley,
1406 Hermann Prof. Bldg., Houston.
Thorning, W. B., Jr.,
1625 Main, Houston.
Tips, Eugene,
3701 Montrose Blvd., Houston.
Torno, Curtis J. (Mil.).
*Trible, John B.,
1625 Medical Arts Bldg., Houston.
Truitt, James J.,
805 Esperson Bldg., Houston.
Tucker, Eli J.,
610 Medical Arts Bldg., Houston.
Tucker, J. Norris.
526 Medical Arts Bldg., Houston.
*Tucker, Sheldon M.,
104 E. 20th, Houston.
Turboff, Sidney Wm.,
1603 Lorraine, Houston.
Turner, B. Weems,
4705 Montrose Blvd., Houston.
Turner, C. Gary,
1422 Medical Arts Bldg., Houston.
Tutner, Russell L., Jr. (In.),
2002 Holcombe Blvd., Houston.
Tusa, Theo. S.,
Esperson Bldg., Houston.
Tusa, Theo S., Jr. (In.),
2802 Westheimer Rd., Houston.
Tuttle, L. L. D.,
1407 Hermann Prof. Bldg., Houston.
Tyner, Furman H.,
704 Medical Arts Bldg., Houston.
Ulert, Izack A.,
3304 Milam, Houston.
Usher, Francis C.,
701 Hermann Prof. Bldg., Houston.
Vanden Bossche, L. J.,
104 East 20th, Houston.
Vanzant, B. T. (Hon.),
2346 N. McGregor, Houston.
*Vanzant, Thos J.,
1403 Hermann Prof. Bldg., Houston.
Vaughan, Luther M.,
Hermann Hospital, Houston.
Veatch, Everett P.,
211 S. Main, Pasadena.
Vick, J. Louise,
4115 Caroline, Houston.
Viehweg, Wayne R.,
222 Medical Arts Bldg., Houston.
Vincent, Terry S., 2012 Crawford, Houston.
Vlahakos, Antonio B.,
211 S. Main, Pasadena.
vonPohle, Kenneth C.,
1010 Banks, Houston.
Wachsman, David V., 1319 Austin, Houston.
Wagner, E. Lionel,
4109 Montrose Blvd., Houston.
Wagner, Robert G.,
2039 Dryden Rd., Houston.
Wahlen, Henry E.,
3758 N. Shepherd, Houston.
Waites, Lucius, Jr. (Mil.).
*Waldron, George W.,
704 Hermann Prof. Bldg., Houston.
Walker, Joseph D.,
3618 Fannin, Houston.
Wall, John A.,
405 Hermann Prof. Bldg., Houston.
*Wallace, Stuart A.,
1200 M. D. Anderson Blvd., Houston.
Wallis, Marshall (Hon.), La Feria.
Wallis, Wm. M. (Sec'y.), 918 Union
National Bank Bldg., Houston.
Walpole, Ben, 3101 Fannin, Houston.
Walter, Paul J.,
304 Hermann Prof. Bldg., Houston.
Warner, Clyde M.,
207 Medical Arts Bldg., Houston.
Warner, Lucien M.,
1418 McGowen, Houston.
Watson, James E., Jr.,
1406 Hermann Prof. Bldg., Houston.
Watson, Thos. D., Jr. (In.),
2002 Holcombe Blvd., Houston.
Weil, Sol B., Jr.,
2246 Dryden Road, Houston.
Weisiger, Ross W.,
3403 Montrose Blvd., Houston.
*Welsh, Hugh C., 2715 Fannin, Houston.
*West, Joseph E., Jr.,
7338 McHenry, Houston.
Westmoreland, James P. (Hon.),
1704 Crawford, Houston.
Westover, H. M. (Hon.),
8910 Humble Rd., Houston.
Westphal, Corinne,
5403 Kirby Dr., Houston.
Wexler, Alvin S.,
6303 S. Park Blvd., Houston.
White, Adair W., Jr.,
3201 Weslayan, Houston.
White, Edgar C.,
M. D. Anderson Hospital, Houston.
White, Roland L. (Mil.).
Whitehurst, James R.,
605 Hermann Prof. Bldg., Houston.
Whitsitt, James J.,
1015 Niels Esperson Bldg., Houston.
*Whitson, Robert O.,
608 W. DeFee, Baytown.
Wible, D. Jordan, 3304 Milam, Houston.
Wiesenthal, Joseph, 200 Wayside, Houston.
*Wigby, Palmer E.,
506 Hermann Prof. Bldg., Houston.
Wilkerson, Bernie J., 705 Main, Houston.
Wilkerson, Edward A., 1320 Eagle, Houston.
Wilkin, Mabel G., 3902 Montrose, Houston.
Williams, Bryan V.,
7338 McHenry, Houston.
Williams, Edward C.,
4704 Montrose Blvd., Houston.
Williford, Louis E. (dead).
Wills, Seward H.,
405 Hermann Prof. Bldg., Houston.
Wilson, Arnold, 906 E. Southmore, Pasadena.
Wilson, Carl S., 1512 W. Alabama, Houston.
Windrow, Frank M.,
1205 Hermann Prof. Bldg., Houston.
Windrow, Nuel C., Jr.,
6328 West Chester, Houston.
Winograd, Eugene,
1214 W. 43rd St., Houston.
Wise, Robert A., P. O. Box 2180, Houston.
Wise, Robert J.,
701 Hermann Prof. Bldg., Houston.
Withers, Ben T.,
902 Hermann Prof. Bldg., Houston.
Withers, Henry W.,
3102 San Jacinto, Houston.
Wolf, E. Trowbridge, 4411 Fannin, Houston.
Wolters, Carlton E.,
1207 Hermann Prof. Bldg., Houston.
Wood, Harold,
1200 M. D. Anderson Blvd., Houston.
Wood, Harold A.,
Deaton Hosp., Galena Park.
*Wootters, John H.,
1008 Hermann Prof. Bldg., Houston.
Wright, Ernest, 2407 N. Main, Houston.
*Wright, Wm. K.,
Hermann Prof. Bldg., Houston.
Yaege, Arlo O. (Mil.).
*Yates, Charles W.,
613 Medical Arts Bldg., Houston.
Yates, William H. (In.),
V. A. Hosp., Houston.
*York, Byron P.,
3911 Montrose Blvd., Houston
Young, Alma L.,
1707 Crawford St., Houston.
Young, Carl B.,
Union Natl. Bank Bldg., Houston.
Young, John B. (In.),
3827 Bellaire Blvd., Houston.
Youngblood, Jarvis C.,
3011 Ellalee Lane, Houston.
Younkin, Chas. R.,
5103 Cedar, Bellaire.
Yow, Ellard M.,
Baylor College of Medicine, Houston.
Zanek, Otto L., Esperson Bldg., Houston.
Zarr, L. Lynn, 414 W. 20th St., Houston.
Zax, Emile, Medical Arts Bldg., Houston.
Zeis, Leander B.,
1213 Medical Ats Bldg, Houston.
Zeluff, Geo. W.,
703 Hermann Prof. Bldg., Houston.
Zepeda, Rudolf F.,
4030 Roseneath, Houston.
Zionts. Martin A.,
3507 Louisiana, Houston.

MONTGOMERY

Anderson, Edgar W., Conroe.
Bell, Henry G., Conroe.
Carroll, I. Emil, Conroe.
Holland, Wm. M., Conroe.
*Hutchins, Melvin G. (Sec'y), Conroe.
Lenon, EE, Conroe.
Phillips, Paul G., Conroe.
Sadler, Deane L., Conroe.
Wilkins, Afton N. (Pres.), Conroe.

POLK-SAN JACINTO

Connell, Anna Beth, Corrigan.
Corso, John, Livingston.
*Dabney, Joseph T., Jr., Livingston.
Dameron, J. H., Livingston.
Flowers, William W., Livingston.
Gardner, Thomas L., Livingston.
Grimes, Ivison (Pres.), Camden.
Hale, Douglas M., Coldspring.
Murphy, Clarence S., Livingston.
Olive, Roy A., Livingston.
Singleton. Paul C. A. (Sec'y), Corrigan.
Wall, Herman A., Jr. (Mil.).

MEMBERSHIP LIST, 1954—*continued*

WALKER-MADISON-TRINITY

Autrey, Stacy L., Trinity.
Barnes, Sam R., Trinity.
Blalock, Raymond B., Huntsville.
Cole, Thomas C., Huntsville.
Goodrich, Wm. A., Sr., Huntsville.
Hanson, Minter D. Huntsville.
Heath, Jesse B. (Sec'y), Madisonville.
*McKay, James A., Madisonville.
Reed, James E., Jr. (Pres.), Madisonville.
*Veazey, William B., Huntsville.
Woodward, Walter Mac, Huntsville.

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Dodd, Tilman E., 3303 Hillview Rd., Austin.
Giddings, Thos. (Pres.), Brenham.
*Hasskarl, Robert A., Brenham.
Hasskarl, Walter F., Jr. (Mil.).
Hasskarl, Walter F., Sr., Brenham.
Hodde, Fred H., Brenham.
Hodde, Herman O., Brenham.
Knolle, Roger E., Brenham.
Knolle, Waldo A., Brenham.
*Pazdral, George V., Somerville.
Roach, Thomas S., Caldwell.
Schoenvogel, C. W. (Mil.).
Schoenvogel, Otto F., Brenham.
Siptak, John E., Caldwell.
Smith, Joe C., Caldwell.
Southern, Charles E. (Sec'y), Brenham.
Steinbach, Herbert L., Brenham.
Tottenham, Edwin P., Brenham.

TENTH DISTRICT

Dr. L. C. Heare, Port Arthur, Councilor

ANGELINA

*Arnett, Robert K., Lufkin.
Clement, J. Carroll, Lufkin.
Clements, Peyton C., Lufkin.
Denman, Byford H., Lufkin.
*Denman, Linwood H., Lufkin.
Estep, Marshall A., Lufkin.
Evans, Charles W., Jr., Lufkin.
Hyman, Bernard, Lufkin.
Klein, James C., Lufkin.
Koch, John C., Lufkin.
Martin, Juan E., Lufkin.
McVicker, Bobby H., Lufkin.
*Medford, U. Gail (Pres.), Lufkin.
Mitchell, William A., Lufkin.
*Orman, Forrest C. (Sec'y), Lufkin.
Peebles, Felix, Jr., Lufkin.
Rice, Lee Roy, Diboll.
*Shepard, Groom S., Lufkin.
Spivey, Dan, Lufkin.
*Taylor, Robert W., Lufkin.
Thames, William D. (Mil.).
Tinkle, Lassiter T., Lufkin.
Wade, Jack H., Lufkin.

HARDIN-TYLER

*Barclay, Watt, Woodville.
Burton, L. Gayle, Woodville.
Gauntt, Eugenia T., Kountze.
Gilchrist, John Q., Woodville.
Parker, Wade M., Silsbee.
Poshataske, W. J., Silsbee.
Rumelt, Allen, Beaumont.
Ryan, Robert L., Sour Lake.
Tate, John H. (Pres.), Kountze.
Tate, Robert A., Kountze.
Tennison, Geo. D. (Sec'y), Silsbee.

JASPER-NEWTON

Dickerson, Joe W., Jasper.
Graham, Gideon, Newton.
Hall, Henry S., Newton.
Jones, Tom R., Pineland.
*Lloyd, R. S., 2205 Bridle Path, Austin.
McCall, John W., Jr., Jasper.
*McCreight, W. F., Kirbyville.
McGrath, J. J., Jasper.
Moore, John T., Kirbyville.
Richardson, A. J., Jr., Jasper.
Richardson, A. J., Sr., Jasper.
Sanders, Wm. S., Jasper.
Stockdale, Rider E., Jr. (Secy), Jasper.
Whitecloud, Thos. S., Newton.
Wilcox, Louise N., Newton.
Worthey, Wm. R., Call.

JEFFERSON

Adams, Robt. M., Groves.
Adkins, Chas. F. (Mil.).
Alexander, Hugh E., 2372 Calder, Beaumont.
Allamon, Emmett L.,
456 1st Fed. Bldg., Beaumont.
Allison, F. Peel, Hotel Beaumont, Beaumont.
Anderson, Roland B.,
2749 Proctor St., Port Arthur.
Bailey, Percy W., Jr.,
675 Fifth St., Beaumont.
Barr, H. Buford,
501 Perlstein Bldg., Beaumont.
Barr, Richard E., 2425 Long Ave., Beaumont.
Bebeau, Eugene R., 1195 East Dr., Beaumont.
*Bevil, H. Grady,
514 Am. Natl. Bank Bldg., Beaumont.
Bevil, Harold H., 2630 Laurel, Beaumont.
Bevil, Lamar C., 2625 Laurel, Beaumont.
Beyt, Frank J., 235 Adams Bldg., Port Arthur.
Blum, Sigmund L., 573 Pearl St., Beaumont.
Boyle, Frank B., 2248 Proctor, Port Arthur.
Brandau, W. H.,
703 American Natl. Bk. Bldg., Beaumont.
Brown, Walter D. (Hon.),
2262 North St., Beaumont.
Browne, Robert S., Adams Bldg., Port Arthur.
Brownrigg, Thos. H.,
1485 Calder, Beaumont.
Bybee, Joe A., 1200 Broadway, Beaumont.
Byram, Dan H. (Pres.),
2600 Proctor, Port Arthur.
Byrd, Houston F., Port Neches.
Byrd, Lee Roy, Jr.,
Gulf Oil Corp., Box 701, Port Arthur.
Caldwell, Pearson C.,
809 Goodhue Bldg., Beaumont.
Carabelle, R. Wm., 2649 Proctor, Port Arthur.
Carter, John H.,
460 1st Fed. Savings Bldg., Beaumont.
*Carter, Louian C., 2600 Proctor, Port Arthur.
Catalano, Russell J.,
502 Goodhue Bldg., Beaumont.
Chiasson, John L. (Hon.), Port Neches.
Chiasson, Mary P.,
261 E. Circuit Dr. Beaumont.
Christie, Alonzo B., Jr.,
Gulf Oil Corp., Port Arthur.
Chunn, B. D., 1200 Broadway, Beaumont.
Cochran, E. Winston, 675 5th, Beaumont.
Colby, Fred W. C., 2380 Hazel, Beaumont.
Colletti, Ben M.,
2401 Thomas Blvd., Port Arthur.
Couch, Ray E., P. O. Box 1059, Port Arthur.
*Crager, Jay C., Goodhue Bldg., Beaumont.
Crawford, George F.,
318 Goodhue Bldg., Beaumont.
Crumpler, W. Emmett,
Adams Bldg., Port Arthur.
*Cunningham, M. A.,
Jefferson Co. T. B. Hospital, Beaumont.
Curry, Dwight E.,
2600 Proctor, Port Arthur.
Darnell, B. C., 2405 Ashley, Beaumont.
Dart, Raymond O., Washington, D. C.
Duplan, Don C., Jr.,
4627 Alamosa Drive, Port Arthur.
*Duren, Norman, Goodhue Bldg., Beaumont.
Eisenstadt, H. B., 2301 Proctor, Port Arthur.
Elster, Benjamin B.,
2301 Proctor, Port Arthur.
English, Dudley M., 550 10th, Beaumont.
*Erhard, Peter S.,
3010 Blackmon Lane, Beaumont.
Esslinger, Josh J. (Mil.).
Fama, Joseph R., 550 10th St., Beaumont.
Farrington, Evan S., Jr.,
2372 Calder Ave., Beaumont.
Fears, T. Alvin, Goodhue Bldg., Beaumont.
*Ferguson, Edward C.,
Goodhue Bldg., Beaumont.
Fertitta, Julian J., 570 Center, Beaumont.
Fertitta, Sam J., Jr., 570 Center, Beaumont.
*Fett, Bennie J., Adams Bldg., Port Arthur.
Fortney, Paul N., 550 10th, Beaumont.
Fulbright, Carl W. (Ina.), Altheimer, Ark.
Fuqua, Wm. Cruse, Box 2867, Beaumont.
*Furey, Ellen D., 1025 Avenue B, Beaumont.
Fuselier, J. D., 749 16th St., Port Arthur.
Gardner, John N.,
Goodhue Bldg., Beaumont.
Gill, George G., 370 10th St., Beaumont.
Glass, Walter W., Jr.,
530 Adams Bldg., Port Arthur.
Goldblum, Harvey H.,
3048 Proctor, Port Arthur.
Goodwin, Chas. R., Nederland,
Graber, W. J.,
610 Am. Natl. Bk. Bldg., Beaumont.
Granata, Samuel V.,
3226 North St., Beaumont.
Greene, W. Leonard, 670 7th St., Beaumont.
*Greenberg, Philip B.,
Perlstein Bldg., Beaumont.
Hager, Dale C., 2081 Park, Beaumont.
*Hamill, James E., 2301 Proctor, Port Arthur.
Harlan, H. D., San Jacinto Bldg., Beaumont.
Harper, J. Y., 849 5th, Port Arthur.
*Hart, Frank B.,
American Natl. Bank Bldg., Beaumont.
Hart, John A., 1297 Calder, Beaumont.
*Hartman, Lee E.,
310 Am. Natl. Bk. Bldg., Beaumont.
*Hartman, Sam F., 545 23rd St., Beaumont.
Healey, Gordon, 525 9th Ave., Port Arthur.
*Heare, Louis C., Box 312, Port Arthur.
Hearn, J. Wm., 5550 Hebert Ave., Beaumont.
Hendry, Cullen H., 390 10th St., Beaumont.
Hennington, H. M.,
723 Washington Blvd., Beaumont.
Hill, Isaac H., 845 Fifth St., Port Arthur.
Hille, Charles D.,
531 Adams Bldg., Port Arthur.
Hines, J. Clarence, Nederland.
Hinshaw, Arvil J.,
714 Goodhue Bldg., Beaumont.
Holmes, Glen I., 590 Center, Beaumont.
*Hosen, Harris, 2649 Proctor, Port Arthur.
Hubner, Alan E., 590 Center St., Beaumont.
Hyman, Barnett M.,
1st Fed. Savings Bldg., Beaumont.
Ivers, James B. (Mil.).
Jack, Laurine D.,
509 Goodhue Bldg., Beaumont.
Jacobson, Harry,
523 Perlstein Bldg., Beaumont.
Jones, Edmund D., 2575 South, Beaumont.
Jones, Edward Harrold,
1026 14th St., Beaumont.
Kaplan, Hyman J.,
2499 Calder Ave., Beaumont.
Keith, Frank R., P. O. Box 1059, Port Arthur.
Killingsworth, W. Price,
541 9th Ave., Port Arthur.
Knight, John A., 2121 McFadden, Beaumont.
Knight, Max J., 900 9th Ave., Port Arthur.
Koskhin, Bernard D., 550 10th St., Beaumont.
Kuhlman, Fred Y.,
218 Adams Bldg., Port Arthur.
Lancaster, Lifford R.,
714 Goodhue Bldg., Beaumont.
Ledbetter, L. H., 820 21st St., Beaumont.
*Lewis, Seab J., 2620 Laurel, Beaumont.
Lindsey, Eugene H., 2372 Calder, Beaumont.
Loewenstein, Jos. M.,
3048 Proctor, Port Arthur.
Lombardo, R. T.,
575 Perlstein Bldg., Beaumont.
Lowry, Harvey M.,
Baptist Hospital, Beaumont.
Lyons, Sam B., 801 Goodhue Bldg., Beaumont.
Makins, James, Medical Bldg., Port Arthur.
*Mann, David A. (Hon.),
1025 Washington Blvd., Beaumont.
Manning, Wiley M., 2305 Neches, Beaumont.
*Martin, John D. (Hon.),
1897 Rivercrest, Beaumont.
Matlock, Thos. B., Adams Bldg., Port Arthur
McNemer, Philip H.,
Perlstein Bldg. Annex, Beaumont.
McRee, Edgar C., Med. Bldg., Port Arthur.
McRee, Walter E., Jr.,
Box 668, Port Arthur.
*Meyer, Paul R., 3121 Proctor, Port Arthur.
Miller, Kenneth T., 509 Center, Beaumont.
Mitchell, Theo C., 2449 Calder, Beaumont.
Mixson, Harold J.,
Goodhue Bldg., Beaumont.
Montagnet, Jos. M., Jr.,
590 Center, Beaumont.
Moore, Darwin D.,
550 10th St., Beaumont.
Moore, Robert E., Nederland.
Neidhart, Heinrich W.,
Baptist Hospital, Beaumont.
Newton, William A.,
1710 College St., Beaumont.
Norris, Thos. A. (Mil.).
Odell, Joyce W.,
506 Goodhue Bldg., Beaumont.
Orrill, R. Ray, Medical Bldg., Port Arthur.
*Pace, Bedford F., 555 10th, Beaumont.
Painton, Clifford E.,
900 9th Ave., Port Arthur.
Pecora, Tony L., Goodhue Bldg., Beaumont.
Pentecost, Chas. L.,
503 Perlstein Bldg., Beaumont.
Petit, Paul T., 2627 Laurel, Beaumont.
Petry, James L.,
2708 Proctor St., Port Arthur.
Phillippi, Geo. M., 675 5th, Beaumont.
Pierson, Rogers, 336 Crockett, Beaumont.
Pitre, Roy P., 3720 7th, Port Arthur.
*Powell, Leslie C., 1710 College, Beaumont.
Powell, Leslie C., Jr. (In.),
901 Mechanic, Galveston.
Prudhomme, E. G., Jr., Winnie.
Pruitt, Lee T. (dead), Beaumont.
Quick, David W., Jr.,
Goodhue Bldg., Beaumont.

MEMBERSHIP LIST, 1954—*continued*

Rafes, Earl H , 675 Fifth St., Beaumont.
Raines, James M., 1942 Proctor, Port Arthur.
Reeves, Thomas J.,
2620 Laurel Ave., Beaumont.
Reid, Wm. L., 570 Center St., Beaumont.
Reimers, Arthur F.,
714 Goodhue Bldg., Beaumont.
Richman, Irving M. (Sec'y),
670 7th St., Beaumont.
*Robert, W. Pierre, 2630 Laurel, Beaumont.
Rollo, William C. (Mil.).
Ross, Oliver H.,
541 Ninth Ave., Port Arthur.
Sappington, T. B., Jr.,
102 Dryden Pl., Port Arthur.
Serafino, Louis C., 1st Fed. Savings &
Loan Bldg., Beaumont.
Shaddix, Arthur C.,
1186 Broadway, Beaumont.
Shorkey, Richard L.,
370 10th St., Beaumont.
Simpson, Rufus K., 2372 Calder, Beaumont.
Sims, Paul M., Jr.,
2081 Park St., Beaumont.
Skarke, Edward A., 2363 Calder, Beaumont.
Sloan, John W.,
2600 Proctor, Port Arthur.
Smith, Denton W.,
390 10th St., Beaumont.
*Smith, John T.,
723 Washington Blvd., Beaumont.
*Smith, William A.,
211 W. Caldwood Dr., Beaumont.
Solis, G. Robert,
2749 Proctor, Port Arthur.
Starr, Harry, 675 5th St., Beaumont.
Stephenson, G. Bruce,
370 10th St., Beaumont.
Stevens, Robt. B., 1297 Calder, Beaumont.
Stoeltje, Joe, 1170 Simmons St., Beaumont.
Stroble, Rosser J., Port Neches.
Suehs, Max E.,
806 San Jacinto Bldg., Beaumont.
Sutton, Fred W., Goodhue Bldg., Beaumont.
Sykes, Walter P.,
1297 Calder Ave., Beaumont.
Tatum, William E. (Hon.),
2449 Calder, Beaumont.
Tew, Alton H.,
723 Washington Blvd., Beaumont.
Thompson, Jas. D.,
2600 Proctor St., Port Arthur.
Thornton, Wm. R., Port Neches.
Todd, Chas. H., Jr.,
517 Goodhue Bldg., Beaumont.
Toomin, Leonard A.,
1093 Broadway, Beaumont.
Torbett, John W., Jr.,
1445 Calder, Beaumont.
Tritico, Joseph J., 947 7th, Port Arthur.
Tyndall, Thos. M.,
2643 McFaddin, Beaumont.
Vaughan, Benjamin H.,
Adams Bldg., Port Arthur.
*Vaughan, Edward W. (Hon.),
Box 1059, Port Arthur.
Walker, Taylor C., 675 5th, Beaumont.
Wallace, Wm. G.,
816 Goodhue Bldg., Beaumont.
Walters, Felix A., Nederland.
Weisbach, Philip T.,
560 Center St., Beaumont.
Weiss, Morris, 590 Center, Beaumont.
Welch, John G. (Hon.), Port Neches.
White, Clarence M.,
San Jacinto Bldg., Beaumont.
*White, J. Milton, Sr.,
3149 Proctor, Port Arthur.
White, John M., Jr.,
3149 Proctor, Port Arthur.
Wier, Stuart T.,
505 Goodhue Bldg., Beaumont.
Williams, Chas. L.,
1776 East Dr., Beaumont.
Williams, F. G.,
Magnolia Refinery, Beaumont.
Williams, Lewis M.,
1297 Calder, Beaumont.
Williams, Stewart M.,
1776 East Drive, Beaumont.
Williford, Herman B.,
San Jacinto Bldg., Beaumont.
Willoughby, Russell C., Groves.
Wilson, Iva G.,
2369 Central Dr., Beaumont.
Woodward, John F., Jr.,
905 Goodhue Bldg., Beaumont.
Young, Isaac T., Box 147, Port Arthur.

LIBERTY-CHAMBERS

Anchell, Melvin, Cleveland.
Ashby, Joe M., Anahuac.
Bellamy, Richard C., Liberty.
Boone, Carroll L., Dayton.
*Castle, Charles W., Liberty.
*Clements, Richard O., Liberty.
Davidson, Eli, Liberty.
Delaney, Albert L., Liberty.
Fahring, George H., Anahuac.
Fahring, Thomas L., Anahuac.
Griffin, Frank S., Liberty.
Harris, Orion W. (Sec'y), Liberty.
Harris, Robert L., Odessa.
*Kirkham, Sam H., Cleveland.
Richter, Ernest R. (Pres.), Dayton.
Schulz, Donald P., Liberty.
Shearer, A. R., Mont Belvieu.
Wilson, Reginald, Dayton.

NACOGDOCHES

Allen, James Ira (Mil.).
Allen, Walter B., Nacogdoches.
*Beall, James Franklin, Nacogdoches.
Buchele, Matthew J., San Augustine.
Coussons, Chas. W., Nacogdoches.
Ferguson, Sarah, Nacogdoches.
Haley, Curtis R., San Augustine.
McKinney, Edgar P., Nacogdoches.
Nelson, Albert L., Nacogdoches.
Neuville, Carroll F., Nacogdoches.
*Pennington, Thos. J. (Sec'y), Nacogdoches.
Rogers, Eugene S. (dead), Nacogdoches.
Rulfs, Carl H. (Hon.), San Augustine.
Taylor, James G., Jr., Nacogdoches.
Tucker, Henry, Nacogdoches.
*Tucker, Stephen B., Nacogdoches.

ORANGE

Bennett, David, Orange.
Covington, Charles M., Orange.
Eastman, George L., Orange.
Gaspar, Geza, McKinney.
Ingram, Robert A. (Sec'y), Orange.
Kent, Earl H., Orange.
McFadden, Irma M., Orange.
Minkus, Robert F., Orange.
Moffitt, O. P., Orange.
Pearce, Henry W., Orange.
Peters, Leo J., Jr., Orange.
Pretz, Earnest C., Orange.
Schofield, Elmer C., Orange.
Seastrunk, Oliver C., Orange.
Shaddock, Carroll B., Orange.
Siddon, Wm. H. Orange.
Smith, L. C., Vidor.
Swickard, George Y., Orange.
Thompson, Lewis O., Orange.
Walsh, John K., Orange.
Williams, Howard O., Orange.
Woolley, Talmadge O., Orange.
Wyllie, James J., Orange.

SHELBY-SAN AUGUSTINE-SABINE

Hurst, Thomas L., Center.
Oates, Laried S. (Pres.), Center.
Thompson, S. G. (Sec'y), Center.
Warren, Walter M., Center.
Warren, Wm. H., Center.
Warren, William Spencer, Center.
Windham, John H., Shelbyville.
Windham, Wm. C., Center.

ELEVENTH DISTRICT

Dr. C. E. Willingham, Tyler, Councilor

ANDERSON-HOUSTON-LEON

*Bell, Robert H., Palestine.
Bentley, Bascom W., Jr., Palestine.
Bing, Roland E., Oakwood.
Brown, Adelbert B., Jr. (Sec'y), Crockett.
Carter, J. Weldon, Palestine.
*Darsey, Edward S. (Pres.), Crockett.
*Dean, John L., Jr., Crockett.
Felder, Fred E., Palestine.
Funderburk, Wm. O. (Hon.), Elkhart.
*Goolsby, Carl B., Crockett.
Hathcock, A. L. (Hon.), Palestine.
Haverlah, Harry A., Palestine.
Humphries, John T., Palestine.
Hunter, Ripley H., Palestine.
Hunter, Rush Q., Palestine.
Joyce, Claude D., Jr., Palestine.
Kay, Royal H., Palestine.
King, Marion A., Frankston.
Moss, Geo. H. (Hon.), Frankston.
Murray, Carl O., Jr., Crockett.
Powell, Elisha P., Centerville.
Stokes, Paul B., Crockett.
Trice, Leroy, Palestine.
Van Wey, Archie E., Buffalo.
Wages, A. D., Palestine.

CHEROKEE

Adams, Clyde, Rusk.
Behrns, Charles L., Rusk.
Bilbro, Griff W., Jacksonville.
Bone, John N., Jacksonville.
Boyd, Jas. T., Jacksonville.
Brigham, Floyd H., Rusk.
Cobble, Thos. H. (Sec'y), Rusk.
Crawford, Joe D., Jacksonville.
Davenport, Harbert, Jr. (Pres.), Jacksonville.
Dubose, Jas. L., Wells.
Etter, Roscoe, Alto.
Gabbert, W. E., Rusk.
Goode, Emmett P., Terrell.
Gray, Maston L., Jacksonville.
Greenwood, Jas. T., Ponta.
*Hilliard, George M., Jacksonville.
Jackson, Claude L., Terrell.
Kuykendall, M. J., Rusk.
Malouf, George M., Hallsville.
Morrison, S. Berger (In.),
4009 Osby Drive, Houston.
Newburn, C. L., Jacksonville.
Rives, Hugh F., Jacksonville.
Rucker, John C., Jacksonville.
Scarbrough, Jas. S.,
3608 W. Brookview Dr., Waco.
Stolzar, Irwin H., Jacksonville.
Stripling, C. H., Jacksonville.
Townsend, Walter R., Rusk.
*Travis, John M., Jacksonville.
Travis, L. L., Jacksonville.
*Travis, R. T., Jacksonville.
Verheyden, Floyd H., Jacksonville.

FREESTONE

Bonner, Leslie L., Fairfield.
Cox, Jack R. (Pres.), Teague.
Gage, Maurice, Teague.
Innis, John J. (Sec'y), Fairfield.
Sneed, William N. (Hon.), Fairfield.

HENDERSON

Buie, Ralph R. (Sec'y), Athens.
*Cockerell, Lonnie L., Athens.
Geddie, Nolen D., Sr., Athens.
Geddie, Nolen Dawson, Jr. (Mil.).
Gibson, John W., Athens.
Haynes, Clifford R., Malakoff.
Henderson, Roy E., Athens.
Kilman, Prather T., Malakoff.
Price, Don (dead), Athens.
Rosenbloom, Joseph (Pres.), Trinidad.
Wilcox, Melvin R., Athens.

PANOLA

Baker, Charles D. (Pres.), Carthage.
Daniel, Dubose B., Carthage.
Gerardy, Carl W., Carthage.
Hooker, Lynn C., Carthage.
Johnson, Glen R. (Sec'y), Carthage.
Perlman, Samuel, Carthage.
Prince, Kenneth C., Carthage.
Smith, Wm. C., Carthage.

RUSK

Boswell, W. E. (Pres.), Henderson.
*Deason, Loyd S., Henderson.
Heiligman, Haskell, Overton.
*Hilbun, Lynn, Henderson.
Kennamer, Harold E., Overton.
Ross, Jesse E., Henderson.
Sadler, Joseph G. (Hon.), Henderson.
Shaw, R. F. (Ina.), Henderson.
Shipp, Loring M., Henderson.
Suehs, Herbert A., Henderson.
Suehs, Paul Edward, Henderson.
Wolfe, Alfred S. (Sec'y), Henderson.

SMITH

Alexander, J. Ernest, Jr.,
214 E. Houston, Tyler.
Allen, George B.,
818 S. Johnson Ave., Tyler.
Anderson, Carter, Jr.,
Fair Foundation Bldg., Tyler.
Bailes, Porter M., Jr.,
315 S. Broadway, Tyler.
Baldwin, Russell E. G.,
Peoples Bank Bldg., Tyler.
Bankhead, Alexander J.,
214 E. Houston, Tyler.
*Baskin, T. Grady,
214 E. Houston, Tyler.
*Birdwell, James W.,
214 E. Houston, Tyler.
Bradford, Sidney W.,
1100 S. Beckham, Tyler.
Brown, George W., 305 Rusk, Tyler.
Brown, Glynne, 223 E. 2nd, Tyler.
Brown, Irving,
Peoples Bank Bldg., Tyler.

MEMBERSHIP LIST, 1954—*continued*

*Brown, John R., Drawer Q, Arp.
Bryant W. Howard,
P. O. Box 600, Tyler.
Bundy, David T. (Hon.),
County Courthouse, Tyler.
Burch, George W.,
557 Fair Foundation Bldg., Tyler.
Caldwell, Elbert H.,
214 E. Houston, Tyler.
Calley, Clifford R.,
315 S. Broadway, Tyler.
Cameron, Harold B.,
423 S. Broadway, Tyler.
Clawater, E. W., Sr.,
1016 Clinic Dr., Tyler.
Clawater, E. W., Jr.,
1016 Clinic Dr., Tyler.
Daniels, Herbert B., Jr.,
808 Peoples Bank Bldg., Tyler.
DeCharles, Patrick M.,
200 E. Houston, Tyler.
*Faber, Edwin G.,
315 S. Broadway, Tyler.
Faust, John J.,
Peoples Bank Bldg., Tyler.
Ferrell, Oran L., Jr., Bullard.
*Freiberg, Milton, 315 S. Broadway, Tyler.
Gibson, Jesse W. (Hon.), Lindale.
Goldfeder, Jesse, Peoples Bank Bldg., Tyler.
Hart, John G., 217 W. Houston, Tyler.
Hughes, Delbert E. (Mil.).
Hughes,Waunnell M.,
Peoples Bank Bldg., Tyler.
*Jarmon, Thomas M.,
Box 1840, San Antonio.
Jones, Joe C., 409 W. Erwin, Tyler.
*Lamberth, Ivey E.,
P. O. Box 3006, Tyler.
Lauck, Robert E., 315 S. Broadway, Tyler.
*Lee, Madison J., Jr.,
1100 S. Beckham, Tyler.
Marshall, Robert L.,
1100 S. Beckham, Tyler.
McCulloh, Albert M.,
410 Citizens Bank Bldg., Tyler.
McMillan, Bruce, Overton.
Mitchell, John H.,
Peoples Bank Bldg., Tyler.
Moore, Masters H.,
612 S. Bois d'Arc, Tyler.
Muntz, Hascall H. (Mil.).
Neill, J. Lawrence, 409 W. Erwin, Tyler.
Neill, Lex T., 409 W. Erwin, Tyler.
Pope, Irvin, Jr., 118 S. Bois d'Arc, Tyler.
Rhine, Leland R.,
Peoples Bank Bldg., Tyler.
Rice, Elbert D., 925 Chilton, Tyler.
Roosth, Harold, 420 S. Chilton, Tyler.
Roosth, Wiley, 420 S. Chilton, Tyler.
Roper, Marjorie F., Bullard.
*Ross, William R.,
c/o Tyler Smith Co. Health Unit, Tyler.
Selman, Joseph, 815 S. College, Tyler.
Shirley, Thos. Clayton,
Citizens Bank Bldg., Tyler.
Smith, John C. (Hon.), Winona.
Stanley, Mildred,
700 S. Bois d'Arc, Tyler.
Taylor, Phillip W. (Sec'y),
315 S. Broadway, Tyler.
Thompson, Cone J., 810 S. Johnson, Tyler.
*Topperman, Samuel,
East Texas T. B. Hosp., Tyler.
*Vaughn, Edgar H.,
Peoples Bank Bldg., Tyler.
Vaughn, James M.,
Peoples Bank Bldg., Tyler.
Whitten, Samuel J., Troup.
Wilcox, Leland G.,
315 E. Houston, Tyler.
*Willingham, Charles E.,
101 N. College, Tyler.
*Wilson, Benjamin N.,
301 South Broadway, Tyler.
*Windham, Lynn B.,
818 S. Johnson Ave., Tyler.
Woldert, Albert (Hon.),
216½ W. Ferguson, Tyler.
*Young, Cuthbert B.,
712 S. Bois d'Arc, Tyler.

WOOD

Black, William T., Quitman.
Mathis, James R., Winnsboro.
Moore, Roscoe O. (Sec'y), Mineola.
Peterson, Thomas H., Mineola.
Reed, Thomas B., Mineola.
Robbins, Virgil E., Quitman.
Williams, James W. (Pres.), Mineola.

TWELFTH DISTRICT

Dr. J. Wilson David, Corsicana, Councilor.

BELL

Alsup, Ace H., Professional Bldg., Temple.
Althaus, John W. A.,
McCloskey V. A. Hospital, Temple.
Anderson, Harold B.,
Scott and White Clinic, Temple.
*Arnold, William O.,
Scott and White Clinic, Temple.
Bain, George P.,
Scott and White Clinic, Temple.
*Bartels, Robert N., 304 S. 22nd, Temple.
Bassel, Paul M.,
Scott and White Clinic, Temple.
Blaine, Mose H., Jr.,
V. A. Hosp., Temple.
Bradfield, Eldon O.,
Scott and White Clinic, Temple.
Brindley, George V.,
Scott and White Clinic, Temple.
*Brindley, George V., Jr.,
Scott and White Clinic, Temple.
Brindley, Hanes H. (Pres.),
Scott and White Clinic, Temple.
Broders, Albert C.,
Scott and White Clinic, Temple.
*Broders, Albert C., Jr.,
Scott and White Clinic, Temple.
Brown, Jesse B.,
Kings Daughters Hospital, Temple.
Burow, F. Paul, Killeen.
*Carabasi, Robert J.,
709 W. Houston Ave., Temple.
*Chernosky, Wm. A.,
Kings Daughters Hospital, Temple.
Chisholm, Jack T. (In.),
Scott and White Clinic, Temple.
Christian, John J.,
Scott and White Clinic, Temple.
Cochran, Leroy M., V. A. Hospital, Temple.
*Coleman, James A., Jr.,
Scott and White Clinic, Temple.
*Cox, Charles H., Jr.,
Professional Bldg., Temple.
Crymes, Thos. P. III (In.),
Scott and White Clinic, Temple.
*Curtis, Raleigh R.,
Scott and White Clinic, Temple.
Daly, Wm. H., Jr. (In.),
213 W. Ave G., Temple.
DeBord, Bert A., 1116 N. 9th, Temple.
Dysart, Donald N.,
Scott and White Clinic, Temple.
*Eanes, David F. S., 518 N. 5th, Temple.
Ellis, Ira D., Troy.
Fay, Frederick J. (In.),
Scott and White Clinic, Temple.
Fowler, Joe A., Killeen.
*Frey, Harry, Belton.
*Galindo, D. L.,
Kings Daughters Hosp., Temple.
*Gillespie, Chas. H.,
Scott and White Clinic, Temple.
Gober, Olin B.,
Scott and White Clinic, Temple.
Goodrich, Wm. A., Jr. (In.),
M. D. Anderson Hosp., Houston.
Goodwin, Martin B. (Mil.).
Graves, John P. (In.),
Scott and White Clinic, Temple.
*Greenlee, Ralph G.,
Scott and White Clinic, Temple.
Greenwood, Joseph H.,
Scott and White Clinic, Temple.
*Haines, Richard D.,
Scott and White Clinic, Temple.
Hammond, Fred M., Jr. (Sec'y),
Scott and White Clinic, Temple.
Harlan, Rudolph K.,
Kings Daughters Hospital, Temple.
Healy, Michael J. (In.),
Scott and White Clinic, Temple.
Higginbotham, Warren H.,
Scott and White Clinic, Temple.
*Hightower, Nicholas, Jr.,
Scott and White Clinic, Temple.
Hodge, James C. (In.), 1800 N. W. 21st,
Oklahoma City, Okla.
*Howell, Floyd W.,
Professional Bldg., Temple.
*Ibarra, Jesse D., Jr.,
Scott and White Clinic, Temple.
Jenkins, Jesse G.,
Farmers State Bank Bldg., Temple.
Johnson, Joel H., 304 S. 22nd, Temple.
*Keil, Ernest W.,
Scott and White Clinic, Temple.
Kilman, Joseph R.,
Scott and White Clinic, Temple.
Kirkley, Alva R., Belton.
Klein, Elihu I., V. A. Center, Temple.
Long, William B., Belton.
Lynch, Donald J. (In.),
Scott & White Clinic, Temple.
MacDonald, Alexander C. (In.),
Scott & White Clinic, Temple.
McCauley, Ernest R., Moody.
McCelvey, John S.,
Kings Daughters Hospital, Temple.
McKenney, John F., Jr.,
411 E. Lamar Drive, Temple.
*McMillan, Charles D.,
Scott and White Clinic, Temple.
McRoberts, Marcus L., Killeen.
Moon, Arthur Ernest,
Scott and White Clinic, Temple.
Moore, James C., 317 N. 2nd, Temple.
*Murray, Robert A.,
Scott and White Clinic, Temple.
Narro, George, Santa Fe Hosp., Temple.
Nichols, Dean (In.),
Scott and White Clinic, Temple.
Padgett, John W., Killeen.
Phillips, Charles,
Scott and White Clinic, Temple.
Pittman, John W., Belton.
Plasek, William W., 803 N. 13th, Temple.
Pollok, Lewis W. (Hon.),
Kings Daughters Hosp., Temple.
*Potter, Claudia (Hon.), 707 S. 3rd, Temple.
Powell, William N.,
Scott and White Clinic, Temple.
Rodarte, Jose G.,
Scott and White Clinic, Temple.
Schubert, Herbert A.,
V. A. Hospital, Temple.
*Scott, Arthur C.,
Scott and White Clinic, Temple.
*Seedorf, Everett E.,
Scott and White Clinic, Temple.
Sewell, Harvey W., Belton.
Sewell, Julian G., Belton.
Sherwood, Marcel W. (Hon.),
Scott and White Clinic, Temple.
Shibler, Samuel W.,
Kings Daughters Hospital, Temple.
Sills, David N., Jr. (In.), Milford, Delaware.
Simmon, Vincent J.,
Scott and White Clinic, Temple.
Sommer, Arno W.,
Scott and White Clinic, Temple.
Speed, Terrell.
Scott and White Clinic, Temple.
*Stevenson, Clyde A.,
Scott and White Clinic, Temple.
*Stevenson, Rufus A., Jr.,
1315 N. 7th, Temple.
Stinson, James C., 213 W. Ave. G., Temple.
Sunbury, Thos. R., Bartlett.
Symon, Wm. Edward (In.),
1413 S. 45th St., Temple.
Talley, J. Bartow, Professional Bldg., Temple.
Talley, Lewis R.,
Kings Daughters Hospital, Temple.
*Veirs, Everett R.,
Scott and White Clinic, Temple.
*Walker, James C.,
Scott and White Clinic, Temple.
Ward, Wendell P., 112 W. Adams, Temple.
Watson, Arthur R. (In.),
1306 S. 27th St., Temple.
Weinblatt, Jack S.,
911 1st Natl. Bk. Bldg., Temple.
*White, Raleigh R.,
Scott and White Clinic, Temple.
*Williams, Bill Henry,
Scott and White Clinic, Temple.
*Williams, Marjorie J.,
V. A. Hospital, Temple.
Wilson, James D.,
Kings Daughters Hospital, Temple.
*Winston, John R.,
Farmers State Bank Bldg., Temple.
Wolf, A. Ford, 613 N. 5th, Temple.
Woodson, W. Butbank,
Professional Bldg., Temple.

BOSQUE

Archer, James T., Jr., Meridian.
Blankenship, W. W., Mosheim.
Cate, C. C. (Hon.), Morgan.
Dudney, N. E. (Sec'y), Clifton.
*Goodall, Van D., Clifton.
Holder, Wiseman T. (Mil.).
*Holt, Russell D., Jr. (Pres.), Meridian.
Long, Austin M., Valley Mills.
Murray, Jas. A. (Hon.), Walnut Springs.
Pike, Arthur N. (Hon.) (dead), Iredell.
Witcher, Seth L., Clifton.

BRAZOS-ROBERTSON

Andres, Dwight W., Bryan.
*Benbow, Robt. H., Bryan.
Boyd, Elvin M., Hearne.

MEMBERSHIP LIST, 1954—*continued*

Cole, Chas. M., Bryan.
Cox, Joseph M., Bryan.
Fleming, Jas. P., Jr., Hearne.
Geppert, Joseph W. (Mil.).
Grant, Richard B., Jr., Bryan.
Guynes, Henry C., Hearne.
Harris, Nena Ann, College Station.
*Harrison, R. H., Jr., Bryan.
Holt, Ernest E., College Station.
Hughes, Louis B., Hearne.
Kirk, Earl H., Bryan.
*Krause, Robert B., Bryan.
Marsh, John E., Sr., College Station.
Marsh, John E., Jr. (Sec'y), Bryan.
Martin, J. W., Jr., Bryan.
McGill, Albert G., Jr., Bryan.
Parker, Wm. S. (Hon.), Calvert.
Perry, Jas. S., Bryan.
*Richardson, S. C. (Hon.), Bryan.
*Sanders, Jewell G., Bremond.
*Searcy, R. M. (Pres.), Bryan.
Searcy, Thos. A., Hearne.
Sharp, Joseph E., Hearne.
Smith, Roy L., Bryan.
Stuart, Lawrence D. (Mil.).
Taylor, Wm. C., Jr., Calvert.
Walton, Thos. O., Jr., College Station.
Walton, Thos. T., Bryan.
Wilkerson, Lonnie O., Bryan.

CORYELL

Brown, John Thos., Gatesville.
Goodall, Edwin, Memphis.
Hamilton, Jas. H. (Hon.), Gatesville.
Jones, Kermit R., Gatesville.
*Lowrey, E. Elworth (Pres.), Gatesville.
Lowrey, Oliver W., Gatesville.
McKay, Patrick H. (Sec'y), Gatesville.

ERATH-HOOD-SOMERVELL

*Bryan, T. F., Dublin.
Cedars, Nathan, Stephenville.
Heare, Charles R., Stephenville.
Jordan, Carl A., Dublin.
Morron, Clyde R., Stephenville.
Pate, Joe J. (Pres.), Dublin.
Redwine, Harry P. (Sec'y), Dublin.
*Terrell, J. C., Stephenville.
*Terrell, Vance, Stephenville.
Terrill, Bruce S. (Mil.).
Young, David B., Stephenville.

FALLS

Barnett, John B., Marlin.
Bennett, Alfred C., Marlin.
Buie, Neil D., Marlin.
Bussell, Jas. S. (Pres.), Marlin.
Collier, Joel I. (Hon.), Long Beach, Calif.
*Cornwell, Chas. H., Marlin.
*Giles, Roy G., Marlin.
Glass, Thos. G., Marlin.
Green, John E., Sr., Marlin.
Hampshire, Geo. H., Marlin.
Hohf, Jerome C. (Sec'y), Marlin.
Hutchings, Edgar P., Marlin.
McKinley, W. Frank, Jr., Marlin.
Miller, Clarence R., Marlin.
Smith, Howard O., Marlin.
Smith, Walter S., Marlin.
*Swepston, Happy J., Rosebud.
Swetland, Douglas R., Marlin.

HAMILTON

Cleveland, Charles C., Hamilton.
Hafer, William F. (Sec'y), Hico.
*Hedges, Homer V. (Pres.), Hico.
Helms, Ed B. (Mil.).
Kooken, Robert A., Hamilton.
Nassour, Herbert R., Jr., Hamilton.

HILL

Arledge, William I. (Hon.), Hillsboro.
Barnes, Livingston (Hon.), Hubbard.
Barnett, Thomas R. (Pres.), Hillsboro.
Beskow, Richard N., Hillsboro.
Boyd, James E., Hillsboro.
Bradford, Andrew L., Coolidge.
Buie, James M., Whitney.
Campbell, Clark C., Itasca.
*Cason, Dick K., Hillsboro.
Garrett, Charles A. (Sec'y), Hillsboro.
Grant, Silas W., Whitney.
Guffy, Joseph L., Hillsboro.
Jenkins, Gaines (Hon), Bynum.
Kabnick, David E., Hubbard.
McPherson, Garland, Hillsboro.
Morris, Thomas M., Mount Calm.
Sammons, Howard P., Hubbard.
Shirey, Robert W., Hillsboro.
Sims, Foster D. (Hon.), Route 5, Waco.
Smith, Nellins C., Hillsboro.
Zacharias, Otis G., Topeka, Kans.

JOHNSON

Allen, Charles Guy, Itasca.
Ball, Wm. P., Cleburne.
Barker, Gates R. (Sec'y), Cleburne.
Bradford, Chas. C., Burleson.
Clark, Elmer L., Cleburne.
English, Robert D., Glen Rose.
Garner, Albert F. (Hon.), Grandview.
Hamilton, Con D., Jr., Cleburne.
Hamilton, Harold C. (Mil.).
Hanna, John J. (Hon.), Glen Rose.
Hanna, Mildred V. (Hon.), Glen Rose.
Jowell, Charlie C., Cleburne.
*Kimbro, Robert W., Cleburne.
Knox, Marshall T., Cleburne.
Little, John G., Cleburne.
Marks, Roger E., Glen Rose.
Peters, Joseph F., Jr., Cleburne.
Pickens, J. Wendell, Cleburne.
Rice, John S., Jr. (Pres.), Cleburne.
Shiflett, Roland M., Jr., Cleburne.
Smyth, Olin T., Jr., Cleburne.
Thomas, Vernon L., Grandview.
Whitehouse, Wm. R., Cleburne.
Wright, Glenn R., Cleburne.
Yater, R. E. Lee (Hon.), Cleburne.
*Yater, Tolbert F., Cleburne.
Youngberg, Russell E. (Mil.).
Zumwalt, A. John (Mil.).

LIMESTONE

*Barger, Marius I., Jr., Mexia.
Brewster, Charles H., Mexia.
*Carrington, Wm. L., Mexia.
Christoffer, O. T., Mexia.
Cox, Stanley (Sec'y), Groesbeck.
Edgar, Cecil C., Mexia.
Huffman, Marion M., Mexia.
McKay, Jack M., Mexia.
McKenzie, Cassimir P., Mexia.
Smith, G. Conwell, Jr., Mexia.
Wilson, Thelbert R. (Pres.), Groesbeck.

McLENNAN

Alexander, Boyd D.,
121 N. 11th, Waco.
Alexander, Robert B.,
121 N. 11th, Waco.
*Anderson, Gilbert I.,
1618 Washington, Waco.
Anspach, Harold M., 2711 Maple, Waco.
*Atkins, Neal M., Box 1487, Waco.
Avent, W. M., 1716 Colcord, Waco.
*Aynesworth, Horace T., Box 1492, Waco.
Aynesworth, M. Brian (Pres.),
105 S. 18th, Waco.
*Barnes, Maurice C., 1310 Austin, Waco.
Baskin, Roy H., Jr. (Sec'y),
702 Prof. Bldg., Waco.
Bellegie, Nicholas J. (Mil.).
Berry, George W., 1724 Austin, Waco.
Berumen, Joe F., Golden Meadow, La.
Bradford, J. C., Mart.
*Brooks, Cleveland H., Amicable Bldg., Waco.
Brown, William W., 1806 Austin, Waco.
Bryant, Geo. C., 1525 N. 15th, Waco.
Burgess, John L., 1314 Austin, Waco.
*Carlisle, Margil C., 1410 Austin, Waco.
Carter, Marion I., P. O. Box 2298, Waco.
Catto, C. Gray,
1010 Professional Bldg., Waco.
*Coffelt, Ralph L.,
1009 Amicable Bldg., Waco.
*Colgin, James H.,
2320 Columbus Ave., Waco.
Colgin, Merchant W.,
Amicable Life Insurance Bldg., Waco.
Collins, C. T., 2320 Columbus Ave., Waco.
Collins, Lawrence D.,
1700 Washington, Waco.
Connally, H. Frank, Jr., 1914 Colcord, Waco.
Crosthwait, R. W., 1724 Austin, Waco.
Crosthwait, W. L., 1724 Austin, Waco.
Cumming, Robert, McGregor.
Cunningham, P. J., Hillcrest Hospital, Waco.
*Dudgeon, Howard R., Jr.,
1700 Washington, Waco.
Dunlap, John C.,
2320 Columbus Ave., Waco.
Even, Martin M., 2505 Washington, Waco.
*Fine, Eldon B., Professional Bldg., Waco.
Flowers, Jack W., 3115 Austin, Waco.
Ford, Walter L., Veterans Hospital, Waco.
Forsythe, John R., 115 S. 18th St., Waco.
Friedman, Carl
604 Medical Arts Bldg., Waco.
Gandy, William M.,
1710 Colcord Ave., Waco.
Garrett, James M., 1408 Austin, Waco.
*Gassler, Robert K.,
1604 Columbus Ave., Waco.
Gidney, William H., West.
Goodman, Aubrey L., 2216 Austin, Waco.
Granger, Wayne H., 409 41st St., Waco.
Gunter, Marion B., McGregor.
Hanks, Robert J.,
609 Professional Bldg., Waco.
Hejtmancik, James H.,
1525 Colcord, Waco.
*Hipps, Herbert E., 1604 Columbus, Waco.
*Hoehn, F. William, 2320 Columbus, Waco.
Husbands, Thos. L., 1914 Colcord, Waco.
*Jaworski, H., 425 Austin, Waco.
*Johnson, Ernest A., 114 S. 5th, Waco.
Katzenstein, William S.,
3001 Corsicana Hwy., Waco.
Kee, John L., 805 Amicable Bldg., Waco.
King, Walter B., Jr.,
2320 Columbus, Waco.
Kingsbery, Lloyd B.,
209 Prof. Bldg., Waco.
Klatt, Wesley W., 505 Park Avenue, Waco.
Kleiman, Richard B.,
115 S. 18th St., Waco.
Kochmann, Walter P.,
1717 Columbus, Waco.
Locke, Corbet C.,
115 S. 18th St., Waco.
Magid, Moreton A., 1525 Colcord, Waco.
Manske, Arnold O., 1917 Austin, Waco.
Marstaller, Wm. E., 2505 Morrow, Waco.
*McMahan, Geo. T., V. A. Center, Waco.
Milam, E. A. (Hon.), 1414 Austin, Waco.
*Miller, Claire F., 3801 Herwol, Waco.
Mitchell, Holland C., 3501 Brookview, Waco.
Montgomery, Hazel I., West.
Murphey, Paul C., 2320 Columbus, Waco.
Nail, Wm. R. (Hon.), 2125 Homan, Waco.
Oliver, Tom M., 1722 Colcord, Waco,
*Power, Paul H.,
607 Professional Bldg., Waco.
Reese, Clarence H., Professional Bldg., Waco.
Richey, Harvey M., 1722 Colcord, Waco.
*Roche, B. F., 711 Professional Bldg., Waco.
Roddy, Wm. N., 115 S. 18th St., Waco.
Ross, Phillip H., 3323 Brook Circle, Waco.
*Rottner, Mark H.,
401 Medical Arts Bldg., Waco.
Sadler, Leslie R.,
2320 Columbus Ave., Waco.
Scanio, Thomas J., West.
Schwartze, Erich W., 1202 Speight St., Waco
Scruggs, James H., Jr.,
2320 Columbus Ave., Waco.
Shellenberger, C. G.,
1318 Austin Ave., Waco.
Shipp, J. Ross.,
Professional Bldg., Waco.
Shipp, W. R. F. (Hon.), Lorena.
Simpson, Neill O.,
111 S. 18th St., Waco.
*Smith, C. Collum, 1804 Austin, Waco.
Souther, William L.,
811 Prof. Bldg., Waco.
Spark, Milton, 3805 Herwol, Waco.
Spencer, Shelby C.,
Professional Bldg., Waco.
Stanislav, Frank J.,
Professional Bldg., Waco.
Steelman, Harry F. (Mil.).
Tabb, T. Edgar, Court House, Waco.
Talley, John E., 1414 Austin Ave., Waco.
Thompson, John E., McGregor.
Traylor, Clayton J., 2123 Colcord, Waco.
Trippet, Horace H., 2320 Columbus, Waco.
Warren, Daniel D., 1722 Colcord, Waco.
Weekley, F. Clay, P. O. Box 3147,
Westview Sta., Waco.
Wilson, Loyal K., 1303 Colcord, Waco.
*Wittstruck, Kenneth P.,
Providence Hosp., Waco.
Wood, R. Spencer,
Professional Bldg., Waco.
*Woodward, Jos. W., 2220 Austin, Waco.
Woolsey, Fleta G., 210 N. 7th, Waco.
Woolsey, Henry U., 210 N. 7th, Waco.
Woolsey, William J., 210 N. 7th, Waco.

MILAM

*Barkley, Thos. S. (Pres.), Rockdale.
Bartlett, Marvin H., Garland.
Denson, Thos. Leland, Cameron.
Hamilton, Lawrence E., Rogers.
Read, E. P., Iraan.
*Richards, John T., Rockdale.
Slaughter, Manuel, Rockdale.
*Swift, Clifford G., Cameron.
Walker, Jack L.,
2703 Lake Austin Blvd., Austin.
Woods, H. S., Jr. (Sec'y), Rockdale.

MEMBERSHIP LIST, 1954—*continued*

NAVARRO

Barnebee, James H., Jr. (Sec'y), Corsicana.
Barron, Stanton J., Corsicana.
*Bone, Robert D., Corsicana.
Burnett, Samuel H., Corsicana.
Carter, William W. (Pres.), Corsicana.
*David, J. Wilson, Corsicana.
Gary, Charles L., Jr., Corsicana.
Gibson, Louis E., Corsicana.
Griffin, Ben H., Frost.
Grizzaffi, Anthony L., Frost.
Hamill, Dan B., Corsicana.
Kelton, Leslie E., Jr., Corsicana.
Logsdon, William K., Corsicana.
Mayfield, William B., Corsicana.
Mertz, Robert D., Corsicana.
Miller, William M., Corsicana.
*Mitchell, Paul H., Corsicana.
Newton, Earl H., Corsicana.
Rosen, Bernard, Corsicana.
Sanders, Gurley H., Kerens.
Sanders, Ivan T. (Mil.).
Shell, Wm. T., Jr., Corsicana.
Sneed, William R., Corsicana.
White, Robert N., Blooming Grove.
Wills, Thomas O., Corsicana.

THIRTEENTH DISTRICT

Dr. R. G. Baker, Fort Worth, Councilor

BAYLOR-KNOX-HASKELL

*Balch, Edwin H., Seymour.
Bowden, Ben W. (Mil.).
Bunkley, E. P. (Hon.), Stamford.
Edwards, Thos. S., Knox City.
Eiland, David C., Munday.
Foy, James W., Seymour.
Frizzell, Thos. P., Knox City.
Markward, Charles G. (Pres.), Knox City.
Newsom, Robert L. (Sec'y), Munday.
Randal, Chas. M., Jr., Seymour.
Rogers, Madison W. (Hon.), Rule.
Scott, Frank C., Haskell.
Selmon, Tony B., Stamford.
Taylor, Wm. M., Goree.
Williams, Temple W., Haskell.
Wilson, Roy E., Seymour.

CLAY-MONTAGUE-WISE

Bryant, David W. (Pres.), Bridgeport.
Crumpler, Hulen P., Bowie.
Crumpler, Prentice, Jr., Bowie.
*Darwin, Jas. T., Decatur.
Dean, Wesley N. (Hon.), Boyd.
Harris, Ewing P., Bowie.
Heins, J. William, Decatur.
Hurn, Robert E., Henrietta.
Inabnett, W. T., Decatur.
Major, A. D., Nocona.
Major, John W., Nocona.
Major, Robert A., Nocona.
Pickett, Lee L., Henrietta.
Rogers, Thomas G., Decatur.
Shilling, Harold C. (Sec'y), Bridgeport.
Squyres, Berry N., Bowie.
*Tyler, Russell E., Bowie.
Valcik, John H., Decatur.

EASTLAND-CALLAHAN-STEPHENS-SHACKELFORD-THROCKMORTON

Addy, Ervin E., Jr., Cisco.
Ball, D., Cisco.
Barrow, W. Barton, Eastland.
Bradley, Ben H., Rising Star.
Brazda, A. W., Ranger.
Brogdon, William M., Gorman.
Brown, Audie A., Gorman.
Cartwright, H. H., Breckenridge.
Caton, James H., Eastland.
Cole, Charles T., Gorman.
Graham, E. L. (Pres.), Cisco.
Harris, Calvin W., Ranger.
Howle, Thos. M., Albany.
Jackson, Thos. G., Gorman.
*Kuykendall, P. M., Ranger.
Payne, Frank C., Breckenridge.
Rodgers, D. V., Gorman.
Stubblefield, M. L., Baird.
Stubblefield, R. L. (Mil.).
Townsend, E. R., Eastland.
Treadwell, M. A., Jr. (Sec'y), Eastland.
Watkins, Wirter P., Ranger.
White, John E. (Mil).
*Whittington, Jas. C. (Mil.).
Wood, Grover C., Breckenridge.

PALO PINTO-PARKER-YOUNG-JACK-ARCHER

Abney, Thomas B., Weatherford.
Allen, Platt L., Weatherford.
Allensworth, John C., Mineral Wells.
Campbell, William M. (Hon.), Weatherford.
Conner, Paul K., Jacksboro.
Divine, Blaine, Graham.
Eidson, Jack L., Weatherford.
Garmany, James F. (Hon.), Mineral Wells.
Gowan, R. E. L., Graham.
Griffin, B. B., Graham.
*Griffin, H. E., Graham.
Harrell, Fred S., Olney.
Jordan, Robbie C., Mineral Wells.
Lassater, Waldo B., Mineral Wells.
Lovett, Raymond E., Olney.
McCall, James D., Mineral Wells.
McCloud, Ben L., Jr., Mineral Wells.
McClure, C. C., Jacksboro.
McKinney, Hugh C., Olney.
Merrick, John B. (Pres.), Weatherford.
Nelson, Joe T. (Sec'y), Weatherford.
Oates, K. D., Graham.
*O'Quin, William A., Mineral Wells.
Padgett, W. O., Graham.
Patterson, Andrew M., Mineral Wells.
Pedigo, Paul C., Strawn.
*Railsback, George D., Jr., Mineral Wells.
Roan, John L., Weatherford.
Roberson, John F. (Hon.), Gordon.
Rosser, V. O., Jr., Graham.
Russell, Earl M., Weatherford.
Smith, John E., Weatherford.
*Smith, Robert H., Palo Pinto.
Spears, Jean Wiley, Graham.
Spratt, John T. (Hon.), Mingus.
Whalen, Carl H., Weatherford.
Wheelis, Brewer D., Jacksboro.
Williams, Charles R., Mineral Wells.
Woods, David R., Rusk.
Yeager, Edward F., Mineral Wells.

TARRANT

Allen, Daisy E. (Hon.),
2256 Fifth Ave., Fort Worth.
Allison, J. A. (Hon.) (dead), Grapevine.
Alliston, Wiley S.,
701 Fifth Ave., Fort Worth.
Altaras, Leon M., Stephenville.
Anderson, Herman W., Jr.,
1307 Pennsylvania Ave., Fort Worth.
*Andujar, John J.,
2951 Benbrook Blvd., Fort Worth.
*Anthony, Ernest E., Jr.,
409 Medical Arts Bldg., Fort Worth.
Anthony, Walter P., Jr.,
708 Medical Arts Bldg., Fort Worth.
Antweil, Abraham,
509 Dan Waggoner Bldg., Fort Worth.
*Archer, Maurice C.,
1216 Pennsylvania Ave., Fort Worth.
*Armstrong, William F.,
1400 8th Ave., Fort Worth.
*Ashworth, Charles T.,
Box 1260, Fort Worth.
Aurin, Fred B.,
1216 Pennsylvania Ave., Fort Worth.
Auringer, Arthur J., Arlington.
Austin, Carl M.,
903 Medical Arts Bldg., Fort Worth.
Avery, Jack W.,
5201 River Oaks Blvd., Fort Worth.
Axtell, Earl C. (Hon.), San Diego, Calif.
Bailey, Noel R.,
1506 W. Terrell, Fort Worth.
*Baker, Robert G.,
715 Medical Arts Bldg., Fort Worth.
Ball, Bert C.,
1607 Medical Arts Bldg., Fort Worth.
Ball, Charles E.,
1405 Medical Arts Bldg., Fort Worth.
Banker, Harry W., Box 1719, Fort Worth.
*Barber, Forest C.,
522 N. Sylvania, Fort Worth.
Barcus, James R.,
708 S. Henderson, Fort Worth.
*Barcus, William Shelton,
708 S. Henderson, Fort Worth.
Barker, Robert C.,
1216 Pennsylvania Ave., Fort Worth.
Barnes, Charles K.,
921 Neil P. Anderson Bldg., Fort Worth.
Barrett, Isaac P.,
409 E. Weatherford, Fort Worth.
Barrier, Charles W.,
Medical Arts Bldg., Fort Worth.
Beall, Frank C. (Hon.),
4805 Bryce Ave., Fort Worth.
Beard, Bruce H.,
1519 Pennsylvania Ave., Fort Worth.
Beasley, C. Harold,
1216 Pennsylvania, Fort Worth.
Beasley, Grace A.,
3226 Odessa, Fort Worth.
Beaton, Hugh,
1316 Medical Arts Bldg., Fort Worth.
Beavers, George H., Jr.,
714 S. Lake St., Fort Worth.
Begley, Grant F.,
1415 Pennsylvania, Fort Worth.
*Bennett, Jerrell,
650 S. Henderson, Fort Worth.
Bibby, Douglas E.,
Medical Arts Bldg., Fort Worth.
Bickel, Robert D.,
302 Professional Bldg., Fort Worth.
Bida, John F., Arlington.
Black, Thomas W.,
808 Eighth Ave., Fort Worth.
Blaha, Frank J.,
2404 W. Seminary Drive, Fort Worth.
Bobo, Zack, Jr., Arlington.
*Bond, Tom B.,
815 Medical Arts Bldg., Fort Worth.
Bonelli, Victor E.,
1409 Medical Arts Bldg., Fort Worth.
Bontley, Paul T., Arlington.
Boone, James B.,
306 W. Broadway, Fort Worth.
Booth, Jack H. (Mil.).
Boren, Darrell W. (In.),
City-County Hosp., Fort Worth.
Bowden, Andy J.,
650 So. Henderson, Fort Worth.
Boyd, Craig H. (In.), New Orleans, La.
Bradshaw, Wilber V., Jr.,
1000 Throckmorton, Fort Worth.
Braselton, Chas. W., Jr.,
1535 Pennsylvania Ave., Fort Worth.
Brasher, Ray V.,
1008 W. Petersmith, Fort Worth.
Brentlinger, Robert W., Arlington.
Brewster, C. Burke,
703 Medical Arts Bldg., Fort Worth.
Brock, Ernest H. (Ina.),
707 Hawkins, Fort Worth.
Bronstad, Morris T. (Mil.).
*Brooks, Jas. W.,
5019 Nolan, Fort Worth.
Brown, Arthur, 1015 Lamar, Fort Worth.
Brown, Charles H., Jr.,
1221 W. Lancaster, Fort Worth.
Brown, W. Porter,
1106 Medical Arts Bldg., Fort Worth.
Brownfield, Jack D.,
806 S. Lake, Fort Worth.
Burgess, Richard M.,
3226 E. Rosedale, Fort Worth.
Bursey, Earnest H. (dead), Fort Worth.
Bursey, Leroy,
6100 Camp Bowie Blvd., Fort Worth.
Bussey, Thomas B.,
414 Medical Arts Bldg., Fort Worth.
Butler, Allan W., Jr.,
1500 Hemphill, Fort Worth.
*Bynum, Frank L.,
650 Fifth Ave., Fort Worth.
*Campbell, James F.,
1311 Medical Arts Bldg., Fort Worth.
Campbell, Robert L. (In.),
City-County Hosp., Fort Worth.
Carpenter, Nathan C.,
905 Fort Worth Natl. Bank Bldg.,
Fort Worth.
Chambers, James O.,
1519 Pennsylvania Ave., Fort Worth.
Childs, Tilden L., Jr.,
3102 Greene, Fort Worth.
Chilton, Wm. E. (Hon.),
406 Dan Waggoner Bldg., Fort Worth.
Chorn, Ethredge H.,
1508 Commercial Std. Bldg., Fort Worth.
Church, John M.,
1221 W. Lancaster, Fort Worth.
Claunch, DeWitt,
3101 Travis Ave., Fort Worth.
*Clayton, Charles F.,
1001 Medical Arts Bldg., Fort Worth.
Cochran, John R.,
1100 Pennsylvania Ave., Fort Worth.
Coffey, Alden (dead), Fort Worth.
Cohen, Frank,
712 S. Henderson, Fort Worth.
Coleman, Thomas J.,
1221 W. Lancaster, Fort Worth.
Collier, Julius W.,
1067 W. Magnolia, Fort Worth.
Colvin, Joseph W.,
5201 Camp Bowie Blvd., Fort Worth.
Compere, Dolphus E.,
1415 Pennsylvania Ave., Fort Worth.
Cook, Percy L., Mansfield.

MEMBERSHIP LIST, 1954—*continued*

Cook, Willis G. (Hon.),
3625 Park Hill Drive, Fort Worth.
Crabb, McKinley H.,
916 Medical Arts Bldg., Fort Worth.
Crawford, Wm. M.,
612 Sixth Ave., Fort Worth.
*Cross, Thomas J.,
1510 Medical Arts Bldg., Fort Worth.
*Cummins, John B. (Hon.),
408 Moore Bldg., Fort Worth.
Cunningham, Ernest S., Jr.,
623 S. Henderson, Fort Worth.
Cyrus, Elbert M.,
404 Medical Arts Bldg., Fort Worth.
Daly, Jack E.,
Medical Arts Bldg., Fort Worth.
Daugherty, Frank J.,
Medical Arts Bldg., Fort Worth
Davenport, Emory,
Box 1719, Fort Worth.
Day, Giles W.,
910 Eighth Ave., Fort Worth.
*Deaton, Hobart O.,
612 Sixth Ave., Fort Worth.
DeBusk, Jack S.,
1216 Pennsylvania Ave., Fort Worth.
Diamond, Wm. D.,
1111 Pennsylvania, Fort Worth.
Dimmette, James E. (In.),
Baylor Hosp., Dallas.
Ditto, Hugh H.,
1508 Commercial Std. Bldg., Fort Worth.
Doss, Alexander K.,
Medical Arts Bldg., Fort Worth.
Doss, Doyle J. (Mil.).
Douglass, Hal C.,
3005 University Dr., Fort Worth.
Dunn, Nelson L. (Ina.),
Medical Arts Bldg., Fort Worth.
Duringer, Wm. C. (Hon.),
2501 Berry St., Fort Worth.
Edwards, Walter T.,
4102 E. Lancaster, Fort Worth.
Ellis, Joe B., 922 E. Broadus, Fort Worth.
*Emery, Oscar J.,
413 Medical Arts Bldg., Fort Worth.
Eschenbrenner, John W.,
1216 Pennsylvania Ave., Fort Worth.
Estes, Ben P. (Mil.).
Etier, Edgar L., Jr.,
1216 Pennsylvania Ave., Fort Worth.
Ezell, Edgar S., Box 1719, Fort Worth.
Farley, Jas. A. (Mil.).
Farris, Chester A., Arlington.
Fershtand, John B.,
1501 Summit, Fort Worth.
Fitzwilliam, C. Dennis,
1300 W. Cannon, Fort Worth.
*Flood, Wm. E.,
Medical Arts Bldg., Fort Worth.
Foster, Riley P. (Mil.).
Frietsch, Werner H. (In.),
City-County Hosp., Fort Worth.
Funk, Theron H.,
623 S. Henderson, Fort Worth.
Furman, John M., Jr.,
660 Fifth Ave., Fort Worth.
Gambill, Alice F.,
1601 Clover Lane, Fort Worth.
Gardiner, Henry G., Jr.,
Box 1719, Fort Worth.
Garnett, John W., Jr.,
650 S. Henderson, Fort Worth.
Gentling, Allen A.,
554 S. Summit, Fort Worth.
Gilliland, Lloyd N., Jr.,
1307 Pennsylvania Ave., Fort Worth.
Godley, Louie O.,
915 Medical Arts Bldg., Fort Worth.
Goggans, Albert M.,
811 5th Ave., Fort Worth.
Goldberg, Abraham I.,
904 Burk Burnett Bldg., Fort Worth.
Goldberg, Morton N.,
905 Burk Burnett Bldg., Fort Worth.
Gooch, Frank B.,
1307 Pennsylvania Ave., Fort Worth.
Goodman, Thomas L. (Hon.),
1601 Clover Lane, Fort Worth.
Grammer, James H.,
1400 Eighth Ave., Fort Worth.
Grammer, Richard B.,
1400 Eighth Ave., Fort Worth.
Gray, Billy N.,
1517 E. Berry, Fort Worth.
Greines, Abe,
1549 N. Main St., Fort Worth.
Greve, Anna M.,
1110 W. T. Waggoner Bldg., Fort Worth.
Griffin, Otho P.,
1101 Medical Arts Bldg., Fort Worth.
*Grogan, Oscar R.,
3200 Avondale, Fort Worth.
Grogan, Roy L.,
921 Fifth Ave., Fort Worth.
*Grunow, Otto H.,
650 Fifth Ave., Fort Worth.
Guerra, Raul L.,
1509 Ellis Ave., Fort Worth.
Haffke, Oscar W.,
1017 Pennsylvania, Fort Worth.
Haggard, Fred A. (Hon.),
Westbrook Hotel, Fort Worth.
*Hall, Ewin P., Jr.,
492 Medical Arts Bldg., Fort Worth.
Hallmark, James A.,
951 W. Magnolia, Fort Worth.
Halpin, Frank W.,
3500 W. 7th, Fort Worth.
Hardwick, B. Randol,
3101 Winthrop, Fort Worth.
Hargis, Chas. P.,
2501 W. Berry, Fort Worth.
Harris, Charles H. (Hon.),
650 Fifth Ave., Fort Worth.
Harris, Charles H., II,
2208 Mistletoe Ave., Fort Worth.
Harris, Earl (Hon.) (dead), Fort Worth.
Harris. J. Robert,
1016 W. Cannon, Fort Worth.
Harrison, Edwin S.,
City-County Hospital, Fort Worth.
Hawker, Laverne J.,
1307 Pennsylvania, Fort Worth.
Hawkins, Charles P.,
1524 Pruitt St., Fort Worth.
Hayes, Charles F. (Hon.),
1609 Harrington, Fort Worth.
*Heberle, Jas. P. (In.),
1300 W. Cannon, Fort Worth.
Helbing, Hugh V.,
1549 N. Main St., Fort Worth.
Hendrix, William C., Jr.,
800 S. Lake, Fort Worth.
Hewatt, John W.,
3301 E. Rosedale, Fort Worth.
Hicks, Charles E.,
3101 Winthrop, Fort Worth.
Hiett, Carey,
815 Fifth Ave., Fort Worth.
Higgins, Wm. P., Jr. (Pres.),
406 Medical Arts Bldg., Fort Worth.
Hightower, Lovick P.,
Box 1719, Fort Worth.
Holmgren, Robert B.,
1501 Pruitt, Fort Worth.
Holsapple, C. K., Jr. (Mil.).
*Hook, James H.,
208 Medical Arts Bldg., Fort Worth.
Hooker, Jas. F., III, Cleburne.
Horn, Will S.,
650 Fifth Ave., Fort Worth.
Horn, Will S., Jr.,
650 Fifth Ave., Fort Worth.
Howard, Rex Z.,
510 Medical Arts Bldg., Fort Worth.
Howard, Rex J.,
510 Medical Arts Bldg., Fort Worth.
Huffman, Andrew M.,
1201 Hemphill St., Fort Worth.
Hulsey, Sim, 701 Fifth Ave., Fort Worth.
Ingham, Mahlon E.,
703 W. Fogg St., Fort Worth.
Innis, E. Renshaw,
914 W. Cannon, Fort Worth.
Irvine, James, Jr. (In.),
City-County Hosp., Fort Worth.
Isaacks, Hub E.,
1415 Pennsylvania Ave., Fort Worth.
Isbell, Marney C., 3908 Earl, Fort Worth.
Jackson, Atras E.,
1112 Medical Arts Bldg., Fort Worth.
*Jackson, Holland T.,
1601 Medical Arts Bldg., Fort Worth.
Jagoda, Samuel, 1501 Summit, Fort Worth.
*Jenkins, Wesley N.,
3102 Greene Ave., Fort Worth.
Jernigan, Lane M.,
2417 W. Berry, Fort Worth.
Jernigan, John M.,
2417 W. Berry, Fort Worth.
Jewell, George W., Jr.,
5201 River Oaks Blvd., Fort Worth.
Johnson, Clive R.,
1216 Pennsylvania, Fort Worth.
Johnson, F. Melvin,
7112 Camp Bowie, Fort Worth.
Jones, John M. (In.),
V. A. Hosp, McKinney.
*Jordan, Carl F.,
301 N. Houston, Fort Worth.
Jorns, Kenneth L.,
Burk Burnett Bldg., Fort Worth.
Kauffmann, Adolph F.,
650 Fifth Ave., Fort Worth.
Keith, Joseph M.,
1216 Pennsylvania, Fort Worth.
Kerr, Walter C. H.,
1511 Medical Arts Bldg., Fort Worth.
Key, Wm. F. (Hon.),
3229 Wabash, Fort Worth.
Key, William F., Jr. (In.),
1500 S. Main, Fort Worth.
Kibbie, Horace K.,
2417 Medford Ct., E., Fort Worth.
Kibbie, Kent V. (Hon.),
Medical Arts Bldg., Fort Worth.
King, Gerald A.,
2611 Clairmount, Fort Worth.
Kingsbury, Herman B.,
316 Medical Arts Bldg., Fort Worth.
Kirkpatrick, Joe S.,
1519 Pennsylvania Ave., Fort Worth.
*Kleuser, Lawrence P.,
Medical Arts Bldg., Fort Worth.
Knox, Warren G.,
2905 Vaughn Blvd., Fort Worth.
Kramer, John T., Jr.,
5050 E. Belknap, Fort Worth.
Kyger, Edgar R., Jr.,
1216 Pennsylvania Ave., Fort Worth.
Lace, Wm. Ted,
W. T. Waggoner Bldg., Fort Worth.
Lacy, George W.,
515 Medical Arts Bldg., Fort Worth.
Ladd, Arnett D.,
306 W. Broadway, Fort Worth.
Lange, Arthur A.,
508 Medical Arts Bldg., Fort Worth.
Lauderdale, Thomas L.,
554 Summit, Fort Worth.
Lawson, Lee Ray (In.),
City-County Hosp., Fort Worth.
*Leach, Cherry-Fern M.,
3529 Bellaire Dr., N., Fort Worth.
Leaffer, Harry,
4208 Rainier Ct., Fort Worth.
Lees, Charles R.,
806 Medical Arts Bldg., Fort Worth.
Lemon, Robert G.,
811 Fifth Ave., Fort Worth.
Lenox, Walter R.,
301 W. Central, Fort Worth.
Leon, Wm. R.,
1216 Pennsylvania Ave., Fort Worth.
Leverett, Jack K.,
Consolidated Vultee, Fort Worth.
*Levy, Louis J.,
1801 Medical Arts Bldg., Fort Worth.
Lindsay, John F., Jr.,
650 Fifth Ave., Fort Worth.
Lindsey, David C. (In.),
McCloskey General Hospital, Temple.
*Lipscomb, Cuvier P.,
1801 Medical Arts Bldg., Fort Worth.
Little, Ruth P.,
3125 Handley Dr., Fort Worth.
Littlepage, Henry B.,
Medical Arts Bldg., Fort Worth.
Looney, Robert H., Jr.,
5534 East Belknap, Fort Worth.
Lorimer, Wishard S.,
901 W. Leuda, Fort Worth.
Lorimer, Wishard S., Jr.,
901 W. Leuda, Fort Worth.
Luke, Edward A.,
3125 Handley Dr., Fort Worth.
Lyle, Judge M.,
1508 Commercial Std. Bldg., Fort Worth.
Maddox, Stephen G., Jr.,
6025 Curzon, Fort Worth.
Mallard, Robert S.,
1313 Medical Arts Bldg., Fort Worth.
Mann, James H. (In.),
3543 Bellaire Dr., N., Fort Worth.
Marietta, John S.,
1216 Pennsylvania Ave., Fort Worth.
*Marrs, Walford D.,
306 Broadway, Fort Worth.
Matheson, Dan N.,
Medical Arts Bldg., Fort Worth.
Mayo, Talmadge D., Jr.,
921 Fifth Ave., Fort Worth.
McBride, James O.,
513 Medical Arts Bldg., Fort Worth.
McCarroll, Molloy C.,
1004 W. Peter Smith, Fort Worth.
McCollum, Charles H., Jr.,
1100 Pennsylvania Ave., Fort Worth.
McDavitt, Bertha S. (Hon.),
3117 Stadium, Fort Worth.
McDonald, Henry C., Jr.,
1801 Medical Arts Bldg., Fort Worth.

MEMBERSHIP LIST, 1954—*continued*

*McDonald, Robert P.,
603 College, Fort Worth.
McKee, Frank,
1016 W. Cannon, Fort Worth.
McKee, Frank S.,
1016 W. Cannon, Fort Worth.
McKenzie, Walten H.,
800 S. Lake, Fort Worth.
McKinney, Wm. W.,
1205 Medical Arts Bldg., Fort Worth.
McKnight, W. Hodges,
Amon Carter Field, Fort Worth.
McKnight, Wm. B. (Hon.), Mansfield.
*McVeigh, Joseph F.,
306 W. Broadway, Fort Worth.
Miller, Richard K. (Mil.).
Millington, George H.,
1612 Columbus Ave., Waco.
Mitchell, Gatlin,
1604 Medical Arts Bldg., Fort Worth.
Mitchell, Robert H.,
Medical Arts Bldg., Fort Worth.
Monaghan, Johnnie E., Jr.,
1017 Pennsylvania, Fort Worth.
*Moorman, Warren W.,
901 W. Leuda, Fort Worth.
*Moreton, Robert D.,
815 Medical Arts Bldg., Fort Worth.
*Morgan, Wm. H.,
1216 Pennsylvania Ave., Fort Worth.
Morphis, Oscar L.,
1942 Fairmount, Fort Worth.
Morris, Abner J.,
809 Medical Arts Bldg., Fort Worth.
Mulkey, Young J.,
618 W. T. Waggoner Bldg., Fort Worth.
Murchison, St. Julian R.,
803 Medical Arts Bldg., Fort Worth.
*Murphy, James D.,
1556 W. Magnolia Ave., Fort Worth.
Mycoskie, Bernard J., Arlington.
Myers, Theodore B.,
Medical Arts Bldg., Fort Worth.
Myers, William T.,
No. 1, Theatre Bldg., Westcliff Center, Fort Worth.
Neal, Durwood E.,
1307 Pennsylvania Ave., Fort Worth.
Needham, Robert H. (Hon.),
601 Continental Life Bldg., Fort Worth.
*Neighbors, DeWitt,
701 Fifth Ave., Fort Worth.
Nesbit, Preston M., Arlington.
Nifong, Harry D., Mansfield.
O'Bannon, Roscoe P.,
650 Fifth Ave., Fort Worth.
Olcott, Eugene D. (Mil.).
O'Reilly, John J. (Hon.),
503 Peak Rd., Austin.
Ott, Wm. O.,
1017 W. Terrell Ave., Fort Worth.
*Owen, May, Box 1719, Fort Worth.
Patterson, John B.,
411 Medical Arts Bldg., Fort Worth.
*Petta, Walter B.,
1556 W. Magnolia, Fort Worth.
*Phillips, Oliver M.,
1221 W. Lancaster, Fort Worth.
Phillips, W. G.,
3111 Race, Fort Worth.
Potts, John (Hon.),
901 Dan Waggoner Bldg., Fort Worth.
Price, Earl P.,
Medical Arts Bldg., Fort Worth.
Price, Richard V.,
1201 Hemphill, Fort Worth.
Price, Sidney A.,
1216 Pennsylvania Ave., Fort Worth.
Prine, John M., Arlington.
Pumphrey, Andrew B.,
1201 Medical Arts Bldg., Fort Worth.
Rape, Joe G., Arlington.
Rapfogel, Irving, 660 Fifth Ave., Fort Worth.
Rathgeber, Van D.,
1305 Medical Arts Bldg., Fort Worth.
Readinger, Ivan H.,
1508 Medical Arts Bldg., Fort Worth.
Reeves, Ernest E.,
509 Medical Arts Bldg., Fort Worth.
*Reeves, Leopold H. (Emer.),
1407 Medical Arts Bldg., Fort Worth.
*Rehfeldt, Frederick C.,
1001 Pennsylvania Ave., Fort Worth.
Renshaw, Horace S.,
914 W. Cannon, Fort Worth.
Richards, John H.,
1017 Pennsylvania, Fort Worth.
Richardson, James J.,
1519 Pruitt, Fort Worth.
*Riddell, J. Murray, Jr.,
1216 Pennsylvania Ave., Fort Worth.
Riddle, Chas. H.,
1025 So. Adams, Fort Worth.
Riddle, Riley N. (In.),
City-County Hosp., Fort Worth.
Riley, Jack C.,
1524 Pruitt, Fort Worth.
Rimmer, Raymond J.,
623 S. Henderson, Fort Worth.
Risley, Thomas W.,
5177-D River Oaks Blvd., Fort Worth.
Roan, Leo N.,
4727 Camp Bowie Blvd., Fort Worth.
Roberts, Albert D., Signal Mt., Tenn.
Robinson, Chas.,
Medical Arts Bldg., Fort Worth.
Rogers, Ernest D.,
609 Throckmorton, Fort Worth.
Rogers, Riveire, L. C. (Hon.),
511 Dan Waggoner Bldg., Fort Worth.
Rohrer, Vern,
907 Medical Arts Bldg., Fort Worth.
Ross, Nealie E., Jr.,
701 Fifth Ave., Fort Worth.
*Rumph, Mal,
705 Medical Arts Bldg., Fort Worth.
Russell, Virginia (In.),
Harris Hosp., Fort Worth.
Rutledge, Art H., Box 1719, Fort Worth.
Saunders, Roy F. (Hon.),
205 N. Rivercrest Dr., Fort Worth.
Savage, Hugh W.,
1216 Pennsylvania Ave., Fort Worth.
Schenck, Charles P.,
1012 Medical Arts Bldg., Fort Worth.
Schoolfield, Emmett C.,
622 Insurance Bldg., Fort Worth.
Schoonover, Frank S., Jr.,
608 S. Adams St., Fort Worth.
Schwarz, Edwin G.,
712 S. Henderson, Fort Worth.
Scroggie, Val D.,
301 S. Henderson, Fort Worth.
*Sealy, Wm. Burgess,
811 Medical Arts Bldg., Fort Worth.
*Sehested, Herman C.,
815 Medical Arts Bldg., Fort Worth.
Sewell, John H. (Mil.).
Sewell, Robert L.,
1221 W. Lancaster, Fort Worth.
Sheddan, Frank G.,
1313 Sinclair Bldg., Fort Worth.
Shelley, Harold J.,
207 Medical Arts Bldg., Fort Worth.
*Shields, Thomas L.,
1216 Pennsylvania Ave., Fort Worth.
Shoemaker, Thomas J. W.,
Stockyards Natl. Bank Bldg., Fort Worth.
Short, James W.,
811 Fifth Ave., Fort Worth.
Siddons, George Y.,
Commercial Std. Bldg., Fort Worth.
Skokan, William,
Medical Arts Bldg., Fort Worth.
Small, David E.,
1519 Pennsylvania Ave., Fort Worth.
Smith, James Ronald,
1607 Medical Arts Bldg., Fort Worth.
*Smith, Stanley C.,
1216 Pennsylvania Ave., Fort Worth.
Smith, Wallace B.,
1408½ N. Main St., Fort Worth.
Snyder, Frank L.,
304 Virginia Place, Fort Worth.
Snyder, Roy E.,
203 Medical Arts Bldg., Fort Worth.
Sokolsky, Irving,
1216 Pennsylvania, Fort Worth.
*Spackman, Edgar W.,
Terrell's Laboratories, Fort Worth.
Spivey, James L. (Hon.) (dead),
Wichita Falls.
Steger, Joseph H.,
923 Pennsylvania Ave., Fort Worth.
Steinberger, Eugene,
901 W. Cannon, Fort Worth.
Stephenson, Henry G., Jr.,
6717 Grapevine Hwy., Fort Worth.
Stewart, George A., Jr.,
609 College, Fort Worth.
Stouffer, James G.,
5057 Penrose Ave., Fort Worth.
Stout, Sidney E.,
650 Fifth Ave., Fort Worth.
Stow, Robert C., Jr.,
306 W. Broadway, Fort Worth.
Sumner, Wendell W.,
600 Bailey, Fort Worth.
Swift, William B.,
1501 Summit, Fort Worth.
Swords, H. Logan,
301 W. Central Ave., Fort Worth.
Tadlock, Marvin E.,
901 Burk Burnett Bldg., Fort Worth.
Tatum, William C.,
1304 Medical Arts Bldg., Fort Worth.
Taylor, Elizabeth A.,
210 Medical Arts Bldg., Fort Worth.
Taylor, Elbert D.,
5534 E. Belknap, Fort Worth.
Teague, Wm. H.,
5050 E. Belknap, Fort Worth.
Terrell, Blanche O.,
1422 Pennsylvania Ave., Fort Worth.
Terrell, Caleb O., Jr.,
1015 Pennsylvania Ave., Fort Worth.
Terrell, Chas. J.,
602 W. 10th, Fort Worth.
*Terrell, Truman C.,
Medical Arts Bldg., Fort Worth.
Thomas, Henry W., Jr.,
908 N. W. 25th, Fort Worth.
Thomas, Hiram C.,
1055 W. Terrell, Fort Worth.
Thomas, Raymond R. (In.),
City-County Hosp., Fort Worth.
Thomason, Thomas H.,
1226 Pennsylvania Ave., Fort Worth.
Thompson, Burl V.,
1400 8th Ave., Fort Worth.
Tipps, D. Conway,
660 Fifth Ave., Fort Worth.
Tom, John C., Jr.,
1104 Medical Arts Bldg., Fort Worth.
Toppin, Bruce E.,
3427 E. Lancaster, Fort Worth.
Tottenham, John W. (Hon.),
3706 Tulsa Way, Fort Worth.
Tottenham, John W., Jr.,
3706 Tulsa Way, Fort Worth.
*Touzel, Cecil S. E.,
1111 Pennsylvania Ave., Fort Worth.
Trimble, T. M., Jr.,
1308 Hemphill, Fort Worth.
Tucker, John T.,
404 W. 3rd St., Fort Worth.
Tucker, John T., Jr.,
404 W. 3rd St., Fort Worth.
Tunstill, James W. (Mil.).
Van Zandt, Isaac L.,
Medical Arts Bldg., Fort Worth.
Viard, Walter S., Jr.,
5201 River Oaks Blvd., Fort Worth.
Walborn, Kenneth B.,
1508 Commercial Std. Bldg., Fort Worth.
Walker, James N.,
3616 Tulsa Way, Fort Worth.
Walker, Webb,
703 Medical Arts Bldg., Fort Worth.
Wallace, E. Frank, Arlington.
Wallace, John L., Jr.,
Medical Arts Bldg., Fort Worth.
*Walsh, Edmund N.,
1310 Medical Arts Bldg., Fort Worth.
Waltrip, P. M., Jr. (Ina.),
3660 Manderly Pl., Fort Worth.
Ware, Drue O. D.,
1302 W. Magnolia Ave., Fort Worth.
Watson, Asa C., Jr.,
875 Fifth Ave., Fort Worth.
Webb, Wm. S.,
1505 Medical Arts Bldg., Fort Worth.
*West, Walter B.,
1067 W. Magnolia, Fort Worth.
Westbrook, Bonnie B. (In.),
City-County Hosp., Fort Worth.
Whayne, Harry U., Jr.,
2501 W. Berry, Fort Worth.
*White, Richard J.,
1214 W. T. Waggoner Bldg., Fort Worth.
*Whittenburg, Ross,
1221 W. Lancaster Ave., Fort Worth.
Whorton, Carl M.,
P. O. Box 1719, Fort Worth.
Wier, Edward M.,
800 5th Ave., Fort Worth.
Wiggins, Kenneth,
1710 Medical Arts Bldg., Fort Worth.
*Wiggins, John A.,
1105 Pennsylvania Ave., Fort Worth.
Willis, Hersel F.,
Medical Arts Bldg., Fort Worth.
Williams, Claude,
815 Medical Arts Bldg., Fort Worth.
Williams, Marion F. (In.),
City-County Hosp., Fort Worth.
Wilson, Edwin B., Jr.,
1501 Summit Ave., Fort Worth.
Wilson, Stephen W. (Sec'y),
208 Medical Arts Bldg., Fort Worth.
*Wise, Joe R.,
1519 Pennsylvania Ave., Fort Worth.

MEMBERSHIP LIST, 1954—*continued*

*Wollenman, O. J., Jr.,
Medical Arts Bldg., Fort Worth.
Womble, Joe Dean, Arlington.
Wood, Wm. W., Jr.,
1408 Medical Arts Bldg., Fort Worth.
*Woodward, Cicero S., Arlington.
Woodward, Mortimer (Hon.),
332 W. Harris, San Angelo.
*Woodward, Valin R., Arlington.
Worrall, Cyrus L.,
6400 Greenway, Fort Worth.
Wyss, Herbert E., Keller.

TAYLOR-JONES

*Adams, Clinton E.,
Alexander Bldg., Abilene.
Adamson, Wm. B., Clinic Bldg., Abilene.
Ailts, Bernard H.,
1052 N. 5th St., Abilene.
Alexander, James M. (Hon.),
Box 58, Abilene.
Anderson, F. Katherine,
1052 N. 5th St., Abilene.
Andrus, Allen G., Anson.
Arrant, Arthur G., 868 Hickory, Abilene.
Barnett, W. H. (Hon.),
1830 N. 3rd St., Abilene.
Bessire, Milton C.,
1325 Hickory, Abilene.
*Bowyer, Mack F.,
1101 N. 19th St., Abilene.
Boyd, Virginia H., Box 333, Abilene.
Bridge, Harry R., 618 Cedar, Abilene.
Bridges, James P., Clinic Bldg., Abilene.
Burditt, Jesse N., Clinic Bldg., Abilene.
Burditt, Tom C., 1442 N. 3rd St., Abilene.
Burns, Coleman C.,
Medical Arts Bldg., Abilene.
Buzbee, H. Ray, 1101 N. 19th St., Abilene.
Cadenhead, James F. (Mil.).
Cash, W. Auda V., Box 1858, Abilene.
*Cockerell, Earl R., Clinic Bldg., Abilene.
Colbert, Robt. E., Rule.
Crow, Jack A., Medical Bldg., Abilene.
*Duff, J. C. (Pres.), Anson.
Estes, J. M., 641 Hickory, Abilene.
*Estes, Sol B., 1502 N. 2nd St., Abilene.
Fain, Robt. H. (Mil.).
Fox, Wm. Irby, 618 Cedar, Abilene.
Gardner, Chester B., Merkel.
Gibson, John P., 202 Grape St., Abilene.
Gilmore, John Frank, 1325 Hickory, Abilene.
Grubbs, L. F. (Hon.), Pine Castle, Fla.
Hamilton, Hinton H., 618 Cedar, Abilene.
Harper, Orville E., Box 2321, Abilene.
Hawkins, Elmer J., Hamlin.
Haynes, Jack S., 725 Leggette Dr., Abilene.
Hedrick, T. Wade, Box 2321, Abilene.
Helcher, Phyllis O., 317 Butternut, Abilene.
Hodges, Frank C.,
1133 N. 19th St., Abilene.
Hollis, Scott W., Medical Arts Bldg., Abilene.
*Hooks, Jim M., 1133 N. 19th St., Abilene.
Hudson, F. E. (Hon.), Stamford.
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WILBARGER

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*Borchardt, Alvin L., Vernon.
Coleman, William C., Vernon.
Featherston, E. W., Vernon.
Hollar, Emory D., Vernon.
Lemee, Raymond A., Vernon.
Miller, Bradford W., Vernon.
Muirhead, James J., Vernon.
Rogers, Albert C., Vernon.
Slaugenhop, J. J., Vernon.
Spaar, Albert P., Jr., Vernon.
*Steele, Franklin B. (Pres.), Vernon.

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Corgill, Donald A., V. A. Hospital, McKinney.
Duff, Robert L., McKinney.
Erwin, J. C., Jr., McKinney.
Hooper, John M., McKinney.
Hutcheson, George O., Jr., McKinney.
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Lovell, Barney W. (In.), McKinney.
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*Wright, William C., Farmersville.
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Wysong, H. Dudley, McKinney.
Wysong, W. S., Sr., McKinney.
Wysong, W. Scott, Jr., McKinney.

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*Atchison, Jas. W., Gainesville.
*Cirone, Vincent C., Gainesville.
Davenport, Howard S., Gainesville.
Evashwick, George (Sec'y), Gainesville.
Fisch, Ben R. (Pres.), Gainesville.
Lusk, Clu Flu. Gainesville.
Mills, Chas. K., Gainesville.
Myrick, Thos. S., Muenster.
Powell, Wm. F., Gainesville.
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610 Medical Arts Bldg., Dallas.
Fischer, John Philip, 8421 Ames, Dallas.
Fisher, Thos. B. (Hon.),
5834 Belmont, Dallas.
Flohr, Leonard J., 2514 Welborn, Dallas.
Fogelman, Morris J.,
Southwestern Medical School, Dallas.
Fogleman, James Douglas,
3330 S. Lancaster Road, Dallas.
*Fowler, Hanes M., 208 S. Zangs, Dallas.
Fowler, W. W. (Hon.),
1521 Medical Arts Bldg., Dallas.
*Fox, Everett C., Medical Arts Bldg., Dallas.
*Franklin, Floyd S., 3606 Maple, Dallas.
Franklow, C. D.,
1506 Medical Arts Bldg., Dallas.
Freeman, George A. (In.),
St. Paul Hosp., Dallas.
Fromm, Chas. S., 3707 Gaston Ave., Dallas.
Fry, Murdock D.,
1132 Medical Arts Bldg., Dallas.
Fuller, Wm. W., 6200 Lemmon. Dallas.
Funk, Presley C., 2615 Inwood Rd., Dallas.
Fuqua, Foster,
426 Medical Arts Bldg., Dallas.
Fuqua, W. N., Jr., 3707 Gaston Ave., Dallas.
Furchgott, Ludwig A.,
Medical Arts Bldg., Dallas.
Gaines, Sidney W., Grand Prairie.
Galt, Jabez, Medical Arts Bldg., Dallas.
Galt, Sidney, Medical Arts Bldg., Dallas.
Garner, Amos D., 3607 Gaston, Dallas.
Garrett, H. Grady,
3427 Cedar Springs, Dallas.
Geary, F. B., Jr., 219 W. 10th, Dallas.
German, James L. (In),
V. A. Hosp., McKinney.
Gibbons, O. W., Medical Arts Bldg., Dallas.
Gilbert, Franklin M., 313 Iowa St., Irving.
Gilbert, Stanley L., 2615 Inwood Rd., Dallas.
Gilbert, Taylor C.,
628 Medical Arts Bldg., Dallas.
*Giles, Robt. B.,
1114 Medical Arts Bldg., Dallas.
*Gill, Atticus J., 7021 Lakeshore Dr., Dallas.
Gill, Dan C., 3623 Gillespie, Dallas.
Gill, Horace E., Okmulgee, Okla.
Gilmore, Jack T., 2615 Welborn, Dallas.
Girard, Percy M., 2601 Welborn, Dallas.
Goff, Gomer F., 3601 Cedar Springs, Dallas.
*Goforth, John L., Box 1074. Dallas.
Goggans, Roy F., Parkland Hospital, Dallas.
Goldfarb, Irvin J. (In.), V. A. Hosp., Dallas.
Goode, James E. (In.),
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*Goode, John V., 3707 Gaston Ave., Dallas.
*Goodfried, M. Paul, 3618 Fairmount, Dallas.
*Gordon, Clarence E., Baylor Hospital, Dallas.
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Gossard, Wayne H., Parkland Hosp., Dallas.
Gottlich, Arthur P.,
800 N. Washington, Dallas.
Graham, Jas. F.,
1418 W. Jefferson, Dallas.
Graham, Marion F.,
182 Casa Linda Plaza, Dallas.
Graham, Russell B., 4105 Live Oak, Dallas.
*Grater, William C.,
614 Medical Arts Bldg., Dallas.
Gray, George A., 3700 Ross Ave., Dallas.
Greathouse, C. W. (In.),
Parkland Hosp., Dallas.
Green, Adam D., 4105 Live Oak, Dallas.
Green, F. Ray, 8327 Santa Clara, Dallas.
Green, Tim R., 1107 W. Jefferson, Dallas.
Greve, Marion J., 3607 Gaston Ave., Dallas.
Griffin, Jack B.,
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Grollman, Arthur, 2211 Oak Lawn, Dallas.
Gross, Perry E., 1406 Forest Ave., Dallas.
*Grossman, Mervin H., St. Paul Hosp., Dallas.
Grow, Max H., 3616 Maple, Dallas.
Guerriero, Wm. F.,
3207 Turtle Creek Blvd., Dallas.
Hale, Martha Helen, 3403 Hall, Dallas.
Halebian, Hratch S.,
806 Medical Arts Bldg., Dallas.
Haley, Arvel E., 201 W. 10th, Dallas.
*Haley, Wm. E.,
702 Medical Arts Bldg., Dallas.
Hall, William L. (In.),
Baylor Hosp., Dallas.
Halley, B. C., Jr., 3707 Gaston Ave., Dallas.
Halpern, Salmon R., 3534 Maple, Dallas.
Hamilton, Chas. F.,
302 Medical Arts Bldg., Dallas.
Hampton, Jas. A.,
1026 Medical Arts Bldg., Dallas.
Harber, Harry P., 4416 Hall St., Dallas.
Hardey, C. Eugene (In.), Lockney.
Hardy, Douglas M., 3330 S. Lancaster, Dallas.
Hare, Henry P., Jr. (In.),
USPHS Hospital, Fort Worth.
Harper, Jack C., 526 E. Jefferson, Dallas.
Harrel, Don G., 220 W. Oakenwald, Dallas.
Harrington, Francis T.,
9962 Rock Brook Lane, Dallas.
*Harrington, Marion R.,
4317 Oak Lawn, Dallas.
*Harrington, S. F., 4317 Oak Lawn, Dallas.
Harris, Alfred W., 3607 Gaston, Dallas.
Harris, M. C., 1516 W. Jefferson, Dallas.
Harris, N. Joe, 4319 Oak Lawn, Dallas.
Harris, William S. (In.),
Parkland Hosp., Dallas.
Harris, Worth W., 8110 Scyene Road, Dallas.
Harrison, Ben F., Jr.,
3707 Gaston Ave., Dallas.
Harrison, Gaston G., 6115 La Vista, Dallas.
Hart, G A., Medical Arts Bldg., Dallas.
*Hartin, Richard B., Garland.
Hartman, Jas. M., Garland.
Harvill, T. Haynes,
302 Medical Arts Bldg., Dallas.
Harwood, Geo. W. (Mil.).
Hataway, Garrett A. (In.),
3819 Maple, Dallas.
Hawkins, Hubert F., 3607 Gaston, Dallas.
Hawkins, Wm. C., 4143 Cole, Dallas.
Hayes, Elmer R., 2514 Welborn, Dallas.
Hayes, H. T. (Mil.).
Haynes, Douglas M.,
Southwestern Medical School, Dallas.
Henderson, Hodgie C., Jr.,
220 W. Oakenwald, Dallas.
Henry, Albert C., Jr., 6003 Victor, Dallas.
Henry, David J., 3606 Maple, Dallas.
Herndon, Ernest T. (In.),
Parkland Hosp., Dallas.
Herndon, Jas. H., Medical Arts Bldg., Dallas.
Herrick, Richard B.,
1125 Medical Arts Bldg., Dallas.
Hesser, Robert N., 3614 Fairmount, Dallas.
Heyer, Howard E., 2606 Oak Lawn, Dallas.
Hill, Joseph M., Baylor Hospital, Dallas.
Hill, S. M., Medical Arts Bldg., Dallas.
Hodges, Harold C.,
1227 S. Buckner Blvd., Mesquite.
Hodges, Leon, 930 N. Edgefield, Dallas.
*Hodges, T. Wiley, 2615 Welborn St., Dallas.
Hoefer, Carl A., Medical Arts Bldg., Dallas.
Hoekstra, Clarence S., 2600 Welborn, Dallas.
Hoffman, Mary S.,
3330 S. Lancaster, Dallas.
Holland, John, III,
3701 Fairmount, Dallas.
Holman, James, Medical Arts Bldg., Dallas.
Holt, C. Zeno, 2615 Inwood Rd., Dallas.
Holt, J. O. S., Jr., Medical Arts Bldg., Dallas.
Hood, Marianna, 4227 Herschel, Dallas.
Hopkins, May Agness,
1032 Medical Arts Bldg., Dallas.
*Horn, Fred W., Grand Prairie.
Horn, J. Morris, 3811 Fairmount, Dallas.
Howard, Ben K. (Mil.).
Howard, George W.,
Medical Arts Bldg., Dallas.
*Howell, Jas. B., Medical Arts Bldg., Dallas.
Hubbard, David G., 3707 Gaston Ave., Dallas.
Hudgins, Ben E. (Hon.), Hutchins.
Hudson, W. Lee (Hon.),
4312 Overhill Dr., Dallas.
Huggins, Clifford S. (Mil.).
Hunter, Richard B. (In.),
6715 Chevy Chase, Dallas.

MEMBERSHIP LIST, 1954—*continued*

Hurt, L. B., 3917 Miramar, Dallas.
*Hutton, Sam B., Jr.,
Medical Arts Bldg., Dallas.
Irvine, Eugene J., 5400 Reiger Ave., Dallas.
Irving, W. M., Jr., 820 Irving Blvd., Irving.
Jablow, Harry B., Medical Arts Bldg., Dallas.
Jackson, Mary Ruth,
3629 Fairmount, Dallas.
Jackson, Michael C. (Mil.).
Jackson, Reuben W., 3716 Maple, Dallas.
James, Geo. Taylor, 3535 Fairmount, Dallas.
*James, Geo. Truett, 3701 Maple, Dallas.
*Jenkins, Marion T.,
Parkland Hospital, Dallas.
Jenkins, Speight,
814 Medical Arts Bldg., Dallas.
Jennings, Mary A., 4210 Lemmon, Dallas.
Jernigan, C. Richard (Mil.).
Johnson, Alvis F. (In.),
2211 Oak Lawn, Dallas.
Jones, Charles B.,
6604 Snider Plaza, Dallas.
*Jones, George M.,
1314 Medical Arts Bldg., Dallas.
*Jones, J. Guy, 2512 Welborn, Dallas.
Jones, Robert A., Lancaster.
Jones, Robert F. (In.),
3519 Fairmount, Dallas.
Jones, W. D., 3116 Live Oak St., Dallas.
Jordan, Irvine G., Jr. (Mil.).
Jordan, J. Russell, 3607 Gaston, Dallas.
Jordan, Lois F., 3607 Gaston, Dallas.
Kahn, Samuel H., Medical Arts Bldg., Dallas.
Kamholz, Jack H.,
3534 Maple Ave., Dallas.
Kantor, Herman I., 3534 Maple, Dallas.
Katz, Sol M., 800 N. Washington, Dallas.
Keene, Albert H. (Mil.).
Kelly, Thos. E., 3520 Greenville Ave., Dallas.
Kent, Jas. M., 182 Casa Linda Plaza, Dallas.
*Kerr, Jack G., 921 Medical Arts Bldg., Dallas.
Kethley, Jerold D. (In.),
Parkland Hospital, Dallas.
*Kidd, Frank H., Jr., 4227 Herschel, Dallas.
*Kilgore, Donald G.,
Medical Arts Bldg., Dallas.
Kilgore, Donald G., Jr.,
Charity Hospital, New Orleans, La.
Kindley, George C., 3116 Live Oak, Dallas.
King, Carey G., 2703 Oak Lawn, Dallas.
King, Karl B., Medical Arts Bldg., Dallas.
Kipp, Dean C.,
921 Medical Arts Bldg., Dallas.
*Kirksey, Thos. M.,
Medical Arts Bldg., Dallas.
Kleban, Nathan (In.),
6151 Parkdale Dr., Dallas.
Kleinsasser, LeRoy J.,
3707 Gaston Ave., Dallas.
Klinger, Paul E., Jr. (Mil.).
Knapp, Joseph L.,
210 N. Westmoreland, Dallas.
Knickerbocker, B. A., 3403 Hall St., Dallas.
Knight, Marvin P., 2618 Welborn, Dallas.
*Knowles, W. Mood,
4317 Oak Lawn, Dallas.
Koch, William T., 6331 Prospect, Dallas.
Krafft, C. James, 3403 Hall, Dallas.
Krag, Cletus L. (Mil.).
Krakusin, Jacob S.,
109 Walnut Hill Village, Dallas.
Krebs, David E., 3330 S. Lancaster, Dallas.
Kregel, Louis A., 3607 Gaston, Dallas.
Krempin, Herman O.,
1511 N. Beckley, Dallas.
Kreymer, Geo. C.,
Medical Arts Bldg., Dallas.
Krusen, Edward M., Jr.,
Baylor Hospital, Dallas.
Kugler, Joseph S., 109 S. Delaware, Irving.
Kurilecz, Michael (Mil.).
LaDue, Chas. N., 2405 Hood St., Dallas.
Lair, Nard, 5 Lake Highlands Village, Dallas.
Laird, Paul C., 122 S. Jefferson, Irving.
Lancaster, Edgar L., Grapevine.
Lancaster, Mary Agnes,
1316 Medical Arts Bldg., Dallas.
Landress, J. Byron, Garland.
Langston, Wm. G., 4227 Herschel, Dallas.
Lanier, Jack E., 2615 Inwood Rd., Dallas.
Lanius, John W., Medical Arts Bldg., Dallas.
Lankford, Frances L. P.,
801 N. E. 17th St., Grand Prairie.
LaRue, Kenneth W. (In.),
Baylor Hospital, Dallas.
*Laugenour, D. P., 4338 Lemmon, Dallas.
Launey, Geo. V., 4536 S. Lindhurst, Dallas.
Leden, Ursula M., 3500 Colgate, Dallas.
*Lee, Ridings E., 3834 Shenandoah, Dallas.
Legg, Eugene P.,
Medical Arts Bldg., Dallas.
Levin, Paul M., Medical Arts Bldg., Dallas.
Levy, Harry R., Medical Arts Bldg., Dallas.
Lewallen, Wm. M. (In.)
V. A. Hosp., McKinney.
Lewis, Jerry M. (In.), 2700 Carroll, Dallas.
Light, Flominda, 7306 Ferguson, Dallas.
Lindsay, Alan E. (Mil.)
Lindsay, Guion A.,
910 Medical Arts Bldg., Dallas.
Linsey, Ralph M., Rockwall.
Lippas, John, 1717 Pacific, Dallas.
Lively, Wm. M., Jr., 526 E. Jefferson, Dallas.
LoBello, Leon C.,
1537 Medical Arts Bldg., Dallas.
Lodowski, Charles H. (Mil.)
Loeb, Ellen (In.), V. A. Hosp., McKinney.
*Loftus, Earl L., Medical Arts Bldg., Dallas.
*Loiselle, Albert O., 2601 Welborn, Dallas.
*Long, Gerald D., 4338 Lemmon, Dallas.
Long, Troy F.,
1510 Medical Arts Bldg., Dallas.
Looney, W. W., 738 W. 10th, Dallas.
Love, Frances M.,
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Love, Horace G., Jr. (Mil.).
Love, Thos. S., 4239 Prescott, Dallas.
Ludden, Keene F., 111 E. Wooden, Dallas.
Luecke, P. E., Box 28, Dallas.
Luhn, Nellie R. (In.)
Parkland Hospital, Dallas.
Lukeman, Hermann J.,
285 Casa Linda Plaza, Dallas.
Lumpkin, F. E., Jr., 936 N. Edgefield, Dallas.
Lumpkin, W. L., Jr. (Mil.).
Lyday, Victor I.,
206 Medical Arts Bldg., Dallas.
Lyon, Edward G., 2013 Commerce, Dallas.
Madison, Leonard L., 2211 Oak Lawn, Dallas.
Maffett, Minnie L.,
706 Medical Arts Bldg., Dallas.
Magers, Morris E., 4105 Live Oak, Dallas.
Mahon, George D., Garland.
Mahon, Ralph D., 6003 Victor, Dallas.
Marchman, Oscar M.,
5328 Live Oak, Dallas.
*Marchman, Oscar M., Jr.,
1434 Medical Arts Bldg., Dallas.
MarDock, Julian (In.)
P. O. Box 2145, Dallas.
Mariash, A. David (Mil.)
Marshall, Jas. H.,
1210 Medical Arts Bldg., Dallas.
Martin, Chas. L., 3501 Gaston, Dallas.
*Martin, Jas. A., 3501 Gaston, Dallas.
Martin, John G., 1511 N. Beckley, Dallas.
Martin, Thomas A., Jr.,
832 Medical Arts Bldg., Dallas.
Martinak, Richard E.,
800 N. Washington, Dallas.
Mason, Porter K.
Medical Arts Bldg., Dallas.
Massey, Warren E.,
1528 Medical Arts Bldg., Dallas.
Mathews, Paul W.,
Medical Arts Bldg., Dallas.
*Mattson, Harold A., 3223 Tennessee, Dallas.
Maupin, W. A. (Hon.), Rowlett.
*Maxfield, Geo. S. (Jack),
Medical Arts Bldg., Dallas.
*Maxfield, James R., Jr.,
St. Paul's Hospital, Dallas.
Maxfield, James R., Sr., 3601 Milton, Dallas.
*Maxwell, Hal W.,
624 Medical Arts Bldg., Dallas.
May, James L. (Mil.)
Mayfield, Imogene, 121 S. Zangs, Dallas.
*McBride, Dayton C., 3205 Oak Lawn, Dallas.
McBride, R. B., 3205 Oak Lawn, Dallas.
McCain, Bernice E.,
V. A. Hospital, McKinney.
McCall, Robert A.,
410 Medical Arts Bldg., Dallas.
McCallum, Chas. (Hon.), Mesquite.
McClung, Hugh L.,
1405 Medical Arts Bldg., Dallas.
*McCracken, J. H., Jr.,
516 Medical Arts Bldg., Dallas.
McCranie, E. James, 2211 Oak Lawn, Dallas.
McCrory, Thos. M.,
206 Medical Arts Bldg., Dallas.
McCullough, John H.,
182 Casa Linda Plaza, Dallas.
McDonald, Viola Y.,
Medical Arts Bldg., Dallas.
McFarland, Gordon B.,
3701 Fairmount, Dallas.
McGuire, Jos. H.,
1110 Medical Arts Bldg., Dallas.
McIver, Julius, 4029 Lemmon, Dallas.
McKinney, Jas. M. (Mil.).
McLaurin, Hugh L. (Hon.)
5036 Senaca, Dallas.
McLaurin, John G. (Hon.)
5542 Wenonah, Dallas.
McLeod, Jas. N.,
824 Medical Arts Bldg., Dallas.
McNamara, James C., Jr.,
7807-A Inwood, Dallas.
McNeill, Arch J.,
Medical Arts Bldg., Dallas.
McNeill, Joseph P., 3707 Gaston Ave., Dallas.
McPherson, Vernon L.,
222 S. Edgefield, Dallas.
Meisenbach, Albert E., Jr.,
300 Medical Arts Bldg., Dallas.
Mendel, E. B., 3702 Worth, Dallas.
Mendenhall, Elliott,
Medical Arts Bldg., Dallas.
*Mengert, Wm. F., 2211 Oak Lawn, Dallas.
Meredith, Chas. S. III (In.),
4500 Lancaster, Dallas.
Merrick, Ben A., 3520 Cedar Springs, Dallas.
Metz, M. Hill, 4319 Oak Lawn, Dallas.
Mewhinney, Logan U., 6115 La Vista, Dallas.
Miller, John F., 1511 N. Beckley, Dallas.
*Miller, J. E., 6407 Forest Lane, Dallas.
*Miller, Tate, Medical Arts Bldg., Dallas.
Miller, Wm. F.,
Southwestern Medical School, Dallas.
Mills, Eldon G. (In.)
St. Paul Hospital, Dallas.
Mills, James T.,
921 Medical Arts Bldg., Dallas.
Milwee, Robert H., 4227 Herschel, Dallas.
Mims, Harold M., 3524 Fairmount, Dallas.
*Minnett, John S., 2929 Welborn, Dallas.
Mitchell, Harry J., 4217 Swiss, Dallas.
Mitchell, Jos. D., Jr.,
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Montgomery, Henry G., Box 28, Dallas.
Montgomery, John C., 911 St. Joseph, Dallas.
Montgomery, Philip O'Bryan,
9039 Devonshire Dr., Dallas.
Moody, Joe V., 1511 N. Beckley, Dallas.
Mooney, Ken.
Medical Arts Bldg., Dallas.
Moore, Halcuit, 4105 Live Oak, Dallas.
Moore, Ramsay, 3631 Fairmount, Dallas.
Moore, Robert L., 3403 Hall, Dallas.
Morris, A. Truitt, 3701 Fairmount, Dallas.
Morris, Charles R.,
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Morris, Donald P.,
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Morris, John W., 4500 S. Lancaster, Dallas.
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*Muirhead, Ernest E.
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Mullikin, Gerald G. (Mil.)
Munsell, Donald W., 3607 Gaston, Dallas.
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Murphy, Robt. E. (Mil.)
Murray, Hugh D. (In).
238 W. 10th St., Dallas.
Mustain, Rhoads, 3607 Gaston, Dallas.
*Nash, Cleve C. (dead), Dallas.
Nash, Gloria H., 1100 Canterbury, Dallas.
Nash, Tom M.,
729 Medical Arts Bldg., Dallas.
Needham, Perry O.,
Medical Arts Bldg., Dallas.
Neel, Joseph C., Medical Arts Bldg., Dallas.
Nelson, Leo A. (Hon).
6333 Richmond, Dallas.
Nesbit, Harold T., Medical Arts Bldg., Dallas.
Nesbitt, Irene T., 4335 Lemmon, Dallas.
Neuman, Albert, 3829 Hall, Dallas.
Newell, Edward A.,
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Newell, Philip D., 930 N. Edgefield, Dallas.
Newman, Harvey M. III (Mil.).
Newson, Asa A., 4227 Herschel, Dallas.
Newson, Asa A., Jr. (Mil.).
Newton, Frank H.,
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Niblo, Grady, Jr., 351 W. Jefferson, Dallas.
Nitsche, E. W., 5749 Gaston, Dallas.
Noonan, Richard L., Grand Prairie.
Norman, Floyd A., 4123 Cole, Dallas.
Obenchain, Thos. H., Jr.,
705 Medical Arts Bldg., Dallas.
O'Brien, Harold A.,
Medical Arts Bldg., Dallas.
O'Brien, Justin D.,
Medical Arts Bldg., Dallas.
Ogle, Joseph C. (In.)
V. A. Hosp., McKinney.
Ormond, Anthony M. (Mil.)
Pace, John M.,
427 Medical Arts Bldg., Dallas.
*Park, Barton E.,
1121 W. Jefferson, Dallas.
Parker, Edward R., 5511 Hudson, Dallas.
Passamonte, Jane A.
1516 W. Jefferson, Dallas.

MEMBERSHIP LIST, 1954—*continued*

Paternostro, C. J.,
Medical Arts Bldg., Dallas.
Patterson, Casey E.,
729 Medical Arts Bldg., Dallas.
*Patterson, Cecil O.,
3537 Southwestern Blvd., Dallas.
Patton, Walter H., 6003 Victor, Dallas.
Paulson, Donald L.,
3810-12 Swiss, Dallas.
*Payne, Virgil M., Jr.,
1209 Medical Arts Bldg., Dallas.
*Payne, Wm. T., 2601 Welborn St., Dallas.
Pearcy, Frank, 2606 Oak Lawn, Dallas.
Peden, James K.,
1420 Medical Arts Bldg., Dallas.
Pence, Ludlow M.,
834 Medical Arts Bldg., Dallas.
Peyton, John B., Medical Arts Bldg., Dallas.
Phillips, James R., Grand Prairie.
Pickard, James M.,
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Pickett, Taylor T., 5702 Goliad, Dallas.
Pickett, Walter F. (Hon.),
6504 Ravendale Lane, Dallas.
Pickett, William H.,
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Pickle, Coy R., Garland.
Pierson, Milton A., 6003 Victor, Dallas.
Piranio, Joe C., 914 N. Avon, Dallas.
Popkess, Fred G., 13616 Preston Rd., Dallas.
Porter, Geo. L., Medical Arts Bldg., Dallas.
Porter, Louis H. (Mil.).
Portman, Robt. K.,
1315 W. Jefferson, Dallas.
Potts, James M. (Hon.)
519 Medical Arts Bldg., Dallas.
Potts, Robert J.,
1113 Magnolia Bldg., Dallas.
Potts, Wm. H., Jr., Box 28, Dallas.
Powell, Homer (Hon.),
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Powell, John C., Jr.,
218 N. Westmoreland, Dallas.
Powers, Hugh W. S.,
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Prejean, Oran V., 4317 Oak Lawn, Dallas.
Price, Harry S., 351 W. Jefferson, Dallas.
Price, Thos. G. (In.)
V. A. Hospital, Dallas.
Puls, Richard J. (In.)
Parkland Hospital, Dallas.
Quilligan, Jas. J., Jr.,
Children's Medical Center, Dallas.
Quinn, Lester H., 3617 Fairmount, Dallas.
Race, Geo. J. (In.),
721 Huntington Ave., Boston, Mass.
Range, N. Haskell, 6331 Prospect, Dallas.
Rattan, Paul M., Medical Arts Bldg., Dalias.
Reagan, A. Morris, 3903 Gaston Ave., Dallas.
Reddick, W. Grady,
Medical Arts Bldg., Dallas.
Reisman, David D., 5118 Lahoma, Dallas.
Renken, Harry J., Jr., 3814 Swiss, Dallas.
Reuss, G. Thomas, Box 8074, Dallas.
Reynolds, Robert A., 4105 Live Oak, Dallas.
Reynolds, Wm. S.,
1314 Medical Arts Bldg., Dallas.
Rhodes, Edward L. (In.)
Methodist Hospital, Dallas.
Richardson, Edward R.,
1610 Medical Arts Bldg., Dallas.
Richburg, Paul L. (In.),
V. A. Hospital, McKinney.
Richmond, Marion B.,
3928 Bryn Mawr Dr., Dallas.
Ricketts, Marion M. (In.)
V. A. Hospital, Dallas.
Riddle, Penn, 202 Medical Arts Bldg., Dallas.
Rifkin, Leonard M.,
Medical Arts Bldg., Dallas.
*Rippy, Edwin L., 3622 Fairmount, Dallas.
Ritchey, Lloyd F., 4317 Oak Lawn, Dallas.
Robbins, Jacob H.,
1406 Forest Ave., Dallas.
Roberts, Joe H., 101 S. Iowa, Irving.
Roberts, Tom Ray, 6331 Prospect, Dallas.
Robertson, James E., 3607 Gaston, Dallas.
Robinson, Wayne T.,
3814 Fairmount, Dallas.
*Roe, Maurice A. (Mil.).
Rogers, Fred T., Box 28, Dallas.
Rogers, Gene W., Methodist Hospital, Dallas.
Rogers, Harriet N.,
West Dallas Health Dept.,
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Rogers, Paul A.,
1514 Medical Arts Bldg., Dallas.
Rosenthal, Raoul S.,
3524 Fairmount, Dallas.
Ross, Edward S., 2929 Welborn, Dallas.
*Ross, James K.,
1119 Medical Arts Bldg., Dallas.
Rosser, Curtice,
710 Medical Arts Bldg., Dallas.
Rothschild, J. E., 3614 Fairmount, Dallas.
Rounsaville, John Q.,
1121 W. Jefferson, Dallas.
*Rouse, M. O.,
1108 Medical Arts Bldg., Dallas.
Rowe, Robert J., 3707 Gaston Ave., Dallas.
Russell, Melvin G., Jr. (In.),
214 S. Wilomet St., Dallas.
Sacher, Clarence B.,
817 Medical Arts Bldg., Dallas.
Saldivar, Julian T.,
2615 Cole Ave., Dallas.
Sams, Lewis C., 201 W. 10th, Dallas.
Sanders, Oscar Perdue (Mil.).
Sazama, John J., Jr., Baylor Hosp., Dallas.
Scales, John G., 400½ W. 9th, Dallas.
Scanland, Viola P.,
623 Medical Arts Bldg., Dallas.
Schaefers, J. G., Jr.,
635 Medical Arts Bldg., Dallas.
*Schenewerk, Geo. A.,
Medical Arts Bldg., Dallas.
Schnitzer, Bernard (Mil.).
*Schoch, Arthur G., Medical Arts Bldg., Dallas.
Schoolfield, Ben L.
Medical Arts Bldg., Dallas.
Schreiber, Gus, Jr., 3719 Hall, Dallas.
Schroeder, Chas. F.,
910 Duncanville Road, Dallas.
Schuett, Albert J., Medical Arts Bldg., Dallas.
Schwenkenberg, Arthur J.,
210 N. Westmoreland, Dallas.
Scott, George W. (dead), Irving.
Scurry, Maurice M.,
3225 Turtle Creek Blvd., Dallas.
Sears, Alvin D. (In.), Parkland Hosp., Dallas.
Sears, William F. (In.)
Methodist Hospital, Dallas.
Seay, Frank O.
1610 Medical Arts Bldg., Dallas.
Sebastian, F. J., 3607 Gaston, Dallas.
Seely, M. Stuart,
416 Medical Arts Bldg., Dallas.
Seidel, Clifford C. (Mil).
Seldin, Donald W.,
2211 Oak Lawn, Dallas.
*Selecman, Frank A. (Pres.)
Medical Arts Bldg., Dallas.
Sellers, Lyle M., Medical Arts Bldg., Dallas.
Sellman, Willard C.,
313 Medical Arts Bldg., Dallas.
Sewell, James W.,
221 Southeast Shopping Center, Dallas.
Sbane, J. Howard,
1421 Medical Arts Bldg., Dallas.
Shannon, Hall,
1229 Medical Arts Bldg., Dallas.
Shannon, Manning B., Jr.,
3512 Fairmount, Dallas.
Shapiro, Alvin P.,
2211 Oak Lawn, Dallas.
Shaw, Robert R.,
3810 Swiss, Dallas.
Shelburne, Samuel A.,
3707 Gaston, Dallas.
Sbeldon, Lawrence B.,
Medical Arts Bldg., Dallas.
Shelmire, J. Bedford,
1410 Medical Arts Bldg., Dallas.
Shelmire, J. Bedford, Jr.,
1410 Medical Arts Bldg., Dallas.
Shelton, Wm. P.,
2600 Welborn, Dallas.
Shessel, Herbert L. (Mil.).
Shinn, Bonner L. (Mil.).
Shires, George T. (Mil.)
Shoecraft, Warren A.,
135 W. 10th, Dallas.
*Sbort, Robert F.,
Medical Arts Bldg., Dallas.
Shortal, Wm. W., 4217 Swiss, Dallas.
Shropulos, George P., 722 N. Beacon, Dallas.
Shuey, Chas. B.,
3510 Fairmount, Dallas.
Siebel, Eldon K., 202 W. 10th St., Dallas.
Siegel, Zundel,
1900 Forest, Dallas.
Sigler, Howard Y., 4217 Swiss, Dallas.
Simner, Robert R., Colma, Calif.
Singleton, John D.,
3704 Dickason, Dallas.
Slaugbter, B. Celia,
4105 Live Oak, Dallas.
Small, Andrew B., 3707 Gaston, Dallas.
Smitb, Alice L., Parkland Hospital, Dallas.
Smith, Cbas. L., Garland.
Smith, C. Robt. (Mil.)
Smith, Lois W.,
3520 Fairmount, Dallas.
Smith, Louis S., St. Paul Hospital, Dallas.
Smith, Ralpb C.,
V. A. Hospital, Dallas.
Smitb, Richard M., Box 28, Dallas.
Smith, Sydnie G. (In.)
Baylor Hospital, Dallas.
Smith, Tom E.,
2600 Welborn St., Dallas.
Smith, Wright K.,
221 Southeast Shopping Center, Dallas.
Sorrells, Chas. C.,
351 W. Jefferson, Dallas.
Sowers, Harry B.,
4618 San Jacinto, Dallas.
*Sparkman, Robt. S.,
4518 University Blvd., Dallas.
Speegle, Jackson H.,
210 N. Westmoreland, Dallas.
Speegle, Robert E., Garland.
Spegal, Doris V.,
6115 La Vista, Dallas.
Spence, Harry M.,
4105 Live Oak, Dallas.
Sprinkle, Davis L.,
1205 S. Buckner Blvd., Dallas.
Stack, John W., Mesquite.
Stanley, E. Stephen,
806 Medical Arts Bldg., Dallas.
Stapp, William F. (In.),
Parkland Hospital, Dallas.
Stayer, David S.,
209 Medical Arts Bldg., Dallas.
Stayer, Glenn C.,
206 W. 10th, Dallas.
Stell, Cecil I.,
3617 Fairmount, Dallas.
Stephenson, James H.,
4523 Cedar Springs, Dallas.
*Stephenson, Wm. O. (Hon.)
4005 Hall, Dallas.
Stevenson, Stanley L. (In.),
3903 Holland, Dallas.
Stewart, Allen T., Jr. (In.),
801 Brooks, Dallas.
Stiles, Wendel A.,
Medical Arts Bldg. Dallas.
Stirman, Jerry A. (Mil.).
Strauss, Elias, 3707 Gaston, Dallas.
Strickland, Wm. M., Jr. (In.),
Parkland Hospital, Dallas.
Strong, James C.,
Dept. of Public Health, Dallas.
Strother, E. B. (Hon.),
3604 Purdue, Dallas.
Strother, Wm. K., Jr.
4227 Herschel, Dallas.
Stuart, John A., Jr.
3207 Turtle Creek Blvd., Dallas.
Super, Archie R.,
420 Medical Arts Bldg., Dallas.
Sutherland, Dan R. (In.),
4019 Maple, Dallas.
Suttle, R. Courtney,
3402 McFarland, Dallas.
Sweeney, J. Shirley,
4005 St. Andrews Dr., Dallas.
Sykes, W. M. (Hon.),
4208 Morrow St., Waco.
Sypert, J. Reed (Hon.),
6443 Del Norte, Dallas.
Talkington, P. C.,
919 Medical Arts Bldg., Dallas.
Tandy, Charles C. (In.),
2926 Maple Springs, Dallas.
Taylor, H. Earl,
Medical Arts Bldg., Dallas.
Taylor, Harvey S. (Hon.),
7902 Jacobie, Dallas.
Terry, J. Glenn,
1001 St. Josepb, Dallas.

MEMBERSHIP LIST, 1954—*continued*

Terry, Jack S.,
5535 Denton Dr., Dallas.
Thomas, Harold R., 3707 Gaston, Dallas.
Thomas, Paul J.,
3814 Swiss, Dallas.
Thomas, W. Maxwell,
Medical Arts Bldg., Dallas.
Thomasson, A. Ray, Jr.,
Medical Arts Bldg., Dallas.
*Thomasson, A. Ray, Sr.,
Medical Arts Bldg., Dallas.
Thompson, B. M., 218 S. Main, Irving.
*Thompson, Leone S.,
724 Medical Arts Bldg., Dallas.
Thompson, Leone S., Jr. (Mil.).
Thornton, Chas. W. (Hon.),
110 S. Bishop, Dallas.
Tigertt, W. D. (Mil.).
Tittle, Guy A.,
3600 Fairmount, Dallas.
Tobian, Louis, Jr. (In.),
2211 Oak Lawn, Dallas.
Tobolowsky, Dave,
Wynnewood Med. & Prof. Bldg., Dallas.
Tobolowsky, Nathan, 1811 Forest, Dallas.
Tocker, Albert M., 915 St. Joseph, Dallas.
Tomkies, Jas. S.,
Medical Arts Bldg., Dallas.
Tompkins, Frances L., Grand Prairie.
Touchstone, Jay L.,
606 Medical Arts Bldg., Dallas.
*Trumbull, Robt. A.,
Medical Arts Bldg., Dallas.
Tsukahara, Wm.,
1400 Forest Ave., Dallas.
Tubb, Cullen L.,
1610 Medical Arts Bldg., Dallas.
Turbeville, Louis R.,
182 Casa Linda Plaza, Dallas.
Uhler, Claude, 226 S. Edgefield, Dallas.
Ulevitch, Herman,
911 St. Joseph St., Dallas.
*Underwood, Geo. M., Box 28, Dallas.
Vanatta, John C. III,
Southwestern Medical School, Dallas.
Van Cleave, Charles E. (In.)
Parkland Hospital, Dallas.
Van Duzen, R. E.,
721 Medical Arts Bldg., Dallas.
Vassallo, Alfred L.,
6738 Glendora, Dallas.
Veninga, Frederick W.,
3520 Cedar Springs, Dallas.
Vermooten, Vincent,
2609 Welborn, Dallas.
Vieaux, Jules W.,
4227 Herschel, Dallas.
Votteler, Theodore P. (In.),
Parkland Hospital, Dallas.
Waddell, Otto Jay,
Medical Arts Bldg., Dallas.
Wade, T. W.,
V. A. Hospital. Dallas.
Wagner, Wilson O., Carrollton.
Wahle, George H., Jr., (Mil.)
Waldman, M. F.,
6115 La Vista, Dallas.
Waldron, W. Doyle,
118 S. Edgefield, Dallas.
Walker, Jack Earl,
Ogbomasho, Nigeria, W. Africa.
Walker, Price M. (Hon.),
2225 Bellefontaine Blvd., Houston.
Wallace, Gordon K.,
Medical Arts Bldg., Dallas.
Ware, Elgin W., Jr.,
426 Medical Arts Bldg., Dallas.
Ware, F. Leon,
2618 Welborn, Dallas.
Warren, Chas. H.,
506 Medical Arts Bldg., Dallas.
Wasserman, Eugene,
3607 Gaston, Dallas.
Watkins, Albert B., Seagoville, Texas.
Watkins, Margaret,
3503 Fairmount, Dallas.
Weary, Willard B.,
3607 Gaston, Dallas.
Webb, Robert W.,
4338 Lemmon, Dallas.
Weed, Olga, 2127 Inwood Rd., Dallas.
Weiner, David O.,
333 Medical Arts Bldg., Dallas.
Weir, Earl F.,
Baylor Hospital, Dallas.
*Weisz, Stephen,
1526 Medical Arts Bldg., Dallas.
*Welch, Mark L.,
906 Medical Arts Bldg., Dallas.
Wells, James T. (Hon.),
330 Irwin-Keasler Bldg., Dallas.
West, Ann,
614 Medical Arts Bldg., Dallas.
Wetegrove, John F. (In.),
V. A. Hospital, McKinney.
Wharton, Turner A.,
Medical Arts Bldg., Dallas.
White, Claud V.,
3525 Cedar Springs, Dallas.
White, Edward,
523-525 Medical Arts Bldg., Dallas.
White, Hugh D.,
3429 University Blvd., Dallas.
*Whitney, David G.,
3607 Gaston Ave., Dallas.
*Whitten, Merritt B.,
1430 Medical Arts Bldg., Dallas.
Whittlesey, P. E., Jr. (In.),
V. A. Hospital, McKinney.
Wilke, Joseph E., Jr.,
930 N. Edgefield, Dallas.
Wilder, Felix F. (In.),
V. A. Hospital, Dallas.
Wilkinson, Wallace B.,
101 N. Zangs, Dallas.
Williams, G. Raworth,
616 Medical Arts Bldg., Dallas.
Williams, Paul C.,
3607 Gaston, Dallas.
Willis, Raymond S.,
6003 Victor, Dallas.
Wilson, Ben J.,
Parkland Hospital, Dallas.
Wilson, Charles M.,
Medical Arts Bldg., Dallas.
Winans, Henry M., Jr. (In.),
Baylor University Hospital, Dallas.
Winans, Henry M.,
2703 Oak Lawn, Dallas.
*Winborn, Claude D.,
3707 Gaston Ave., Dallas.
Winn, Robert E.,
2606 Welborn, Dallas.
Winn, Watt W.,
2606 Welborn, Dallas.
Winslow, Grover C. (In.),
2347 Log Cabin Ave., Dallas.
*Witt, Guy F.,
1530 Medical Arts Bldg., Dallas.
Wolfe, Joseph,
3609 Cedar Springs, Dallas.
Wolff, Paul M.,
Medical Arts Bldg., Dallas.
Wolford, Robert B.
1114 Commerce, Dallas.
Womack, Jack I.,
3627 Gillespie, Dallas.
*Wood, Joe B.,
6631 Golf Drive, Dallas.
Woodard, Gay T.,
121 S. Zangs, Dallas.
Woodard, T. Leroy,
202 Medical Arts Bldg., Dallas.
*Woods, Ozro T.,
4105 Live Oak, Dallas.
Woolf, Jack I.,
3607 Gaston, Dallas.
Wynne, Buck Jim (In.),
5100 Cornell, Chicago, Ill.
Yarbrough, O. Carl, (In.),
Parkland Hospital, Dallas.
Yelle, John E. (In.),
V. A. Hospital, Dallas.
Young, John G.,
4005 St. Andrews, Dallas.
Youngblood, J. Wade,
4239 Prescott, Dallas.

DENTON

Adami, Gilbert E., Denton.
Allen, Joseph H. (Hon.), Justin.
*Boyd, Dickson K., Denton.
Burgess, H. M., Denton.
Carrigan, Thos. A., Denton.
Davis, Bert E., Denton.
Farber, Harry, Denton.
Glass, Paul F., Jr., (Mil.)
Hayes, Lindley O., Denton.
Hinkle, George W., Denton.
Holland, Joseph W., Denton.
Holland, Martin L., Denton.
*Jones, James H., Denton.
Kinard, Conrad L., Denton.
McLendon, Harry M., Denton.
Maddox, W. Gordon., Denton.
Miller, Walter S., Jr., Denton.
Moreland, Virginia L. (Sec'y), Denton.
Norgaard, Hal V., Denton.
Palmer, Robert B., Lewisville.
Patterson, Thos. V., Denton.
Remley, William Arch, Denton.
Shirley, Geraldine W. S., Denton.
Short, Bobby J. (Ina.), Denton.
Strahan, Eva E., Denton.
Sullivan, John M., Sanger.
Thomas, J. David (Pres.), Denton.
Trotter, Raleigh F. (Mil.),
Weathers, Paul E., Pilot Point.
Wyss, Albert E., Denton.

ELLIS

Baker, Edmund F., Ennis.
Ball, Wm. P., Jr. (Pres.), Waxahachie.
Clark, Joseph L., Ennis.
Curby, John H. (Hon.), Maypearl.
*Donnell, Herbert, Waxahachie.
Dykes, Arthur O., Italy.
Estes, Ted G., Waxahachie.
Gough, Edgar F. (Hon.), Waxahachie.
Gray, C. E. (Hon.), Ennis.
*Hastings, Miles E., Waxahachie.
Jenkins, John B. (Dead), Waxahachie.
*Jeter, James R., Ennis.
Jones. J. Edward, Waxahachie.
King, John D. (Mil.)
Kochevar, Gerald J., Midlothian.
*McCall, Walter P., Ennis.
*McLean, Raymond N. Waxahachie.
Silman, James B., (Sec'y), Waxahachie.
Skrivanek, Daniel A., Ennis.
Skrivanek, E. J., Ennis.
Somer, Frank A., Ennis.
Stein, Ben, Ferris.
Stoker, G. P. (Hon.), Red Oak.
Story, Fred, Ennis.
Swanson, LaVerne Robt., Ferris.
*Tenery, R. Mayo, Waxahachie.
Tenery, Wm. C., Waxahachie.
*Thomas, Anton L., Ennis.
*Wallace, B. C., Jr., Waxahachie.
*Watson, Seaborn H., Waxahachie.
West, Norman L., Waxahachie.

FANNIN

Biggers, Lawton C., Bonham.
Davis, James W., Leonard.
Donaldson, James M., Bonham.
Morgan, Lewie E. (Pres.), Bonham.
Risser, Joe A., Bonham.
Saunders, David J. (Hon.), Bonham.
Sellers, Sidney P., Honey Grove.
Stevens, Joe L., Bonham.
Williams, Ethelbert C. (Sec'y), Bonham.

GRAYSON

Ackert, Joseph W., Denison.
Bates, I. C., Sherman.
Blassingame, W. Doak, Denison.
Boyd, Arthur M., Sherman.
Brandt, Donald H., Denison.
Brown, Hubert L., Sherman.
Carter, Wilbur, Sherman.
Clayton, Stanley, Denison.
Dildy, R. H. (Mil.)

MEMBERSHIP LIST, 1954—*continued*

Donaghey, Chas. J., Sherman.
*Duncan, Robt. W., Denison.
Ellis, John W., Sherman.
Enloe, David C., Sherman.
*Essin, Emmett M., Sherman.
*Etter, Edward F., Sherman.
Fowler, Forest F., Denison.
Freeman, Don W., Denison.
Gerard, Rene G., Denison.
*Gleckler, Arthur, Sherman.
Hailey, Eugene L., Denison.
Hardy, John M., Sherman.
Kepler, Corliss C., Denison.
Levin, Samuel O., Denison.
McFarling, James E., Denison.
Miller, Frank P., Denison.
Mize, William B., Sherman.
Monroe, Stanley E., Sherman.
Moorman, T. A., Denison.
Norman, Lois L., Sherman.
Perlson, Samuel G. (Mil.).
Pierce, Paul L. (Pres.), Denison.
Reid, Creighton, Sherman.
Rowland, Robt. H., Jr., Sherman.
Rowlett, Geo. S., Jr., Sherman.
Shytles, Harry M., Jr., Sherman.
*Southerland, Wm. I., Sherman.
Sporer, Frank M., Van Alstyne.
Stoolfire,, Arthur W., Sherman.
Stout, Henry I., Sherman.
Stout, Joseph H. (Sec'y), Sherman.
Strother, Coble D., Sherman.
Thompson, George R. (Mil.)
Tuck, Vernon L., Sherman.
Weisburg, Maurice A., Denison.
*Woodward, Max R., Sherman.

HOPKINS-FRANKLIN

Chandler, Henry E., Mt. Vernon.
Hanna, Wm. Ray, Sulphur Springs.
Hodges, Lester A. (Sec'y), Sulphur Springs.
Kirkpatrick, Omer F., Sulphur Springs.
Longino, Joseph B., Sulphur Springs.
Longino, S. Byrd, Sulphur Springs.
Longino, Stephen B., Jr., Sulphur Springs.
McConnell, Thos. H., Sulphur Springs.
Peeples, George R. (Pres.), Mt. Vernon.
Saunders, Weaver B., Sulphur Springs.
Stanford, Henry, Mt. Vernon.
Stevens, Thos. H., Sulphur Springs.
Stirling, Earl, Sulphur Springs.
Worsham, Archer B. (Dead),
Sulphur Springs.

HUNT-ROCKWALL-RAINS-DELTA

Allen, Clarence G., Commerce.
Becton, Joe D., Greenville.
Bradford, Harry M. (Hon.),
1232 N. Selva Dr., Dallas.
Bruce, Robert Grady, Greenville.
Carruthers, F. S., Greenville.
Cheatham, James C. (Hon.), Wolfe City.
Cooper, John S., Greenville.
*Crim, E. Truett, Greenville.
Hancock, Warren E., 12331 Gardenia, Dallas.
Jenks, Ralph W. (Sec'y), Greenville.
*Kennedy, Chas T., Greenville.
Leberman, Lowell H., Commerce.
Maier, Henry W., Greenville.
Savage, Carroll D., Greenville.
Seyler, Louis W., Commerce.
Sheldon, Clifford C., Greenville.
Strickland, Thomas C., Greenville.
Trentham, J. C., Greenville.
Turbeville, Fred M., Greenville.
Vallancey, John C. (Pres.), Greenville.
Ward, James W. (Hon.), Greenville.
Weis, Charles B., Greenville.
*Whitten, Samuel D. (Hon.), Greenville.

KAUFMAN

Alexander, Gough H., Terrell.
Conradt, Louis W., Terrell.
DeVlaming, Wm., Kaufman.
Friddell, Delmas T., Terrell.
Hall, Edward I. (Pres.), Kaufman.
Holton, Robt. W., Terrell.
Hudgins, D. H. (Hon.), Forney.
Johnston, Lawrence W., Terrell.
Lane, Early D., Terrell.
Leinart, O. S., Jr., Terrell.
Lyon, Floy E., Terrell.
Powell, Geo. F. (Hon.), Abilene.
Rowell, Robert C., Terrell.
Shands, Percy C. (Hon.), Mesquite.
Shaw, Guy G., Jr., Kaufman.
Taylor, Homer A., Kemp.
Walker, Christine Z. (Sec'y), Forney.

LAMAR

*Armstrong, James E., Paris.
Barker, Carl D., Paris.
Barker, Nym L., Paris.
Breneman, Fairfax V., Paris.
Cooke, Lane B., Paris.
Gilmore, Clarence E., Paris.
*Hammond, D. Scott, Paris.
Hunt, Harold E., Paris.
*Hunt, Thomas E., Jr., Paris.
Hunt, Thomas E., Sr., Paris.
Janes, Olen G., Cooper.
Janes, Oscar G., Cooper.
Janes, Osler Y., Cooper.
Johnson, Malcolm L., Paris.
Jopling, Anna H., Paris.
Jopling, Julian L., Paris.
Kerbow, Dock F., Paris.
Lewis, Donald R. (Pres.), Paris.
Lewis, Robert L., Paris.
Lowry, David O., Cooper.
O'Neill, Owen R., Paris.
Parchman, Hugh W., Paris.
*Phillips, John M., Jr. (Sec'y), Paris.
Powell, James N., Paris.
Robinson, Oscar W., Paris.
Stephens, John A., Paris.
Townsend, Courtney M., Paris.
Walker, Marcellus A., Paris.
White, Hal H., Paris.
Woodfin, George S., Paris.

VAN ZANDT

*Baker, Horace A., Wills Point.
Brandon, Ben B. (Sec'y), Edgewood.
Cozby, Raymond W., Grand Saline.
Fry, Harry T., Wills Point.
Garland, W. L., Grand Saline.
Garrett, William J., Van.
Hilliard, George Jr., Canton.
Hood, Grace H., Canton.
Marsh, George B., Jr., Grand Saline.
Sanders, D. Leon (Hon.), Wills Point.
Travis, John M., Jr. (Pres.), Wills Point.

FIFTEENTH DISTRICT

Dr. H. O. Padgett, Marshall, Councilor

BOWIE

Audette, Paul John,
Southern Clinic, Texarkana.
Baldridge, Max, 5th and Hazel, Texarkana.
Bintliff, Chas. V., 520 Pine, Texarkana.
Birdsong, Karl K., DeKalb.
Brunazzi, Richard R.,
6th and Walnut, Texarkana.
Carney, Henry M.,
619 Main St., Texarkana.
Chappell, Robert H.,
Kroger Bldg., Texarkana.
*Collom, Spencer A., Jr.,
619 Main, Texarkana.
Daniel, Noble B.,
202 Beck Bldg., Texarkana.
Davis, Elmer L.,
317 State Line Ave., Texarkana.
Dawson, Wm. D.,
317 State Line, Texarkana.
Ellison, Eugene T., 619 Main, Texarkana.
Frank, Charles H.,
322 E. 5th St., Texarkana.
Good, Louis P.,
5th and Hazel Sts., Texarkana.
Hargrove, Fred T., 2431 Oaklawn, Texarkana.
Harrell, Wm. B., 202 Beck Bldg., Texarkana.
Harrison, Robert K., 525 Olive, Texarkana.
Hawkins, Henry A., New Boston.
*Hibbitts, William, 308 Texarkana Natl.
Bank Bldg., Texarkana.
Hughes, Mary Witt,
2401 State Line Ave., Texarkana.
*Hughes, Raymond P., 205 Texarkana Natl.
Bank Bldg., Texarkana.
Jones, John Walter,
401 E. 5th St., Texarkana.
Jones, William E., 619 Main St., Texarkana.
Kitchens, Chester E.,
723 Main St., Texarkana.
Klein, Cyrus P., 322 E. 5th, Texarkana.
McGee, Ellis B., New Boston.
McGee, Joel R. (Hon.), New Boston.
Merritt, Wm. H. (Sec'y),
619 Main, Texarkana.
Monte, Melville R.,
317 State Line Ave., Texarkana.
Parson, George W., Box 778, Texarkana.
Roberts, A. Warren, 217 Texarkana
Natl. Bank Bldg., Texarkana.
Robison, Jas. T.,
6th and Walnut, Texarkana.
Rorie, Jean E., 619 Main, Texarkana.
*Smith, Chas. A. (Pres.),
723 Wood, Texarkana.
Smith, Charles G.,
State Natl. Bank Bldg., Texarkana.
Stuart, Chas. C., 525 Olive, Texarkana.
Williams, Marvin L.,
619 Main St., Texarkana.

CAMP-MORRIS-TITUS

Baber, Dunbar R., Daingerfield.
Ball, James E., Mt. Pleasant.
Ellis, John M., Mt. Pleasant.
Fender, Ernest L., Jr., Mt. Pleasant.
Hardman, Robert L., Mt. Pleasant.
Johnson, Robt. L. (Pres.), Pittsburg.
Leeves, James S., Naples.
Pendergrass, Robt. K., Pittsburg.
Philips, Harry O., Lone Star.
Reitz, Percy A., Pittsburg.
Rutledge, Lowell E., Daingerfield.
Smith, James C., Jr. (Sec'y), Omaha.
Taylor, William A., Mt. Pleasant.
Taylor, Willis A., Mt. Pleasant.
Truitt, Crawford S., Daingerfield.
Wheat, E. Baxter, Daingerfield.
Wise, Charles J., Naples.

CASS-MARION

Allen, Jas. I., Bloomburg.
Brooks, Jesse M., Atlanta.
Brooks, M. James, Jr. (Pres.), Atlanta.
Bucy, Roy S. (Sec'y), Linden.
DeWare, Jesse M. III, Jefferson.
Glenn, Vernon B., Jr., Linden.
Grumbles, Ernest W., Atlanta.
Jenkins, Homer L. D., Hughes Springs.
Joslin, Blocker, Atlanta.
*Nichols, Joe D., Atlanta.
Nichols, Thos. K., Atlanta.
Starnes, Adolphus E. (Hon.)
Hughes Springs.
Steed, Thurmon M., Jr., Hughes Springs.
Taylor, Orval R., Linden.
*Terry, Wm. S., Jefferson.
Woods, Andrew J., Jefferson.

GREGG

Adams, James N., Longview.
Adams, Joe E., Kilgore.
Allums, Loraine L., Kilgore.
Andres, Ben, Longview.
Awalt, Elmer W., Longview.
Barker, Wm. E., Longview.
Bloom, Chas. S., Gladewater.
Cave, Walter, Longview.
Clanton, Benjamin Reid, Longview.
Cook, Hardy, Longview.
Crawley, Henry K., Kilgore.
D'Aversa, Gene, Longview.
Dingler, Clark M., Jr., Longview.
Downs, Seth R. (Pres.), Kilgore.
Echols, Robert B., Kilgore.
Elkins, Oliver W., Longview.

Farrar, William P., Longview.
Fleming, John W., Jr., Kilgore.
Hancock, A. R., Gladewater.
Hart, Walter F., Gladewater.
Hudspeth, Ray, Gladewater.
*Hurst, V. R., Longview.
Johnson, Cecil A., Longview.
Johnson, James H., Jr., Longview.
Leake, Bain, Longview.
Loftis, John R., Jr., Longview.
Massad, Eugene M., Gladewater.
McGrede, Henry C., Longview.
McKean, Jesse C., Gladewater.
McKellar, G. G., Longview.
McRee, Judson T., Longview.
*Mondrik, Frank V., Longview.
Moser, Emil R., Gladewater.
Nichols, Carl, Gladewater.
*Niehuss, Henry H., Longview.
Norman, Wayman B., Longview.
Parrish, Wilmer E., Longview.
Payton, Calvin W., Longview.
Rappeport, Joseph H., Longview.
Robberson, G. W. J. (Sec'y), Kilgore.
Roberts, Joe D., Longview.
Routon, Wm. Mack, Kilgore.
Rushing, Garland S., Longview.
Simmons, D. C., Kilgore.
Slade, Robert E. (Mil.)
Swinney, Bluford A., Longview.
Tate, George W., Longview.
Velinsky, Morris, Kilgore.
Walker, Joe A., Gladewater.
Watkins, E. O., Greggton.
Wilkinson, Jacques D. (Mil.)

HARRISON

Bennett, George E., Marshall.
Bennett, Wm. H., Marshall.
Carter, Ray H., Marshall.
Dieste, Antonio, Marshall.
Farquhar, George A., Marshall.
Feducia, Samuel J., Marshall.
Granbery, Richard G., Marshall.
Harmon, Roger Q., Marshall.
*Harris, James H., Marshall.
Heidelberg, Chas. H., Marshall.
Hill, John E., Marshall.
Holcomb, Norman F. (Sec'y), Marshall.
Kemper, Thomas W., Marshall.
Littlejohn, Frank S., Marshall.
McNatt, Malcolm, Marshall.
Murphy, Maurice H., Marshall.
*Padgett, Harold O., Marshall.
Rains, George P. (Hon.), Marshall.
Redding, Leman M., Marshall.
Tenney, Samuel W., Marshall.
Wyatt, Charles A. (Pres.), Marshall.

RED RIVER

*Brooks, Earl E. (Sec'y), Bogata.
Marx, Melvin, Jr., Clarksville.
Payne, Ross W. (Pres.), Clarksville.
Reed, Charles B., Clarksville.
Watson, Nowlin, Clarksville.
Wright, James L., Clarksville.

UPSHUR

*Daniels, John G., Gilmer.
Fenlaw, Joseph L., Gilmer.
O'Keefe, John B. (Pres.), Gilmer.
Ragland, Hugh M., Gilmer.
Ragland, Madison S., Gilmer.
Reed, Richard J. (Sec'y), Gilmer.

President's Page

SCIENTIFIC INTERCHANGE—1955

Plans are well under way for an outstanding program at our annual meeting in Fort Worth next April 24-27.

The Council on Scientific Work, with the enthusiastic backing of the Advisory Committee to the President, held a meeting in Austin on May 30 with officers of the Association's scientific sections and representatives from almost all of the specialty societies present. At this meeting, and also subsequently by mail, an invitation was extended from the Texas Medical Association to all medical specialty societies in the state to join in an annual meeting which will be integrated to offer one of the finest scientific programs available anywhere. A number of specialty societies, some of which have and some of which have not met in conjunction with the Association in previous years, have already expressed their desire to participate in the 1955 annual session. Other specialty groups, although blocked by by-law provisions or other reasons from accepting the proposal, have pledged the cooperation of individual members in making our annual session a success.

The exchange of guest speakers among the specialty groups, the sections, and the Association's general assemblies and the teaching of concentrated refresher courses were discussed. Such sharing of speaker-talent with an underwriting of speaker expenses jointly by the Association and the specialty groups was approved by most of the physicians present.

A guest list totaling between twenty and thirty distinguished out-of-state speakers is being developed and will be released soon.

It is estimated that about fifteen specialty groups will hold their annual or semiannual meetings during the April 24-27 period in Fort Worth next spring and that there will be varying degrees of integration of the general and specialty meetings.

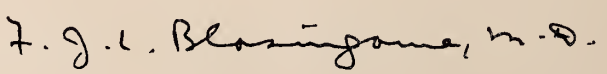
Societies of physicians who specialize in specific phases of medical practice, the general practice group, and the postgraduate assemblies

which have been developed more or less on a regional basis have been created to fill real needs. Such organizations should be encouraged so long as they assist physicians to improve themselves. Nevertheless, no member of our profession and no group of physicians should lose sight of the prime importance of professionwide organizations which, through the years, have catered to our basic scientific and economic needs and have served as organizations to speak for medicine in affairs requiring an authoritative voice.

American medicine must give serious consideration to a program of convergence of our professional interests and efforts. In Texas, this program is obviously needed. No trend as solidly entrenched as that toward subdivision and divergence in medical organizations can be reversed overnight. Texas physicians will continue to be plagued with too many meetings and demands of many medical groups. However, with the cooperative spirit displayed as plans for the 1955 annual session of the Texas Medical Association get under way, it appears possible that within a few years the majority of statewide medical societies in Texas will be meeting at the same period and providing such splendid opportunities for scientific interchange, discussion of socio-economic problems, and fellowship that the number of other meetings can be reduced considerably and more of a spirit of oneness be regenerated through the healthy and sound expansion of the annual session of our Association.

Through a strong, integrated scientific program and through other means, the Texas Medical Association is in a peculiarly favorable position to lead the way back from this divergence which threatens to damage our profession and to encourage a convergence of interests and efforts by means of which the various segments of the medical fraternity can help each other and thereby strengthen the entire profession.

Your thoughtful consideration of this proposed integration of our efforts is suggested. One practical way each member of our Association can assist is to plan to attend our 1955 annual session next April and to encourage other physicians to do likewise.



PR diagnotes

REPORT OF COMMITTEE ON PUBLIC RELATIONS: The Texas delegation, already high in AMA's esteem, strengthened that position at this year's annual meeting, San Francisco, June 21-25. The delegation opened a hospitality room—Texas style. Trick was to secure donation of all refreshments served in the room, modeled after Judge Roy Bean's Court and complete with two longhorn steer heads shipped from Texas for the occasion. Refreshments furnished were primarily from Texas firms—Duncan Coffee Company donated enough coffee for 3,000 people. Preliminary report had it that the Texas Room was one of the most successful state affairs ever sponsored at an AMA annual meeting.

The Texas Medical Association's survey of doctor distribution is proceeding methodically, with excellent results thus far. Nearing completion is a survey of Councilor District 8. Results—good, in that there were no requests received within the first three weeks. No actual shortage has been turned up, and at the same time, favorable lay reaction has resulted in several communities.

FROM OVER THE STATE: Another step in sound internal relations taken by the Dallas County Medical Society was a letter to the graduating students at Southwestern Medical School. Directed from the society president, Dr. Frank Selecman, the letter states in part:

"The physician cannot stand alone in the community.

"The key organization, the foundation of all medical organizations and the unit through which every physician works, is the county medical society.

"Within a few days you will be eligible to affiliate with the recognized medical profession. Let me urge you to do so at your earliest convenience, in whatever community you locate."

New members entering that group are given a concise orientation program on policies, mechanics, and aims of the county society.

An example of wholly successful projects which may be sponsored by medical societies in small to medium size communities is the recent series of public panel discussions held in Palestine. Three meetings, held at monthly intervals, consisted of the showing of one or more films issued by the American Cancer Society followed by a discussion by members of the local hospital staff and a question period which lasted for well over an hour in each case. Almost 150 persons attended. As a result of the success, a film on cancer of the lung was shown to the five civic clubs in Palestine. Each showing was attended by a member of the hospital staff. Word of these programs spread through the county, and invitations have been received from five rural school PTA groups.

El Paso County Medical Society had gratifying success with its series of health forums sponsored jointly with the El Paso Herald-Post. Lay attendance was high, and the question and answer session following each discussion was extremely popular.

ON THE NATIONAL FRONT: The Florida Medical Association has published "A Positive Public Relations Program" in brochure form. Highly complete, the booklet contains a check list designed to help each society evaluate its own program. The five-point program includes the following: (1) medical care for all, (2) paying for medical care, (3) information and education, (4) working with others, and (5) medical society's unity. County societies that wish to explore this very sound program may write directly to the Florida Medical Association, Box 1018, Florida Theatre Building, Jacksonville 1.

TIP OF THE MONTH

The patient who cannot find a parking place near the doctor's office or who receives a parking ticket because the doctor was late in seeing her, often complains loudly about doctors. Consequently, many physicians and medical societies are making special parking arrangements for the convenience of such persons. It makes good public relations sense.

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DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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VISITATION PROGRAM BEGUN

A marked improvement in the two-way communication of information between county medical societies and the state association is forecast during the coming year with the inauguration of a visitation program which has been approved by Dr. F. J. L. Blasingame, the President, and his Advisory Committee.

The program has been designed to increase visitations to county medical societies by officers of the Texas Medical Association and by representatives of its central office in Austin. Dr. Blasingame has promised that an officer or a staff member will meet at least once during the year with each of the 116 county medical societies, or at least all of them willing to extend invitations.

The visits will be made primarily by the President, the President-Elect, the Vice-President, the Legal Counsel, the Public Relations Counsel, the Executive Secretary, and the Assistant Executive Secretary, with periodic assistance by other officers. The central office staff will coordinate the program, handling all correspondence with the county medical societies and scheduling guest appearances.

It is gratifying that officers of many county societies have responded so quickly and enthusiastically to this proposal. Letters were written in June to the presidents of the county societies informing them that state officers and staff would appreciate an opportunity to meet with the membership on any stipulated date during the coming year. Responses were received in the return mail from seven societies. Invitations continue to arrive daily.

Though most county societies "adjourn" for the summer, several guest appearances already have been scheduled. The visitation program was initiated officially on June 29 when the President and a representative of the central office traveled to Brownwood to meet with the Brown-Comanche-Mills-San Saba Counties Medical Society.

At these meetings, state officers and staff members will seek to gain firsthand informa-

REMEMBER TO VOTE ON JULY 24

tion on problems confronting the county societies. They will survey informally the membership on several important national and state issues to make certain that the programs and policies of the Texas Medical Association represent the thinking of the majority. At the same time, they will report on current activities, programs, and problems which are vital to organized medicine.

Through this new program, the state association will make a determined effort to aid county medical societies to strengthen their membership, attendance, programs, and prestige. The objective is to help each society to become in its community the most potent force in health and medical activities.

The program has definite merit. It is hoped that all county medical societies in Texas will exhibit the same degree of enthusiasm as those groups which responded so promptly to Dr. Blasingame's letter.

ANNUAL SESSION PAPERS WANTED

Members of the Texas Medical Association who talked loudly of insufficient opportunity on the 1954 annual session program to present their essays will have no such excuse come 1955. In addition to some new flourishes such as concentrated refresher courses each day, the session next spring will return to the plan of separate programs for the scientific sections of the organization. Even though there will be an imposing array of out-of-state guests to appear on these section programs as well as before general assemblies and as faculty for the previously mentioned courses, perhaps ten papers per section will be expected from local talent.

Officers of the sections are expected to have tentative plans for speakers and topics worked out by September 1, although no program will be closed until January. Physicians interested in contributing papers should write as promptly as possible to the appropriate officers, suggesting subjects and outlining briefly their proposed development. Names and mailing addresses of the section officers follow:

GENERAL PRACTICE

Dr. Van D. Goodall, Clifton, chairman.
Dr. John M. Smith, 205 Camden, San Antonio, secretary.

INTERNAL MEDICINE

Dr. John R. Winston, Farmers State Bank Building, Temple, chairman.
Dr. Mavis P. Kelsey, Hermann Professional Building, Houston, secretary.

SURGERY

Dr. Robert F. Short, Jr., Medical Arts Building, Dallas, chairman.
Dr. Norman Duren, Goodhue Building, Beaumont, secretary.

OBSTETRICS AND GYNECOLOGY

Dr. S. Foster Moore, 401 W. Summit, San Antonio, chairman.
Dr. Dennis M. Voulgaris, Wharton, secretary.

EYE, EAR, NOSE, AND THROAT

Dr. Oliver W. Suehs, 120 W. Seventh, Austin, chairman.
Dr. Robert Marion Johnson, Hermann Professional Building, Houston, secretary.

RADIOLOGY

Dr. Delphin von Briesen, First National Bank Building, El Paso, chairman.
Dr. David H. Allen, 1600 Eighth, Wichita Falls, secretary.

PUBLIC HEALTH

Dr. Austin E. Hill, 1300 Capitol, Houston, chairman.
Dr. L. P. Walter, 3212 Meredith, Austin, secretary.

CLINICAL PATHOLOGY

Dr. J. L. Goforth, Box 1074, Dallas, chairman.
Dr. John H. Childers, 815 Strand, Galveston, secretary.

PEDIATRICS

Dr. Robert A. Gardner, 4041 Ellalee Lane, Houston, chairman.
Dr. B. H. Williams, Scott and White Clinic, Temple, secretary.

Next February or March will be too late. Even if it seems like a hot and uncomfortable time to begin worrying about writing a paper, now is the time to put in a bid for a spot on that program the last week in April, 1955.

FOUR LICENSES REVOKED

The Texas State Board of Medical Examiners has announced cancellation of the licenses of the following: Winton L. Welsh, D. O., Mesquite; James E. Sherman, M. D., Brownsville; J. G. Dickie, D. O., San Antonio; and Fred W. B. Rockett, M. D., San Antonio.

ORIGINAL ARTICLES

PROBLEMS IN BLOOD TRANSFUSION
I. Relationship of the Physician to Problems of Blood Banking

JARRETT E. WILLIAMS, M. D., Abilene, Texas

FOR four years I have been associated with a community hospital blood bank in a relatively small city serving a wide territory in West Texas. From its inception, there have been both successful and disheartening experiences upon which I shall feel free to draw in this discussion. Although this bank has many imperfections, I can state freely that no other type of bank could possibly have satisfied our needs and that our community would resist any effort to change its essential structure or operative policy. The success of this blood bank testifies to the philosophy that any community large enough to need a blood bank can operate a blood bank as an independent unit through its recognized medical organizations and do so successfully, under normal circumstances at least, without constantly seeking outside aid, provided such a bank has the basic interest and support of the medical profession. It seems appropriate to note that more than half of the blood used in civilian hospitals in this country is contributed through community or hospital blood banks such as ours.

GROWTH OF BLOOD BANKING

The phenomenal growth of blood banking in the past fifteen years challenges the imagination. Its growth has been one of mushrooming, devoid of careful planning and thought, by virtue of its rapid growth. Experience has shown that when the demand was sufficient, blood banks were established in spite of the lack of materials or personnel—yes, sometime even in the face of professional indolence. Contrary to a conception popular with the medical profession, all too frequently the physician was not the prime mover in the establishment of blood banks, nor has he always continued to play the dominant role in blood banking. I like to think of blood banking as one of the great advances of medical services and hence believe that it should not be disassociated from close professional contacts, which contacts the profession should not be allowed to shirk or waive.

Read before Section A (Medical), Texas Medical Association, Annual Session, San Antonio, May 4, 1954.

Throughout the early history of blood transfusions as applied to human beings, the physician has by necessity been the principal agent. A source of compatible blood had to be obtained in advance; permission had to be secured from donor and patient; and the actual transfusing of whole blood often was done under the personal supervision and watchful eye of the physician. However great was this time-consuming chore, it had its own reward reflected in the close personal physician-patient relationship. The physician's every wish was a respected command to a grateful patient and his family. The community responded with offers of blood donations. This was generous and "neighborly." Transfusion service had been developed by trial and error, but nevertheless it was the physician who held the reins for the moment.

The first blood bank for the storage of whole blood was established in 1936, and there followed a tremendous increase in the therapeutic use of whole blood with the consequent growth in the number of blood banks.[2] With the general establishment of blood banks the quality of technical procedures improved. New and safer tests of compatibility were developed, and new and better blood bank facilities became available. The influence of and the participation by the physician began to wane. And here for the first time we see the physician willingly giving up his dominant role in blood transfusions.

With this surrender, however justified it may have been, the clinician also surrendered much of his interest in blood banking and transfusions. The failure of the clinician to maintain interest, participation, and responsibility in this medical service often carried with it another penalty—the failure to be alert to and cognizant of problems arising in the service. Much of this recognition requires some hematologic knowledge and clinical judgment, but, of necessity, it has been delegated on many occasions to technical staffs, well trained to be sure, but not clinicians. It is to the credit of the nonmedical personnel of thousands of blood banks that in spite of the lack of the physician's intense interest in blood banking, these workers have developed high skills in the art and

science of blood banking. This high skill has been attained without any common method of training, control, or even evaluation. Perhaps pride in their work and pride in the institutions they represent exert the greatest effect for excellence. Perhaps, too, the blood banking personnel has a far greater interest in the welfare of people than we have recognized and an esprit de corps of which the medical profession itself could well be proud.

Nevertheless, it is my opinion that blood banking, being a medical service, always should be maintained as an arm of the medical profession. It seems appropriate, therefore, for all physicians to be aware of simple standards for donors and recipients. It seems appropriate, too, that all physicians should be aware of the administrative, technical, and procurement problems connected with blood banking and be willing to give some time and thought to meet them.

RECOMMENDATIONS

In this connection it does not seem out of place to raise a voice against a growing abuse of blood transfusions. I refer particularly to the ill advised or needless transfusions—the giving of transfusions on the score that they will do no harm and may do some good. The striking increase in the number of transfusions with the establishment of a blood bank in a community is a fine tribute to the success of blood banking. However, the great increase in the number of transfusions is due in part at least to the ease of getting blood and implies that blood often is given without thoughtful consideration. Physicians should recall that a decade ago compatibility was judged on the basis of the four primary blood groups in the A-B-O system presented by Landsteiner. However, Landsteiner and Wiener later demonstrated the Rh factor as a cause of hemolytic reactions even when blood grouping might otherwise be correct.[2] Other speakers will present the modern methods of compatibility testing, but even with these we cannot say that any transfusion may not introduce some vulnerability. We may reasonably expect a new Landsteiner or Wiener to demonstrate a now unknown factor potentially dangerous even in the face of presently known compatibility tests. With this constantly in mind the reckless use of whole blood would be abandoned and the number of transfusions reduced to a necessary minimum.

The administrative problems in blood banking usually may be settled in advance by simple sound rules. First of all, the establishment of a blood bank should have the complete endorsement of the local county medical society and the local hospitals. Records, filing, and indexing must be as accurate as humanly possible. Minimum requirements should equal or exceed those of the National Institute of Health. The procurement of blood must be on the basis of a replacement or a penalty fee.

It is the procurement problem that generally plagues the community bank, which problem can be minimized or aggravated by the efforts of the physician. I cannot share the attitude of any who feel that it is the sole responsibility of the blood bank to obtain the kind and quantity of blood needed. If one wishes to become sentimental concerning this, it is easy to point to the ancient traditions and attitudes concerning blood. It seems inconceivable that the profession would willingly lose this easy and natural bridge to patients and patients' families. I am astonished sometimes to hear a busy surgeon or internist deny all knowledge of how his blood bank works, how an inventory is maintained, how blood is secured. Suffice it that all the blood needed is available.

Those who have been active in blood banking have learned by experience to welcome and appreciate the utmost cooperation of the clinician but seldom to expect it. In general, it does not arise apparently from unwillingness to help but rather inability to recognize the responsibility. In our blood bank we place the responsibility on the recipient and his physician, where we think it belongs. We place it there, first, because it is the most effective means of replacement and, second, because it maintains the physician in a dominant role in blood banking. It is a responsibility we will not allow him to waive.

Too often in the past we have been confronted by the patient who says he made no plans for replacement because his physician had not discussed it with him. The shop-worn excuse of the busy doctor is not impressive. We do not permit him this indolence. When the physician is discussing his fee, the anesthesia, the room in the hospital, he can also emphasize the need to replace blood. The staffs of blood banks need the assistance of the physicians in initiating the discussion concerning replacement. After this the blood bank personnel follow simple plans of interviewing the patient or patient's family, stressing the need for replacement instead of purchasing blood, allaying any fears concerning the giving of blood, glorifying the giving of blood as something more than a common donation. If the physician makes the entree, we can usually do the rest with a well trained staff. We are constantly alert to the need of educating the public in blood donations, and we find that people generally respond when approached properly.

In some parts of the country where the replacement problem is most acute an effort has been made to solve it with the purchase of blood through the medium of private or commercial nonprofit banks. This tends to put blood in the same category as a

manufactured medicine. That this has created new problems I need only point to a recent article on hospitalization insurance coverage of blood transfusion cost[1] which reads in part as follows:

> The legend at the bottom of your stationery, "Give a Pint and Save a Life" prompts me to call to your attention that we and other insurance companies have recently had some objections from blood banks in other cities to any practice of paying for blood used in transfusions. The objection arises from the philosophy that a blood bank can only serve the community adequately if people have an incentive for replacing the blood which has been transfused. Apparently some blood banks have found that the community spirit which prompts a voluntary donation of blood deteriorates rapidly when people learn that monetary considerations attach to the blood used, and that the supply of blood available for transfusions in the community decreased rapidly. As a matter of fact, we and other companies have been asked by some larger city blood banks to reconsider our practice of paying for the cost of the blood used in transfusions, in order that there will again be the community incentive for persons engaged in industry and insured under group plans to voluntarily contribute through organized donor clubs.

Now the physician has a stake in this. Why has this situation developed? It has come about either by invitation or assent of the medical profession, which has said in effect, "I don't care where you get the blood, just get it."

I do think it makes an important difference. If this service can be prostituted to a dollar and cent item, so can any other medical service. This is a life-saving service presenting an unusual appeal and opportunity for fine public relationship. Friends and relatives of patients represent a rotating cross segment of our population which in peacetime, at least, can present a continuous flow of blood into our banks. This segment represents thousands who can "get in the habit" of donating blood when needed. There is no better agency for getting our entire population into the act than the American Association of Blood Banks, since it reaches intimately into every nook and cranny of the nation through the community blood banks. It can present a far more personal appeal, for its appeal in each case is for an immediate need for a given person. This segment just mentioned represents that part of the population not ordinarily donating blood to Red Cross or commercial banks, leaving the latter group for mass blood collection or major disaster needs. Indeed, I wager that if given the challenge, the member banks of the American Association of Blood Banks can flood this country with blood collected under ideal circumstances cheaper than any other agency, and with enormous good will. But the habit of giving as replacements needs to be maintained, and the physician needs to stake out and work this natural claim so that the service will not run afoul and become cheapened by commercialism or sensationalism.

REFERENCES

1. American Association of Blood Banks, Fifth Annual Meeting, Oct. 9-11, 1952, p. 4.
2. DeGowin, E. L.; Hardin, R. C.; and Alsever, J. B.: Blood Transfusion, Philadelphia, W. B. Saunders Co., 1949, pp. 3; 79.

Hendrick Memorial Hospital.

II. Techniques in Modern Blood Banking

O. J. WOLLENMAN, JR., M. D., Fort Worth, Texas

SINCE the establishment of the first blood bank in the United States, the past eighteen years have witnessed the creation of a new medical specialty. The multitude of problems in grouping, crossmatching, preserving, and dispensing of blood experienced by the founders are still the plague of the blood bank specialist. Since these early days the comparatively simple identity of blood groups has been expanded into subgroups, Rh types, and numerous other factors. The discovery of Rh antigens has added to the safety of blood transfusions and is of equal value to a new field of research in immunology and genetics. Although this discovery has increased an understanding of some diseases, still the hard-earned experience of the founders forms the basic principles of modern technical methods.

Read before Section A (Medical), Texas Medical Association, Annual Session, San Antonio, May 4, 1954.

The technical methods evolved by research and experience and tested by phenomenal numbers of successful blood transfusions have as a goal one fundamental principle. This principle is the restoration of deficient blood volume with blood which will survive a normal or near normal span of time without detriment to the recipient.

The restoration of blood volume should not be considered a simple or harmless procedure. It can be a two-edged sword, in fact, more crippling or lethal than some surgical procedures. It has been stated that "the mortality rate from transfusion is higher than that of appendicitis or of ether anesthesia."[1] In contrast to many transfusions, surgical procedures are performed only after considerable deliberation and consultation. It has been estimated that the mortality rate from transfusions is approximately 1 in 1,000 to 1 in 3,000 recipients.[1,2] Disability incurred from

transfused blood such as pyrogenic and allergic reactions, emboli, thrombophlebitis, circulatory overload, and transmission of disease cannot be accurately evaluated. The Korean study of hepatitis presented a 3.6 per cent incidence of hepatitis in whole blood transfusions and 21.9 per cent in plasma or blood and plasma.[7] The administration of blood should be weighed in the balance of thoughtful evaluation and critical judgment. Although technical methods have been developed to a phenomenal degree, there always exist the errors due to the personal equation, which usually is responsible for lethal transfusions. Unfortunately, these errors are due to ABO incompatibility resulting in the most serious of hemolytic reactions. The human errors of failure to distinguish between recipients of similar names, inaccurate records, and misinterpretation of labels account for a greater number of serious transfusion reactions than all other causes combined.[4]

The life of a blood recipient is entrusted to the skill and judgment of a laboratory technician or a nurse trained in blood bank techniques. It cannot be overemphasized that careful selection, prolonged training, and close supervision of these persons are mandatory. A blood bank, no matter how small, must have as a director a physician who has the interest and has taken the time and energy to inform himself of technical and administrative problems. He must have intimate knowledge of hospital organization and the confidence of the staff. Usually the director's duties are not sufficient for a full-time position, but, no matter how small a bank, the responsibility is great.

The selection of donors should be based on rigid adherence to established standards conceived to produce a satisfactory unit of blood and guard the health and welfare of the donor. It is imperative that an accurate medical history be obtained from a prospective donor. Since a complete physical examination is neither feasible nor frequently informative in excluding a transmissible disease, strict adherence to an accurate medical history is paramount.

Blood must be collected under absolutely sterile technique. Bacterial contamination of blood may occur from four sources: the skin or blood of the donor; imperfect seal in the bottle cap; unsterile bottles or donor equipment; and introduction of air and airborne organisms during the phlebotomy. The incidence of bacterial contamination is not known. Thirty-eight (2.24 per cent) bacterial contaminations, most frequently nonpathogenic, were isolated from 1,697 pints of blood in one series.[3] The detection of bacterial contamination in stored blood is difficult. These bacterial contaminants that produce hemolysis are detected by gross inspection of the unit of blood. Unfortunately, there are lethal bacterial contaminations that produce no gross hemolysis and survive and proliferate at storage temperature. Six instances of cold growing gram-negative rod contaminations in 3,000 units have been reported.[9] There have been several recently reported incidences of fatal transfusions traced to such bacterial contaminations.[2, 3, 9] Stevens and others[9] suggested that "examination of a stained smear of every blood should be made immediately preceding its administration." This procedure is open to question, for, if applied to small samples, it too is subject to error and in addition may in itself lead to contamination. Careful meticulous sterile technique in collection, disposable donor sets and containers, and prompt and proper refrigeration are at present the only satisfactory safeguards. As yet prophylactic antibiotic introduced in each unit has not proved satisfactory.

GROUPING (ABO)

The recommended procedure for grouping utilizes a fresh, potent anti-A and anti-B serum free of contaminants and at room temperature. Errors may occur if weak, deteriorated, or contaminated serum are used and if the temperature of the test is elevated. The A and B isoagglutinins are weakened by increased temperature. As a safeguard against these factors and the ever prevalent human error, a confirmation grouping test is recommended. The unknown inactivated serum of the donor is tested with freshly prepared 2 per cent saline suspension of group A and group B cells. Identified group A and AB blood is further identified as A_1 or A_1B and A_2 or A_2B.

TYPING (Rh)

Landsteiner and Wiener[6] in 1940 reported an agglutinable factor or antigen in human blood which was designated the Rh factor. Subsequent detection of unknown antibodies within the Rh type resulted in an Rh genetic pattern which not only proved of extreme importance in the crossmatching of blood but also in parental genetic studies and in the understanding of erythroblastosis fetalis.

Two systems of nomenclature have been devised to identify the Rh antigenic factors, namely, the Rh system and the CDE system:

Rh System	*CDE System*
Rho	D
rh′	C
rh″	E
Hro	d
hr′	c
hr″	e

The policy recommended by the American Association of Blood Banks and followed by most blood

banks is to determine eight Rh types as recorded in table 1.

TABLE 1.—*Rh Determinations Recommended by American Association of Blood Banks.*

Cell Type	(Anti-D) Anti-Rho	(Anti-C) Anti-rh'	(Anti-E) Anti-rh"	Approximate % in White Persons
rh (cde)	—	—	—	15.0
rh' (Cde)	—	+	—	1.0
rh" (cdE)	—	—	+	0.7
rh'rh" (CdE)	—	+	+	0.02
Rho (cDe)	+	—	—	1.5
Rho' (CDe)	+	+	—	54.0
Rho" (cDE)	+	—	+	14.5
Rho' Rho" (CDE)	+	+	+	13.2

The red cells possess antigens, each of which when exposed to the specific antiserum results in agglutination, thereby identifying the Rh antigen or type present in the red cells. These antigens, termed agglutinogens, are capable of inducing in susceptible persons, not possessing these specific agglutinogens, the formation of antibodies specific for these antigens or agglutinogens. Serums containing these antibodies are used for diagnostic purposes. These produced antibodies are of great importance in transfusion reactions and, of course, in Rh-negative pregnant mothers.

It soon became evident that certain Rh antibodies could not be demonstrated by routine methods. The usual saline suspension of red cells did not always agglutinate in specific antiserums. The addition of albumin or high protein solutions to the cells resulted in clumping. The terms blocking antibodies, incomplete antibodies, univalent antibodies, and others were applied to these antibodies that were not demonstrable as saline agglutinins.

An additional method of detection of weak Rh agglutinins was introduced by Coombs[5] in 1945. An antihuman serum was prepared by injecting human serum or plasma into animals. The antibody produced was designated antihuman globulin, antiglobulin, or Coombs' serum. Certain antibodies when subjected to their specific antigens will not cause visible agglutination, but when antiglobulin or Coombs' serum under proper condition is exposed to the antigen, visible agglutination results in the presence of the specific antibody.

There are two types of Coombs' tests: a direct and an indirect. The direct Coombs' test is devised to demonstrate a substance fixed to the red cells of certain patients suffering from acquired hemolytic anemia and in anemia or jaundice of the newborn. Occasionally a direct Coombs' test in hemolytic transfusion reactions will demonstrate a fixed antibody on the recipient's red cells.

The indirect Coombs' test demonstrates antibodies in the serum or plasma. Cells of known antigenic structure are incubated with serum containing unknown antibodies and then subjected to Coombs' serum, resulting in specific identifiable agglutination. The indirect technique is also utilized in testing unknown cell antigens with known antiserums. The indirect Coombs' test is of great importance in certain transfusion cases.

It is imperative that one adheres to the recommended procedure prescribed by the processor of the testing serum. It cannot be overemphasized that the processor's direction be followed exactly. Not only does this apply to Rh testing serum but to Coombs' serum or antiglobulin serum utilized in demonstrating blocking (incomplete) antibodies.

Experience has demonstrated that there exist variations in the D antigen of some persons. The red cells of some persons fail to agglutinate in the presence of potent anti-D serum but when subsequently tested with Coombs' serum (antihuman globulin) will agglutinate. These cells possess a factor termed D^u. Studies of Caucasian blood have demonstrated the rarity of the D^u factor among cells which lack C or E factors. The screening tests must employ antiserums not only of D, but also of E and C. Most D^u cells will be identified among cells containing the factors of C and E. Thus most D^u persons should be considered as Rh-positive donors and Rh-negative recipients.

There are numerous other blood factors which on occasion must be identified. The average hospital blood bank will not encounter these rare factors as a cause of incompatibility in a frequency requiring the procurement of specific antiserum. The fundamental studies employing high protein and Coombs' serum are imperative procedures which will demonstrate these remote factors but not identify them. Identity of the antigenic factors requires specific antiserum.

The identity of Rh factors, as previously stated, has been instrumental in reducing transfusion reactions. By the same token it has expanded our knowledge of blood factors and agglutinogens to recognize more than 50,000 varieties of blood.[11]

CROSSMATCHING

The discovery of blocking antibodies has necessitated the discarding of the time honored saline method of crossmatching of blood. The blocking antibody will not agglutinate cells unless the protein concentration is more than 3 per cent. Optimal agglutination is observed at 15 to 20 per cent protein concentration. Saline type crossmatching fails to demonstrate in a fairly high percentage of cases incompatibilities that may be lethal. Saline crossmatching should be performed but paralleled with high protein crossmatching. Occasionally there are demonstrated in recipient's serum antibodies which are not

demonstrated at 37 C. in high protein preparations. Although ABO compatibility may exist, agglutination in the major match may occur, usually indicating the recipient has been immunized to Rh or Hr agglutinogens on the donor's cells. The recipient's Rh should be carefully checked and a corresponding donor Rh pattern crossmatched.

Agglutination on the minor side where ABO compatibility has been established indicates Rh, Hr, or other immunized antibodies in the donor's serum.

Recipients of recent or multiple transfusions, a history of previous transfusion reactions, or women who are pregnant or recently pregnant require, in addition to the saline and high protein crossmatch, an indirect Coombs' test. Such persons may have developed antibodies which are not detected by saline or high protein crossmatch but may be quite obvious in the indirect Coombs' test.

CONCLUSION

The technical problems of modern day blood banking are ever increasing as our knowledge expands. The widespread administration of blood has been instrumental in the discovery of the large number of immunologically distinct blood factors and in broadening the horizons of genetics. At the same time, this increased use of blood has been responsible for an alarming number of deaths and innumerable sensitizing reactions. Deaths from transfusions probably will remain at a constant ratio to the number of transfusions administered as it is based on the human error which cannot be erased as long as one man's life is entrusted to the hands of another.

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Medical Arts Building.

Improvement in 1953 Mortality Rates

The year 1953 was the sixth in succession in which the death rate in the United States was less than 10 per 1,000 population, statisticians of the Metropolitan Life Insurance Company report. The rate for 1953 was 9.6 per 1,000.

The outstanding feature of the year's health record, the statisticians state, was the large reduction in mortality from tuberculosis. The death rate from this disease was less than 13 per 100,000 population and may show a decline of close to a fourth from the previous year. As recently as 1949 the rate was double the 1953 figure.

Infant mortality was at a new minimum, the rate being estimated at 28 per 1,000 live births. The maternal mortality rate declined to less than 6 per 1,000 live births, the lowest in the country's history and 50 per cent less than five years ago.

The death rate from poliomyelitis was about 1 per 100,000 population in 1953, and the total number of cases was nearly 40 per cent less than in 1952.

Despite the high prevalence of acute respiratory diseases early in 1953, the death rate from these conditions showed only a moderate increase over 1952. There was a small increase in mortality from chronic diseases of the heart, kidneys, and arteries and from cancer, the result to a large extent of the rising proportion of older persons in the population, the statisticians say. The death rate from diabetes showed little change.

Some progress in controlling accidents is noted. Despite a continued increase in the number of cars and in automobile mileage, the death rate from motor vehicle accidents showed no appreciable change in 1953. The death rate for occupational accidents showed a slight decline, as did that for home accidents. The suicide and homicide rates were appreciably lower than in 1952.

POISON IVY TREATMENT

Hydrocortisone has been used in the treatment of dermatitis from contact with poison ivy or poison oak by Dr. Leon Goldman and Dr. Robert H. Preston, Cincinnati. The doctors reported in the April 17 *Journal of the American Medical Association* that hydrocortisone in tablet or ointment form was given to 47 persons suffering from reactions with "much improvement" resulting in 36 of the cases. The doctors stated that they found hydrocortisone 66 to 100 per cent more effective in such cases than other hormone drugs which have been used. Treatment should begin as soon as possible after contact with the plants, the doctors stated. They added that side reactions to the drug were mild.

Blood Banks

The American Association of Blood Banks will hold its seventh annual meeting at the Shoreham Hotel, Washington, D. C., September 13-15. The meeting will include scientific programs, exhibits, and a special course for technologists. Additional information can be obtained from the office of the secretary, 3500 Gaston Avenue, Dallas.

III. Minor Incompatible Blood Transfusions and Acquired Hemolytic Anemia

E. E. MUIRHEAD, M. D., Dallas, Texas
With the Assistance of Margaret Groves

THE interaction of erythrocytic antigens and their corresponding isoantibodies constitutes the basis for an incompatibility of blood. The antibodies may occur naturally (as in the ABO system) or they may be induced by prior blood transfusions, injections of blood, or incompatibilities between the child and mother during pregnancy (as in the Rh, MNS, Kell, Lewis, Duffy, and other systems).[15] In the test tube or on a slide the incompatibility is demonstrated mainly by the agglutination of red blood cells.* In the body the incompatibility is attended by an increased rate of destruction of the affected red blood cells.[12] The rate of hemolysis may be mild, thus approximating the normal survival of red blood cells (110 to 130 days), or it may be characterized by the destruction of the transfused red cells within a few hours or in a few days. Between these extremes of erythrocytic destruction various increased rates of destruction of transfused red cells as induced by isoantibodies may occur.

The adverse clinical responses to incompatible blood vary markedly, apparently as a consequence of the variations in the rates of destruction of the transfused red cells. The variations in the rate of erythrocytic destruction, on the other hand, appear to depend in part on the titer of the involved isoantibodies. Incompatible blood transfusions may be classified arbitrarily into the major and minor types, according to the adversities which they evoke in the recipient.

MAJOR INCOMPATIBLE BLOOD TRANSFUSION

The major incompatible blood transfusion is considered to exist when the rate of destruction of red blood cells by isoantibodies is sufficiently rapid to cause hemoglobinemia and hemoglobinuria. Under these conditions the conscious patient has a reaction characterized by a chill and fever (temperature elevation of 2 to 6 degrees F., average 4 degrees F.) and generalized signs and symptoms. Thirty per cent of these patients develop a hemorrhagic state, and 80 to 90 per cent develop some degree of acute renal failure.[13] The emphasis on hemoglobinuria rests on the high likelihood of serious complications when it occurs.

MINOR INCOMPATIBLE BLOOD TRANSFUSION

The minor incompatibility was emphasized by Wiener[17] under the designation of "minor hemolytic transfusion reactions." The main adversity in Wiener's cases consisted of febrile reactions. Two-thirds of the 22 patients developed jaundice after the transfusions, and in some the infused blood failed to yield the expected rise in the hemoglobin concentration. Wiener[18, 19] also emphasized under the term "inapparent hemolysis" the least evident of the minor incompatibilities of blood.[17] The latter transfusions were unassociated with clinical signs of adversity and occurred even though the original crossmatch of the blood was satisfactory. The abnormality was identified mainly by the increased rate of destruction of the red blood cells within the recipient's circulation as indicated by the Ashby technique.[1] The rate of hemolysis under these conditions may be associated with the removal of all transfused red blood cells within 20 to 60 days as compared to the expected normal of 120 days $\pm$ 10.

Since certain of Wiener's cases may now be considered of major proportions, it seems preferable to define a minor incompatibility more stringently. The minor incompatible blood transfusion may be considered to result from increased rates of destruction of red blood cells due to isoantibodies in association with which no readily detectable hemoglobinuria or renal failure develops. The patient may experience a reaction characterized by a chill, fever, and generalized complaints. Conversely, there may be no immediate adverse response as in Wiener's category of "inapparent hemolysis." Although hemoglobinuria is not evident, hemoglobinemia may be demonstrated and the serum bilirubin may be elevated within three to six hours.[12]

Mollison[12] has pointed out that under certain conditions the transfused incompatible red cells become coated with incomplete antibodies while they are destroyed more rapidly than normal, even though no

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**Erythrocytic agglutination may be demonstrated by different procedures: (1) with a saline suspension of red blood cells ("saline agglutinin"); (2) in a colloid medium as concentrated albumin (albumin or colloid type of incomplete antibody); (3) with the Coombs antiglobulin test (direct or indirect).*

reaction results. Under these conditions, blood taken from the patient shows a positive direct Coombs' antiglobulin test. This direct Coombs' test, however, results from the coating of the donor's red cells since the antibodies do not attach themselves to the recipient's cells. This combination of increased rates of destruction of red cells plus a positive direct Coombs' test makes the circumstances of the incompatibility resemble those of acquired hemolytic anemia.

ACQUIRED HEMOLYTIC ANEMIA

There are two types of acquired hemolytic anemia, the idiopathic variety and that which is secondary or symptomatic to a series of other diseases outstanding among which are malignant lymphomas, collagen diseases, and various types of granulomas. Since the original demonstration by Boorman, Dodd, and Loutit,[3] experience has indicated an almost universal encounter of a positive direct Coombs' test in the idiopathic form of acquired hemolytic anemia. In the secondary form of acquired hemolytic anemia this test has been reported positive in half of the cases.[5] In addition, it is not uncommon to encounter a positive indirect Coombs' test in the acquired hemolytic anemias when the patient's serum is incubated with the erythrocytes of others.[20] Thus, these tests have assumed a central position in the characterization of acquired hemolytic anemia.

The factor causing the positive direct Coombs' test in acquired hemolytic anemia can be eluted from the erythrocytes[9, 10] and demonstrated to attach itself to erythrocytes from other persons, thus causing a positive Coombs' test in these secondarily coated erythrocytes. Since the factor involved appears to be a globulin it has been considered to be an antibody and this disease has been termed "auto-immune hemolytic disease."[21]

It is apparent from these considerations that minor incompatible blood transfusions may be associated with elevated rates of destruction of transfused red cells (the hemolytic state) plus the occurrence of positive direct and indirect Coombs' tests. Under these circumstances the direct Coombs' test seems to result from the coating of the transfused red cells with its corresponding incomplete antibody. Also in the acquired hemolytic anemias there are increased rates of destruction of the patient's red cells, which at the same time are coated with globulins that act like incomplete antibodies and give rise to a positive direct Coombs' test. Similarities between these two conditions are evident.

PRESENT STUDY

The present discussion is based on observations on 12 patients. These patients had a "refractory anemia" associated with various diseases (table 1). Among the diseases were included carcinoma, bone marrow failure, chronic uremia, idiopathic thrombocytopenia, cirrhosis, disseminated lupus erythematosus, and familial telangiectasia. All patients received multiple blood transfusions which at times caused chills and fever without overt hemoglobinuria. Since these patients received multiple blood transfusions an attempt was made to determine whether or not the reactions resulted from minor incompatibilities.

TABLE 1.—*Race, Sex, Age, and Clinical Diagnosis for 12 Cases of Probable Minor Incompatible Blood Transfusion.*

Case*	Race	Sex	Age (yr.)	Diagnosis
1	W	M	60	Refractory anemia (aregenerative)
2	W	M	60	Carcinoma, prostate
3	N	F	18	Carcinoma, pharynx, myelofibrosis
4	W	F	49	Disseminated lupus erythematosus
5	N	F	33	Aplastic anemia
6	W	F	42	Diabetes mellitus, chronic pyelonephritis
7	W	F	34	Familial telangiectasia
8	W	F	48	Aplastic anemia
9	W	M	52	Carcinoma, kidney
10	N	F	41	Thrombocytopenia, idiopathic
11	W	M	43	Cirrhosis
12	N	F	55	Chronic uremia

**The numerical arrangement is the same in this table and tables 2 and 3.*

Methods

The Coombs' tests[4] were performed with the use of at least two and frequently three of the Coombs' antiglobulin serums as available on the market. These serums were tested in this laboratory against red cells that had been coated lightly and heavily with known incomplete antibodies, and their reactions were considered satisfactory. In the direct Coombs' test the red cells were suspended in saline solution (2 per cent) and washed three times with abundant quantities of saline at room temperature. After the third wash the test tube was turned up and allowed to drain. To the erythrocytes suspended in the remaining saline solution two drops of the human antiglobulin Coombs' serum were added. The mixture was allowed to stand for thirty minutes after which it was centrifuged for one minute at 500 to 1,000 rpm. The button of cells was shaken lightly into the supernatant and was evaluated for gross agglutination as follows: A solid button represented a 4+ reaction, a few large clumps were considered as 3+, multiple scattered clumps were 2+, and a definitely granular suspension with fine clumps was 1+. All grossly detectable degrees of agglutination were checked microscopically and the clumps of erythrocytes were demonstrated to be stable. A smooth or fairly smooth gross suspension which microscopically yielded scattered clumps was designated ± and was not included in these results.

The indirect Coombs' test was conducted by in-

cubating erythrocytes from different persons of the same ABO and main Rh blood types with the serum of the patient at 37 C. for one hour, then treating the red cells as in the direct Coombs' test. In some instances type O blood of the same general Rh type was used for these tests.

Eluates of red cells were prepared according to an adaption of the Landsteiner-Miller procedure[11] as follows: From 15 to 20 cc. of defibrinated blood were centrifuged, the serum was removed, and the erythrocytes were washed four times with abundant saline solution. A final 50 per cent suspension of erythrocytes in saline was heated to 56 C. for six to eight minutes while constantly agitated. The saline was then separated while warm. These eluates in the saline solution did not produce direct agglutination when incubated with a group of human red blood cells. The ability of the eluates to produce agglutination by means of the indirect Coombs' test was tested with the same red blood cells which were used in the tests against the serum as described earlier.

Survival of the red blood cells transfused into 8 of these patients was determined by the Ashby technique as described by Kaplan and Zuelzer.[8] In all of these instances type O blood was given to persons of type A, B, or AB. In procuring blood for this purpose only the red cells that gave negative indirect Coombs' test results in the crossmatch were used.

Results

The patients reported in this discussion received from more than 10 to more than 50 blood transfusions.

Direct Coombs' Test.—In table 2 the characteristics of the direct Coombs' test are given for the same patients listed in table 1. It will be noted that 10 of the 12 patients (cases 1, 3-7, 9-12) had a positive direct Coombs' test when first observed; that an additional example became positive within two to three months (case 2); and that the final patient had a positive test within six months (case 8). The degree of agglutination in the positive direct Coombs' test was usually at the level of 2+ to 3+. In 11 of these patients the direct Coombs' test became negative within two to six months, usually after three months. This phenomenon is strengthened by the fact that many appraisals of the direct Coombs' tests were conducted during this interval (table 2).

TABLE 2.—*Results of Direct Coombs' Test Applied to Circulating Red Blood Cells of 12 Cases of Probable Minor Incompatible Blood Transfusion.*

Case	Month of Observation 1	2-3	6	No. Tests (Positive/Total)
1	3+	+	Neg.	6/19
2	Neg.	2+	Neg.	1/4
3	1+			1/5
	Neg.			
4	+	+	Neg.	7/14
5	2+	3+	Neg.	5/7
6	+	+		4/4
7	2+	+	Neg.	3/5
8	Neg.		2+	2/4
9	+	+		2/2
10	3+	Neg.		3/4
11	3+	Neg.		2/5
12	2+	Neg.		2/3

The positive direct Coombs' test was a transient phenomenon either in the absence of transfusions or in association with transfusions crossmatched by means of the indirect Coombs' test.

Indirect Coombs' Test with Use of Patient's Serum.—Table 3 reveals the incidence of positive indirect Coombs' tests when a panel of red blood cells of the same ABO type or of type O and the same general Rh type was tested against the patient's serum. In none of the cases was there a 100 per cent positive result indicating that the serum, by means of the indirect Coombs' test, showed a specificity.* The specificity varied considerably and was partly dependent on the number of cells used in the panel. In general it varied between 30 and 80 per cent.

TABLE 3.—*Incidence of Positive Indirect Coombs' Tests Against Various Panels of Erythrocytes as Applied to Serum from 12 Patients with Probable Minor Incompatible Blood Transfusions and to Eluate from Red Cells at the Time the Direct Coombs' Test Was Positive.*

Case	Serum Incidence (Positive/Total Tests)	Eluate Incidence (Positive/Total Tests)
1	32/39	26/34
2	15/23	10 Neg.
3	7/10	Not tested
4	65/80	10 Neg.
5	3/10	4/10
6	Crossmatch satisfactory	
7	11/15	4/15
8	21/40	21/40
9	7/12	8/10
10	3/10	3/10
11	8/10	7/10
12	14/19	13/19

The presence of a specificity in the serum against a panel of erythrocytes by means of the indirect Coombs' test suggests the presence of incomplete antibodies.

Indirect Coombs' Test Using Eluate from Patient's Red Cells.—Eluates were prepared from the red cells at the time that the direct Coombs' test showed a 2+ to 3+ degree of agglutination. It is shown in table 3 that the eluates showed various specificities against the panel of erythrocytes. The specificity varied between 30 and 80 per cent. In 7 of the cases

*By specificity is meant that with red cells representing a sample of the population the serum gave positive results with some but not others. The percentage of positives is the specificity.

the specificity of the eluate was comparable to the specificity of the serum when measured against the same erythrocytes. In 1 case there was a disparity between the two and in 2 cases the eluates were negative.

These observations tend to indicate that the cause for the positive direct Coombs' test was an antibody which had an activity comparable to the activity encountered in the serum.

Survival of Transfused Red Cells.—Ten red blood survival curves were obtained in 8 of these patients (cases 1-6, 11, 12). In all instances the transfused blood was of type O and the indirect Coombs' test for these red cells was negative. In all instances the curve described in the survival measurements indicated an increased rate of destruction of the transfused red cells (fig. 1). If one projects the first main

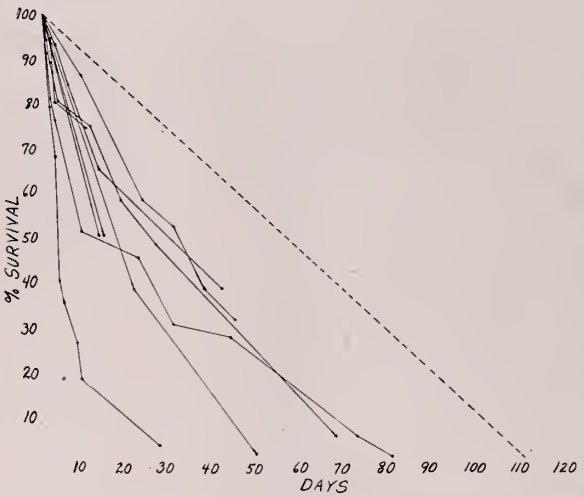

FIG. 1. The Ashby red blood cell survival curves as obtained after transfusion of the appropriate O or MN blood into 8 of the patients represented in tables 1, 2, and 3. The straight dotted line indicates the expected normal disappearance curve for transfused red cells. It is apparent that a shortened survival was depicted in all instances tested.

drop in the concentration of the surviving red cells to the base line, in accordance with Dornhorst's suggestion,[6] and considers this as the average survival of the red cells, the average survival for the 8 cases consisted of the following number of days: 8, 10, 30, 38, 40, and 60. Thus, in most of these cases there was indication for a substantial shortening of the period during which the transfused red cells remained in the circulation.

Reactions to Blood.—All of these patients gave a history of varying degrees of reactions in the past following transfusions, including chills and fever. Upon using blood yielding a negative indirect Coombs' test the reactions were markedly diminished or eradicated, even though the survival of the transfused red cells was still reduced.

Summary of Results.—The following abnormalities encountered in these patients can be emphasized: (1) a positive direct Coombs' test; (2) fluctuations in the direct Coombs' test with a tendency for the test to become negative after two to three months when no transfusions were given or when stringently crossmatched transfusions were given; (3) a specificity of the serum as indicated by the use of the indirect Coombs' test with a panel of red cells; (4) retainment of the serum specificity after the direct Coombs' test became negative; (5) a specificity of the eluates obtained at the time the direct Coombs' test was positive which was comparable to the specificity of the serum; (6) the disappearance or amelioration of reactions following blood transfusions as the direct Coombs' test became negative; and (7) the demonstration that transfused blood, even with a negative indirect Coombs' test, showed a decreased survival within the recipient.

Exemplary Case

CASE 5 (tables 1, 2, 3, 4).—A 33 year old Negro woman had been hospitalized for normal pregnancies on three occasions during the five years before the present admission. Each time she was moderately anemic but otherwise normal. On this admission she had severe menorrhagia and severe anemia. Following transfusion of 6 liters of blood a vaginal hysterectomy was performed. Later the patient was found to have a prominent pancytopenia (table 4) and a palpable spleen. Two bone marrow preparations appeared slightly hypocellular and showed evidence of degeneration and necrosis of bone marrow cells including the megakaryocytes. In addition, increased numbers of plasma and mast cells and abundant hemosiderin were seen in the smear of the bone marrow. The direct Coombs' test was positive. One additional liter of blood was given, but within fourteen days the hemoglobin concentration dropped to 4.8 Gm. per 100 cc. At this time the serum bilirubin determination indicated a minute reading of 0.2 mg. per 100 cc. and a total reading of 3.8 mg. per 100 cc., and the stool urobilinogen output per twenty-four hours, as obtained by a four day collection, was 240 units. The hemolytic index was 152 (normal 10-20). The reticulocyte count remained near 0.5 per cent. The direct Coombs' test remained positive for two additional months. A red cell survival study

TABLE 4.—*Data from a Case of Aplastic Anemia (Case 5).*

Month	Day	Hgb. (Gm./100 cc.)	WBC (×1,000)	Platelets (×1,000)	Direct Coombs' Test	Blood Transfusions (cc.)
March	21	1.0	4.2			
	21-31	9.0				6,000
April	6	8.7	2.3	12	2+	1,000
	14	4.8	2.0	12	1+	1,000
		7.8				
	23	8.5	4.6		1+	
May	2				2+	
	7	9.2	2.8	16		
	21	6.9	3.8	18		
June	11	8.0			3+	
	18	8.0	4.8	38		
	23					500
July	2	8.3	4.8	14		
	30	8.5	3.6	26		
August	13	9.0	2.6	30	Neg.	
	27	8.7	2.9	22	Neg.	

three months after the operation, when the direct Coombs' test was negative, yielded evidence for an increased rate of erythrocytic destruction (approximately 1.6 per cent per day). The indirect Coombs' test as applied to the patient's serum gave 3 positive results of 10, while at the same time the same cells applied to an eluate from the red cells gave 4 positive results of 10. Although the patient remained pancytopenic, the direct Coombs' test became negative. The final diagnosis was that of aplastic anemia.

COMMENT

The similarities between certain minor incompatible blood transfusions and acquired hemolytic anemia result from the fact that each condition consists of a hemolytic state in which the direct and indirect Coombs' (antiglobulin) tests may be positive. The cases reviewed in the present discussion are considered more likely as examples of minor incompatible blood transfusions for the following reasons: (1) the positive direct Coombs' test became negative when blood transfusions were discontinued or when blood subjected to the indirect Coombs' crossmatch was used; (2) the serum specificity against a panel of red cells demonstrated by the indirect Coombs' test indicated the presence of incomplete antibodies of the isoimmune type (against specific antigens in other persons' red cells; (3) the eluate specificity obtained by the indirect Coombs' test was frequently comparable to that of the serum, although not always identical to it, thus indicating coating of the red cells with specific isoimmune antibodies; and (4) the disappearance or amelioration of the reactions to blood when red cells yielding a negative indirect Coombs' test were used and while the direct Coombs' test became negative suggested that the reactions were related to the action of the antibodies. Moreover, these findings were encountered within a background of diseases known to cause a "refractory anemia" for which multiple blood transfusions had been given.

There is no problem in differentiating minor incompatible blood transfusions and acquired hemolytic anemia when a hemolytic state associated with positive Coombs' test is encountered in a patient who has received no blood transfusions within three to four months. This circumstance has been well illustrated, as in the cases reported by Young and co-workers.[20, 21] The difficulty arises under two circumstances: (1) in patients known to have acquired hemolytic anemia but who, in addition, have received multiple blood transfusions within three months and (2) in patients with a previously undiagnosed anemia who are found to have a hemolytic state associated with positive Coombs' tests and are known to have received multiple blood transfusions recently. If the patients in the second group are found to have a disease capable of causing a "refractory anemia," the possibility of minor incompatibilities should be considered. The greatest diagnostic difficulties occur when the two conditions are suspected of occurring concomitantly and an attempt is made to determine which is the more prominent at the time of observation.

Attempts to differentiate these two hemolytic states is not always evident in reports in the literature. Thus, one is concerned about reports purporting the development of "autoimmune" or "acquired" hemolytic anemia in association with aplastic anemia, sickle cell anemia, Cooley's anemia, paroxysmal nocturnal hemoglobinuria, idiopathic thrombocytopenia, congenital spherocytic anemia, malignant neoplastic diseases, and other conditions in which multiple blood transfusions represented a feature of the management. Such analyses often depend greatly on the presence of a positive direct Coombs' test without reference to its relation to the schedule of blood transfusions.

It follows that the diagnosis and management of minor incompatible blood transfusions have practical bearings on the care of patients. Its appreciation may prevent unnecessary splenectomies, and its identification may improve the value of blood transfusions.

The value of a blood transfusion for an anemic state is directly related to the duration of stay of the red blood cells within the recipient's circulation. In the most efficient transfusions the red cells remain in the circulation for an average of 60 days[7] and a segment remains for 120 days ($\pm$ 10). Over a prolonged course of transfusion therapy considerable doubt can be raised concerning the value of red cells that survive for eight to twenty days only. Eventually the products of hemolysis may be harmful.[2, 14, 16] On the other hand, transfusions can be considered helpful in certain cases even though their efficiency is distinctly below the expected normal, as when all of the red blood cells disappear from the circulation within forty to eighty days and the average survival is in the range of twenty to forty days.

The survival of the red blood cells in the presently recorded cases was less than the expected normal, even under the best circumstances for this institution, and indicated an inefficiency of the transfusions. This shortened survival of transfused erythrocytes was obtained usually at a time when the direct Coombs' test was negative. In accordance with prevailing definitions in the literature this finding would be considered indicative of a secondary or symptomatic acquired hemolytic anemia associated with a negative direct Coombs' test. The term "secondary or symptomatic" is used since each patient had a distinct "primary" disease. In the light of the other observations already discussed, particularly the references to the Coombs' test and the reactions to blood, it is theo-

retically possible that the shortened survival of other persons' red cells within these patients resulted from "hidden" or "occult" antibodies, that is, antibodies which are not detected by presently utilized techniques. The fundamental question of whether the patient's own red cells survive normally in their natural environment remains to be demonstrated but is being pursued.

The identification of minor erythrocytic incompatibilities can be greatly strengthened by the identification of specific antibodies,[15] either in the serum or from the erythrocytic eluates. Unfortunately this was not always possible in the cases recorded herein. This deficiency in the data is not considered to detract crucially from the points discussed but does constitute a failure to supply the ultimate proof of the premises considered.

Identification of the specific incomplete antibodies involved in minor incompatibilities may be a complex and difficult task since there is the possibility of multiple antibodies being concerned, and their titers in the serum may be low and variable. The process involved in the development of the positive direct Coombs' test under these circumstances consists of the removal of the antibodies from the serum as they coat the transfused red cells. It is fortunate, however, that even when specific identification is not possible, one has available the indirect Coombs' test as the most efficient method for the establishment of an adequate crossmatch.*

The potential role of minor incompatibilities is emphasized by the multiple sources of antibodies as indicated by the many red cell antigens. The minor incompatibility is theoretically possible for any one or any combination of red cell antigens. The list of known antigens continues to grow and includes the following antigens and their subgroups: ABO, Rh, MNS, P, Kell, Lewis, Lutheran, Duffy, Kidd, Levay, and more recently u, f, Tj, and He. It is likely that minor incompatibilities are more common than ordinarily considered.

**A negative indirect Coombs' test (donor's cells incubated in recipient's serum) does not preclude a minor incompatibility as the recipient at that moment may be in the negative phase of antibody titer or "hidden" antibodies may be present. It does minimize or decrease the intensity of this possibility.*

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COST OF MEDICAL DIPLOMA

Medical college training in America costs approximately $9,200 today, according to a recent report in the *Journal of Medical Education*. This average does not include the cost of premedical training, internship, and residency training, or the cost of setting up in practice.

The study, which was conducted by John M. Stalnaker and Sara Counts of the Association of American Medical Colleges, was based on answers to 6,251 questionnaires from students at twenty-six medical schools in the United States. One-third of the students who answered expected to be in debt when they are graduated from medical school. About half of the students are single and living away from home, and most of the money for their medical education comes from parents. The married students who answered this questionnaire reported that most of their medical education is paid for by their wives.

Six civil defense survival secrets will double your chance of living through an atomic attack. They are: (1) Take cover in a basement, subway, ditch or doorway; (2) drop flat; (3) bury your face in your arms; (4) stay put for a few minutes after the explosion; (5) don't take chances later with exposed food or water; and (6) don't start rumors that might cause panic and cost you your life.

ANTIBODIES AS CAUSES OF HUMAN DISEASE

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IT is an apparent paradox that antibodies should become important in the role of causative agents of human disease. They always have been important in exactly the opposite role, namely, as a part of the body defense mechanism against disease.

The history of this subject yields some startling revelations. Widal, Abrami, and Brule[19, 20] very early in this century, concisely defined the entity of acquired hemolytic anemia and presented evidence that the disease was due to antibodies (hemolysin). Methods of easy confirmation of this work were not available at that time, and as a result this report was all but forgotten. In 1922 Bedson[2] produced an antithrombocyte serum, and when this antibody was injected into animals of the same species, it produced a disease, including purpura, thrombocytopenia, and megakaryocytic hyperplasia of the marrow, which satisfactorily duplicated idiopathic thrombocytopenic purpura in the human being. In 1925 Bedson and Johnson[3] extended this work. These reports were also laid aside.

During the forties Cavelti and Cavelti[5, 6, 7] reported the production of autoantibodies in rats against homologous tissues. In rats infected with Streptococcus hemolyticus, they were able by injecting an antigen made up of connective tissues and heart muscle to produce an antibody which was active against heart tissues. When this serum was administered to normal rats, there developed in the myocardium lesions which were not unlike those of human rheumatic fever. These authors accomplished similar results with combined Streptococcus and kidney antigen and were able to produce a disease simulating glomerulonephritis. This caused a bit more of a stir, and soon people in important positions, including Karl Meyer, William Kerr, David Seegal, Robert Loeb, and Lester Evans, became interested and encouraged the Caveltis to continue their work. However, it can be said with accuracy that medicine in general had ignored these developments.

In the meantime (1939 and 1940) Levine[16] discovered an antibody in the blood of a woman who had delivered a stillborn baby, and Weiner[22] produced an antibody in rabbits by injecting Rhesus blood. The two, who were students of Landsteiner, soon developed the fact that the antibody from the woman and the antibody from the rabbits had the same specificity, and from this beginning came the development of our knowledge of the Rh-Hr blood system. These events, with the subsequent developments which are well known to all doctors, gave a tremendous impetus to the study of the role of antibodies as causes of human disease.

In 1947 R. R. A. Coombs[9] developed what is now known as the Coombs' test. It is a test for coating or blocking type antibodies. It actually tests for human globulin. When human globulin is coated on red blood cells in antibody form, this serum detects it by causing the cells to agglutinate. Second only to the discovery of Rh-Hr system, this event has been the most significant development in the entire study of the relationship of antibodies to the etiology of human disease. Soon this test was being applied to a number of diseases which had the potential of being caused by antibodies. Many workers reported within a short time that the Coombs' test was regularly positive in acquired hemolytic anemia. This became such a regular finding that it was not long until Evans and others[12, 13] suggested that the name of the disease should be changed to immunohemolytic anemia.

Now we come to the significant role which American physicians have played in the further development of knowledge of this subject. Evans and others[13] of Stanford University in January, 1951, and Harrington and his co-workers[14] at Washington University in St. Louis in July, 1951, reported some significant observations. Evans suggested a spectrum-like relationship between acquired hemolytic anemia and idiopathic thrombocytopenic purpura. He demonstrated that a significant number of patients with acquired hemolytic anemia also had thrombocytopenia and that a small number of the latter actually had accompanying thrombocytopenic purpura. Further, he demonstrated that certain patients who presented themselves with the picture of idiopathic thrombocytopenic purpura without anemia revealed red cell sensitization as demonstrated by the Coombs' test. Harrington's work complemented that of Evans completely. He demonstrated that of 10 cases of idiopathic thrombocytopenic purpura, 8 had a plasma "factor" which was transferrable and that when whole blood or plasma in regular transfusion volume was transfused into normal persons, thrombocytopenia developed, in some cases being accompanied by prolongation of the bleeding time and delay in clot retraction. In a few cases hemorrhagic manifestations in the skin and from the gastrointestinal tract developed. The thrombopenia and the other manifestations were transient as one would expect with passive transfer.

From the Children's Hospital.

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This substance in the plasma has been called a thrombopenic factor, but subsequently it has been shown by Stefanini and others[17] to be present in the gamma globulins and to behave like an antibody. These same workers working in Boston extended Harrington's work and presented studies of 1 person in particular whose blood or plasma, when transfused, regularly caused the full picture of thrombocytopenic purpura in volunteers.

Subsequently, Stefanini,[18] Harrington,[15] and others have developed evidence of platelet types. Stefanini and his group[18] showed that a coating antibody specific for thrombocytes was present in certain cases of idiopathic thrombocytopenic purpura and that the Coombs' test could be applied to platelets. It may be said then, that there is now considerable evidence that each human individual is of a platelet type in the same manner that he is of an ABO, MN, and Rh-Hr type.

THROMBOCYTOPENIC PURPURA

The theory of the individualized platelet type explains, as Harrington[15] has suggested, the two types of congenital thrombocytopenic purpura. In one type the mother has purpura with the full picture of idiopathic thrombocytopenic purpura and the baby is born showing thrombocytopenia with or without purpura. This is the common form and is an example of passive transfer of the antibody from an affected mother; if the baby is brought successfully through the first ten or fifteen days of life, his problem, because he is passively immunized, resolves itself. In the other type the mother does not have idiopathic thrombocytopenic purpura, but the baby in utero has a platelet type which differs from that of the mother. The mother becomes actively isoimmunized in a manner identical pathogenetically with erythroblastosis fetalis. In this instance, the return of the antibody passively to the baby results in thrombocytopenia with or without purpura, and the course of the illness in the baby follows the same course as the other form of passive transfer noted previously. This theory is extremely interesting and deserves active study whereever the opportunity presents itself.

In our laboratory, Dr. Osmun H. Hull has confirmed the presence of a coating antibody on platelets in 4 cases of thrombocytopenic purpura. He has developed a technique which permits him to obtain a satisfactory and sufficient platelet suspension from 10 cc. of whole blood. I should like to emphasize the fact that coated platelets react sharply with Coombs' serum. Positive and negative results are definite and decisive. Dr. Hull also found that the serum of the patients with idiopathic thrombocytopenic purpura clumped platelets from blood donors on the 5 samples which were used. He also was unable to demonstrate an antibody in the serum or a positive Coombs' reaction in the platelets of 3 patients with Henoch-Schönlein purpura.

Not all cases of purpura are due to antibodies. Purpura occurring during the course of infections may or may not be thrombocytopenic and may or may not be associated with antibodies. Purpura from toxic causes has the same possibilities. Toxic agents which injure the bone marrow and cause amegakaryocytic thrombocytopenia are not associated with antibodies. On the other hand, Sedormid and quinidine purpura are both associated with antibodies, and Ackroyd[1] has shown that the presence of the drug is necessary to complete the reaction in demonstrating the antibody. The major group associated with antibodies encompasses most of the cases of classic idiopathic thrombocytopenic purpura.

There remains splenomegalic or secondary thrombocytopenic purpura. The term splenomegalic purpura is preferred by many because it is descriptive and indicates that the enlarged spleen has a part in the pathogenesis, but it gives no suggestion of a mechanism. The mechanism by which purpura is produced in this group is not known, but it is true that splenomegaly from any cause may and often does result in thrombocytopenia with purpura, and this may or may not be accompanied by granulopenia and anemia. In most cases of splenomegalic purpura one is not able to demonstrate an antibody. Whether or not the slaughter house function of the spleen is accentuated when the spleen is enlarged or whether it influences adversely the production or release of platelets and blood cell elements from the bone marrow is unsettled. The term hypersplenism is applicable to this group. There is no other group in which this name can be used without some qualification.

A word about splenomegaly in idiopathic thrombocytopenic purpura. In spite of statements which recur in edition after edition of textbooks that up to 30 per cent of the patients with idiopathic thrombocytopenic purpura have splenomegaly, the spleen is not enlarged in this disease as a primary manifestation. I believe that the origin of the statement comes from the fact that about 30 per cent of the cases become chronic. These chronic cases require transfusions because of hemorrhage. After repeated transfusions, splenomegaly occurs because of hemosiderosis. Therefore, one can say that the spleen is not enlarged in idiopathic thrombocytopenic purpura except in those patients who have repeated transfusions. In a patient with purpura who has not had transfusions and who has splenomegaly one should consider the splenomegalic (secondary) form rather than idiopathic thrombocytopenic purpura until proved otherwise.

Ehrlich and Schwartz[11] at the Hektoen Institute studied 110 cases of purpura hemorrhagica. Thirteen of these patients had large spleens. All but 1 of these cases were of the secondary type. The large spleen which apparently was not secondary was in a 14 year old boy who also had lymphadenopathy. Eleven of the 13 patients had granulopenia. The course in the splenomegalic type as compared with the immuno variety is apt to be less dramatic and less emergent. Splenectomy improves the condition.

ACQUIRED HEMOLYTIC ANEMIA

In acquired hemolytic anemia the antibodies may be of the warm or of the cold type. Both may be present and occasionally an antibody with a wide range of temperature specificity is found. Each of these antibodies may coat red blood cells. One of the most interesting and most recent developments in the study of the specificity of the antibodies which coat the red cells in cases of acquired hemolytic anemia has been the findings by Dacie and others[10] of London that both autoantibodies and isoantibodies are frequently present, and autoantibodies with the specificity for Rh or Hr antigens frequently are concerned. He found "e" and "C" antibodies to be concerned in different cases. This is an unexpected development. He also found more than one antibody in a number of cases. In some of his cases the specificity of each antibody could not be determined. This information fits with a recent report by Weiner and others[23] that specificity of certain antibodies in acquired hemolytic anemia had been for the nucleus of the Rh-Hr antigen.

The difference between an *auto*antibody and an *iso*antibody is that the person who actively builds up the *iso*antibody does not have in his system the antigen which causes it to be built up. The *auto*antibody develops in those who do have that antigen. It is not unexpected to see *iso*antibodies develop in cases of acquired hemolytic anemia due to *auto*antibodies in patients who have had blood transfusions. But to find antibodies present which were *auto*specific for the patients' own Rh or Hr antigens was unexpected. The observation, however, lends support to Cavelti's findings of autospecific antibodies in rheumatic fever and glomerulonephritis in that it supplies an analogous situation.

Application of these methods to the study of granulopenia has not been extensive. However, the L-E factor is known to be present in gamma globulin,[4] has characteristics of an antibody, has undergone passive transfer to babies in utero,[4] and does act against leukocytes.

ADDITIONAL POSSIBILITIES

The group of additional diseases which are being studied for evidence of antibody causation includes most of the members of the collagen group and may be listed as glomerulonephritis, rheumatic fever, lupus erythematosus, polyarteritis nodosa, and related entities.

Are transfusions contributing to the problem? Realizing the tremendous number of antigens contained in whole blood—which now apparently includes a number of platelet types—can one expect to give multiple transfusions without causing *iso*antibodies to develop and perhaps complicate the course of the patient's illness? Certainly one cannot expect to match blood so that donor and recipient are antigenically the same. It is increasingly apparent that with the advent of the use of corticotropin and cortisone one can use transfusions less and less in diseases in which an immune mechanism is concerned. In many other situations, the information assembled concerning the development or occurrence of *iso*antibodies and *auto*antibodies in human disease may well be considered before elective transfusion therapy is practiced.

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EVALUATION OF A CEREBRAL PALSY TREATMENT PROGRAM

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FOR many years after spastic paralysis was first described by Little in 1861, it was generally held that the affected ones were mentally retarded and could benefit little by any treatment; consequently the only treatment these unfortunates received was directed toward their orthopedic problems. In recent years, however, studies have emphasized that a multiplicity of involvement of the disabling symptoms is possible.[16] This new concept of cerebral palsy has led to the establishment of treatment centers throughout the country. The rapid rise of these institutions makes it possible to evaluate the results of the therapy programs. This is an analysis of the Austin Cerebral Palsy Center, an out-patient treatment clinic.

To determine the progress made in the treatment of 100 consecutive clients of the center from its inception in 1947 to June 1, 1953, it was necessary to classify the disabilities upon entrance to the center and reevaluate these as the study progressed.

In analyzing each case, orthopedic involvement, speech involvement, mental status and educability, emotional status, and general physical condition were compared with the admission observation from time to time during the observation period.

Twenty-seven cases were eliminated from the study because of incompleteness of historical data or too short an attendance at the center to evaluate improvement in the conditions present; further, severely mentally retarded children were not accepted for therapy in view of the limitation of facilities. As a result of the location of the State Schools for the Deaf and the Blind in Austin, and as consequence of cooperation with them, the incidence of associated defects in the auditory and visual areas was higher than in other reported surveys.

RESULTS

All other published surveys of cerebral palsy patients show the male to be more commonly involved, the percentage varying from 52 to 55 per cent,[3] whereas in our study 32 out of 73 patients were males.

Orthopedic Involvement.—Severity of the orthopedic involvement was determined from the evaluations of examining physicians and physical therapists. The degree of involvement was recorded on the master chart in terms of a four-point scale: 0—no involvement, 1—mild, 2—moderate, and 3—severe.

The criteria were as follows:

Spastic type.
1. Mild contractures, slight difficulty with locomotion or use of hands.
2. Moderate contractures, increased difficulty in locomotion and hand use.
3. Severe contractures and extreme difficulty in locomotion and hand use to the point of complete inability to walk or use the hands for any practical purposes.

Athetoid type.
1. Slight difficulty in locomotion and gross hand use.
2. Moderate difficulty in locomotion and gross hand use.
3. Severe difficulty in locomotion and fine voluntary hand movements practically impossible.

Ataxic type.
1. Mild muscular incoordination, slight impairment of balance.
2. Moderate muscular incoordination, staggering.
3. Extreme muscular incoordination, very poor balance, frequent falls.

Other types (rigid, tremor, tension athetoid, flaccid atonic, and combinations of two or more types).
Criteria dependent upon the mixture of clinical signs present.

The type of manifestation in this analysis included 42 spastics, 12 athetoids, 3 ataxics, and 16 mixed types out of a total of 73 patients. These proportions are within the ranges reported in similar studies by

Burgenmeister and Blum,[4] Wolfe,[17] Pohl,[15] and Phelps.[13]

The degree of involvement of the patients is variable in all the studies compared. Sixty-six of our cases had orthopedic involvement; of this group only 2 had surgery, 18 had braces, and 54 had physiotherapy. In Wolfe's survey 18 per cent had surgery, but this variance is due to the fact that his series was of hospitalized cases and ours is an out-patient group.

Speech Involvement.—Severity of the speech involvement was determined from the speech therapist's examination, which included evaluation of peripheral speech mechanism, understandability, phonation, articulation, and rate. For the present study, however, it was not necessary to rate speech involvement in these different aspects, but in a more general way on a four-point scale:

0—No observable impairment of the patient's speech.
1—Mild impairment.
2—Moderate impairment.
3—Severe impairment or complete absence of speech.

Such a rating scale takes all of the previously mentioned evaluations into account, but is largely concerned with understandability. Speech and language problems not associated with cerebral palsy such as stuttering, "baby talk," and English language problems of children with a bilingual background were not included.

Speech therapy was given at the center by the speech therapist, and, as in the case of physical therapy, this was supplemented by work done at home. The patient or his parents were given instructions for the home therapy, and whenever possible the parent observed several therapy sessions at the center. Therapy at the center was both individual and group, there being appropriate groups for different age levels.

Out of 65 subjects, 7 showed no speech involvement, 9 slight, 22 moderate, and 27 severe speech involvement. The distribution of the 58 cases of speech involvement among the various types of cerebral palsy showed 23 spastic, 7 athetoid, 2 ataxic, and 16 in the mixed cases.

Mental Status.—Subjects of the study ranged in chronological age from 2½ to 30 years. Educational attainment included attendance in regular elementary schools, special room in a regular school, special school, high school, and university, and several patients with or working toward graduate degrees. Few of the subjects were considered uneducable. This is undoubtedly due to the fact that applicants with severe mental retardation are not usually accepted by the center. Some applicants with suspected retardation, however, are taken on a trial basis. Psychometric reports and other data with which to estimate the mental status were available for 63 cases. Of these, 28 patients were judged to have average or above average intelligence, 2 were rated as dull normal, 15 as borderline, and 18 as definitely retarded. In table 1 these findings, expressed in approximate percentages, are compared with those of Burgemeister and Blum.[4]

TABLE 1.—*Mental Status of Cerebral Palsy Patients.*

	Retarded (%)	Borderline (%)	Dull Normal (%)	Average or Above (%)
Present study	29	24	3	44
Burgemeister and Blum[4]	50	2	8	40

Emotional Status.—Notes on the behavior of the patients during speech and physical therapy periods such as desire for improvement, attitude toward the therapist, and cooperation; adjustment to peer groups at the center; occurrence of tantrums and other antisocial behavior; shyness; and extreme introversion were obtained from the case histories and from members of the staff. This, together with similar information from the psychometric reports and other personal information forms and from reports from the public schools and referring agency provided data from which the severity of personality problems could be estimated.

Each patient for whom sufficient information was available was rated 0, 1, 2, or 3 for adjustment. The criteria were as follows:

0—No observable problems or indication of maladjustment.
1—Mild antisocial behavior.
2—Behavior problems of sufficient severity to impede therapy.
3—Severe emotional problems.

One aspect of cerebral palsy that often has been neglected is that of adjustment. Several authors have mentioned the personal and social adjustment problems of individuals with cerebral palsy. Little[8] stated, "Physicians and others who have treated children suffering from cerebral palsy have long been aware that there are often strong and disturbing emotional reactions in the patient and his family, which interfere with successful medical treatment and the individual's general adjustment." He found that 21 out of 22 families studied showed marked evidence of emotional disturbance secondary to having a child with cerebral palsy.

Bice[2] reported that 7 per cent of the major problems encountered by the New Jersey State Crippled Children's Commission in a typical year involved behavior problems.

In the present study, for the group of 62 cases for

whom information concerning personal and social adjustment was available, 21 had severe emotional problems, 13 had behavior problems that impeded therapy, 1 had slight antisocial behavior, and 27 gave no indications of personality problems.

General Physical Condition.—Allied defects noted in this group were 12 cases of severely decreased vision, 13 of strabismus, 6 of nystagmus, 19 of marked hearing loss, and 1 of bile-stained enamel. Other disease processes did not seem to occur with unusual incidence.

Convulsive seizures were present in 15 of the 73 cases (13 grand mal and 2 petit mal type). Wolfe[17] reported 35 per cent and Benda 65 per cent with convulsions. Of the 15 in our series, 8 were in spastics, 3 in athetoids, and 4 in the other types. Six of those with convulsions had mild, 5 had moderate, and 4 had severe orthopedic involvement.

ETIOLOGY

Etiologically speaking the parity of the mother was of no significance. There were two families with multiple cases in the study. In one family 3 of 4 siblings with no discernible cause were affected; in one family, 2 children born after thirty-hour labors were cerebral palsied, but the third sibling, delivered by section, is normal.

In various studies differing percentages of instrumentation as a causative factor may be explained only on the basis of lack of sufficient historical information as to the indication for and type of instrument application. Comparison of some of the birth factors noted in various series of cerebral palsy patients is shown in table 2.

As possible etiologic factors, the prenatal or toxic processes included 1 case each of German measles, kernicterus, and maternal diabetes, and 3 cases of severe maternal toxemia.

TABLE 2.—*Birth Factors in Cerebral Palsy Patients.*

	Gen. Pop. (%)	This Study (%)	Wolfe[17] (%)	Benda[1] (%)	Pohl[15] (%)	Gustafson[6] (%)
Normal birth	11.5	34				
Precipitate birth	2.7	21	38	3.7	42	
Prolonged labor		22	14	22.0		
Premature birth		22*	42	37.0	36	30
Breech birth	3.6	5	10	5.6		9
Instrument delivery	8.5	15	24	8.0		19
Cesarean delivery		3				
Face presentation		1				

*This number included 4 who were 1 of twins. In 2 the other twin was alive and normal and in 2, death of the other twin occurred during the newborn period.

SUMMARY AND CONCLUSIONS

The various manifestations of cerebral palsy in this study are in general agreement with published data.

Almost all of the cases had orthopedic involvement. Four-fifths of these showed slight to considerable improvement under therapy.

Four-fifths of the patients had speech defects, and four-fifths of these showed slight to considerable improvement under our speech program.

About half showed slight to moderate mental retardation.

About half had personal social adjustment problems, and of these about two-thirds showed improvement while at the treatment center.

In view of our findings, we believe that the function of a cerebral palsy center is threefold: treatment, research, and training.

Prior to the initiation of treatment, finite diagnosis of the brain injury is essential. This demands neurologic, otologic, ophthalmologic, and general physical evaluation along with speech survey and a study of the mental and emotional status of each individual case. There is an acute need for the development of specialized methods of intelligence testing to overcome the inaccuracies obtained from present tests due to the physical handicaps of the palsied. Research into improved diagnostic and therapeutic methods is essential as is study that will lead to decreasing the number of brain injuries. The training function is of varied scope and nature. Education of the parent as to the disability of the cerebral palsied patient and teaching the parent to become the active therapist and to carry the treatments into the home is essential to gain maximum results. Job training and vocational guidance should begin in the early teens to aid in making the handicapped person self sufficient.

Training of psychologic workers to use play therapy or group therapy techniques is an essential for more rapid results in clearing emotional problems and in verifying intelligence testing.

Workshops, internships, and so forth should be developed for all concerned in care, treatment, and education. Well staffed centers should have programs for training all types of therapists. Postgraduate medical education should be expanded. Histories and progress records should be kept in good order. Constant evaluation of the patient and his progress under therapy should be done. Emotional and educational speech and physiotherapy progress must be frequently scrutinized at intervals and changed to meet the changing demands of the cerebral palsied child.

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DIARRHEA IN SAN ANTONIO
Analysis of 1,000 Hospital Cases

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ALTHOUGH the disease process called diarrhea has been recognized and studied for centuries, knowledge of its complexities remains incomplete. So there is yet a challenge which perforce must stimulate the imagination and encourage a continuing endeavor to understand better such a significant and implacable enemy to infant life. In the quest for the necessary truths, experience may prove to be one of the lamps by which we can be guided, and a morsel of genuine history may be valuable. It has been, then, this concept which prompted us to report 1,000 hospitalized cases of diarrhea occurring endemically in this area.

Because of many factors, including semitropical climate and a large Latin-American population living under substandard conditions, the death rate from diarrhea in San Antonio remains ten times as high as comparative figures for the United States as a whole. Fourteen per cent of 10,000 infants delivered at Brooke Army Hospital from 1946 through 1951 were brought to the hospital's Pediatric Clinic at some time during the first six years because of diarrhea.

Diarrhea accounted for 2.6 per cent of 100,000 out-patient visits during this period; 22.5 per cent, or 590, of these patients required admission to the hospital, accounting for 9.7 per cent of 6,076 hospital admissions during the years 1946 through 1951. Although the case fatality rate was only 4.1 per cent, diarrhea accounted for 17.6 per cent of all pediatric deaths at Brooke Army Hospital. This study was undertaken to summarize some of the factors responsible for this persistently high morbidity and mortality. During the same period, 3,509 cases of diarrhea were reported to the City Health Department in San Antonio. Of these patients 842 died, a case fatality rate of 24 per cent. There is little variation from year to year, the number of deaths varying from a low of 90 in 1947 to a high of 150 in 1949. That the cases reported are chiefly hospital cases is evident from the fact that 2,630 patients with diarrhea were seen in the Out-Patient Clinic at Brooke Army Hospital during this period, and 590 of these patients were admitted to the hospital. During 1949, 1950, and 1951, 414 patients were studied at the Santa Rosa Hospital.

TABLE 1.—*Incidence of Diarrhea by Month.*

Month	San Antonio % Deaths	Santa Rosa Hospital % Admissions	Brooke Army Hospital % Admissions	Brooke Army Hospital % Deaths
Jan.	6.8	3.3	11.0	7.7
Feb.	5.6	1.4	6.0	7.7
March	6.0	1.4	3.0	7.7
April	9.6	9.0	5.0	3.8
May	19.0	24.2	8.0	23.2
June	13.0	14.7	7.0	7.7
July	12.9	10.4	8.0	15.4
Aug.	6.0	5 7	7.0	3.8
Sept.	2.6	5.2	7.0	7.7
Oct.	3.6	9.5	8.0	7.7
Nov.	6.0	10.0	13.0	3.8
Dec.	8.9	5.2	17.0	3.8

The study at Santa Rosa was initiated by Dr. Arild Hansen, and the results compiled by his staff for 1947 will be reported separately. The total number

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Read before the Section on Pediatrics, Texas Medical Association, Annual Session, Houston, April 28, 1953.

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of cases included in the present study is 1,004, including the 590 in-patients at Brooke Army Hospital from 1946 through 1951 and 414 patients at Santa Rosa Hospital from 1949 through 1951.

ANALYSIS OF CASES

Seasonal Incidence.—Diarrhea is an endemic disease in San Antonio with cases and deaths being reported each month (table 1). There is a peak in May, June, and July, and, surprisingly, another in November, December, and January. The winter increase may be due partially to the epidemics of nausea and vomiting and diarrhea which occur at that time each year. The spring increase begins each year shortly after the Fiesta de San Jacinto although the gathering of huge crowds during this week may not have any direct influence. It may be postulated that, with the coming of warmer weather, windows are thrown open, doors are left ajar, and infants and children begin to spend more and more time outdoors. These environmental factors, coupled with a concomitant increase in the fly population, possibly could explain part of this seasonal spurt in the incidence of diarrhea.

Race.—It is apparent from table 2 that the majority of deaths occur in Latin-American infants. Brooke Army Hospital treats only the dependents of military personnel, and Latin-Americans make up only 15 per cent of patients registered in the Out-Patient Clinic. This group does not contribute an inordinate percentage of admissions for diarrhea but makes up 33 per cent of the deaths. It appears that the Latin-American infant has no monopoly on diarrhea but rather has a priority on death from diarrhea once contracted. The higher percentage of deaths in the first twenty-four hours (usually the first six hours) reflects the desperate condition which these infants are allowed to reach before they are brought for medical care.

TABLE 2.—*Incidence of Diarrhea by Race.*

	San Antonio			Santa Rosa Hospital			Brooke Army Hospital		
	Latin-American	Negro	White	Latin-American	Negro	White	Latin-American	Negro	White
% Clinic patients							15.0	3.0	82.0
% Diarrhea				82.3	3.1	14.6	20.0	3.5	66.5
% Diarrhea deaths	89.4	3.1	7.5	76.0	4.0	20.0	33.0	12.0	55.0

Age and Sex.—Age is of the utmost importance both as to incidence and to death from diarrhea (table 3), the relationship being geometrical. That age affects mortality more than morbidity is illustrated by the fact that the group less than 6 months of age comprises about two-thirds of all deaths from diarrhea, whereas only 5 to 8 per cent of deaths are in patients more than 1 year of age.

Of passing interest is the fact that 65 per cent of diarrhea patients were boys, but deaths were equally divided between the two sexes.

Prior Nutrition.—The quality of care the infant has received before he contracts diarrhea influences both morbidity and prognosis. Fifty-three per cent of all infants admitted for diarrhea were markedly underweight, and 80 per cent of the infants who died were at least 25 per cent underweight prior to the onset of illness. Poor nutritional status is indicated furthermore by anemia, 39 per cent of infants with diarrhea having less than 10 Gm. of hemoglobin per cubic millimeter of blood at the time of admission. Hemoglobin was less than 7 Gm. in 7 per cent.

Infection.—Aside from the possible importance of infection as an etiologic factor in the production of parenteral diarrhea, 13 per cent of infants had other infections, and an additional 8 per cent had some other type of disease, such as congenital anomalies.

Symptoms and Signs.—The onset was sudden with vomiting in about half the cases. Convulsions occurred in 7 per cent. Fifty-five per cent of the patients had between five and ten stools a day and 33 per cent more than ten stools a day. Temperature was more than 103 F. in 55 per cent of the patients and more than 105 F. in 14 per cent. Dehydration was moderate in 40 per cent and severe in 30 per cent at the time of admission. Carbon dioxide combining power was determined in 65 per cent of patients and was less than 20 volumes per cent in 16 per cent of these. It was less than 30 volumes per cent in 41 per cent of these patients. These determinations were not run on many of the sickest patients since emergency therapy took precedence over investigation. The white blood cell count was between 10,000 and 20,000 per cubic millimeter in 60 per cent of patients, values being lower in 31 per cent and higher in 9 per cent.

Etiology.—In this series, after the cases properly attributable to parenteral infection have been counted, and after the cases properly attributable to enteric infection with bacteria and parasites have been counted, there remains a significantly large segment (41 per cent) which must be allowed to fall into the slot, "gastroenteritis, cause undetermined" (table 4). Perhaps this disclosure should be regarded as a challenge, or at least an invitation, to evaluate minimal physical findings more meticulously so that parenteral infections can be assigned their true role with greater accuracy. Or it may be an incentive for more exhaustive investigation with better techniques in the

areas of virology, bacteriology, and parasitology. We definitely must not be satisfied with such a large proportion of cases in which, employing our present skills, the cause has not been determined.

Intense efforts were applied continuously to obtain positive cultures by direct rectal swabs cultured immediately on appropriate media according to the methods of Hardy. Refinements such as the feeding of stool to suckling mice have not increased the percentage of positive cultures. As tabulated it appears that only 41 per cent of patients have diarrhea of unknown cause. Actually, the percentage is higher since diarrhea due to parenteral infection may be coincidental and the pathogenicity of Pseudomonas and Proteus doubtful. Even the recovery of Shigella or Salmonella at a rate of this order of magnitude does not prove cause because of the high carrier rate in the San Antonio vicinity. The demonstration of blood and pus in the stool is just as indicative of shigellosis as the actual recovery of the organisms.

TABLE 3.—*Incidence of and Deaths from Diarrhea by Age.*

Age	Incidence		Deaths		
	Santa Rosa Hospital	Brooke Army Hospital	San Antonio	Santa Rosa Hospital	Brooke Army Hospital
1-3 mo.	23.0	22.0	31.0	32.0	44.0
3-6 mo.	30.0 } 75	22.2 } 64.7	32.0 } 92	32.0 } 92	29.0 } 95
6-12 mo.	22.0	20.5	29.0	28.0	22.0
1-3 yr.	23.0	25.0	6.0	4.0	2.5
>3 yr.	2.0	10.3	2.0	4.0	2.5

TABLE 4.—*Etiology of Diarrhea in 1,004 Hospitalized Patients.*

Causes	% of Cases
Bacterial	
Shigella (in order of frequency: paradysenteriae, Flexner II, sonnei, Flexner IV, Flexner III)	12.7
Salmonella (in order of frequency: typhimurium, schottmülleri, Poona, Panama, Orienberg, Illinois, Urbani, Thompson, London, Rubislaw)	5.3
Mixed Shigella and Salmonella	2.0
Other organisms predominant on culture considered possible pathogens (in order of frequency: Pseudomonas aeruginosa, Proteus morganii, Proteus mirabilis, Proteus vulgaris, Proteus aerogenes)	23.5
Parasitic	
Endamoeba histolytica	0.6
Giardia lamblia	0.6
Other causes	
Parenteral diarrhea (in order of frequency: otitis media, pyelitis, pneumonia)	11.6
Pancreatic fibrosis	2.5
Ulcerative colitis	0.2
Gastroenteritis, cause undetermined	41.0

We have been unable to recover a virus from any of these patients. In 1947 and again in 1949 there were observed at Brooke Army Hospital cases in which encephalitis as manifested by pleocytosis in the spinal fluid was the dominant feature of the disease. The onset was insidious. These patients had only a few stools each day, but their volume was so great that they often covered the bed. They were expelled with explosive force. Distention and vomiting were prominent features. The maintenance of water and electrolyte homeostasis was not a great problem to these children. Even though weight and serum electrolytes were maintained at normal levels, they became progressively more critically ill. Almost all of them had convulsions and stayed in a convulsive state from twenty-four to seventy-two hours. Although the mortality was 30 per cent, those who recovered seemed to be perfectly normal. No pathogenic organisms could be obtained on complete bacteriologic studies of stool and tissue. There were no significant autopsy findings.

In July, 1949, 20 per cent fecal suspensions were made on 11 patients with clinical syndrome of infant diarrhea. Each specimen was treated with 25 units of penicillin and 1,000 units of streptomycin per cubic centimeter, and 0.01 cc. was inoculated intracranially into two 3 day old suckling mice. The animals were observed for thirty days with no gross signs of disease. At the end of this period the animals were killed, the brains removed, and a suspension of this tissue reinoculated into litters of suckling mice, which were observed for a second thirty day period. No agent was isolated. Specimens from ileum, brain (cerebrum, cerebellum, and spinal cord), lung, and abdominal lymph nodes on 3 patients also were obtained at autopsy. Twenty per cent suspensions of these tissues were prepared in 10 per cent inactivated normal rabbit serum and inoculated intracerebrally in both mature and suckling mice. No virus was isolated despite attempts at successful passage.

Mortality.—The high fatality rate (table 5) at Santa Rosa Hospital for patients dying in less than twenty-four hours is due to the hopeless condition in which these patients are received. The relatively large number of deaths after more than seven days of hospitalization at Brooke Army Hospital can be attributed to the patients with a presumably virus diarrhea as previously described.

TABLE 5.—*Mortality from Diarrhea.*

Death	Santa Rosa Hospital		Brooke Army Hospital	
	No.	%	No.	%
<24 hr.	21	5.1	8	1.3
>24 hr.	13	3.1	16	2.7
1-7 days	10	2.4	3	0.5
>7 days	3	.72	13	2.2
Total	34	8.2	24	4.1

Hospital Stay.—The average hospital stay at the Santa Rosa Hospital was 9.6 days and at Brooke Army Hospital 10.1 days.

TREATMENT

The treatment of diarrhea remains nonspecific and its essence is the support of the homeostatic mech-

anism. Patients at the Santa Rosa Hospital were treated by fluid replacement according to the method of Darrow and those at Brooke Army Hospital according to the method of Hartmann. Potassium was used occasionally at Brooke Army Hospital when hypokalemia could be demonstrated. That potassium deficiency has not been a more pressing problem may be due to the fact that we have long been convinced that prolonged withholding of oral alimentation serves no good purpose once vomiting has ceased. Seldom has milk been deferred from the diet for more than twenty-four hours.

As newer antibiotics have been introduced, we have attempted to evaluate them in the treatment of diarrhea, and although we believe them of value, in the presence of acute parenteral infection or shigellosis we are unconvinced that their advent has altered the morbidity or the mortality of infantile diarrhea. The prime essential remains an interested and energetic physician, preferably a resident house physician well oriented on fluid electrolyte balance and the use of blood transfusions.

Agents used for various series during this study were sulfadiazine, streptomycin, Chloromycetin, penicillin, Aureomycin, Terramycin, aerosporin, streptomycin and glycuronolacton, and various substances designed to decrease intestinal motility. It has not been possible to conclude that any of them contributed significantly to the successful treatment of our cases. On the contrary, it would seem to be a fallacy to place any great degree of emphasis upon the usefulness of milligrams of this or teaspoonsful of that, whether it be antibiotic or chemotherapeutic substance, in the treatment of severe diarrhea. Instead, there should be a deemphasis upon any approach which does not place first things first. While no disparagement upon the use of antibiotics and/or chemotherapeutic agents is intended, we stress that if they are used, they must be integrated into a program of total care of the patient who has the diarrhea.

SUMMARY

Hospitalized cases of diarrhea in infants and young children totaling 1,004 have been analyzed as to incidence by month, race, age, and etiology. The relationship between age and mortality rate has been presented. The correlation between the age and nutritional status of the infant and between morbidity and mortality has been shown. The analysis has included, also, an account of symptoms, signs, and laboratory data. Basic concepts of treatment have been discussed.

CONCLUSION

Our study of slightly more than 1,000 patients with diarrhea, all of them sufficiently ill to require hospitalization, disclosed a startlingly large group (41 per cent) which could not be classified as to etiology in the usual concept of the word. It seems clear, however, that in its broader aspects, diarrhea in the general infant population is to a large extent a socioeconomic disease, whatever specific or nonspecific category it may otherwise occupy. Morbidity and mortality can be correlated with the infants' previous nutritional state, and prognosis is particularly unfavorable in Latin-American infants less than 1 year of age and in infants who, before the onset of their diarrhea, are grossly underweight.

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ABSTRACT OF DISCUSSION

Dr. J. M. COLEMAN, Austin: Diarrhea, a disease as old as history, still resists our efforts in medicine to bring about complete elucidation of its mysteries. That our knowledge is still inadequate is evidenced by our lack of agreement on the following points:

Terminology.—The terms diarrhea, dysentery, enteritis, gastroenteritis, and colitis are all applied to this disease. Failure to report etiology of any infection causes confusion, but equally confusing is the pattern of procedure which would lump all of the cases without investigation into a category called "virus." If progress is to be made, cases should be reported adequately, and health department study of outbreaks should yield results.

Etiology.—This paper has revealed our lack of information about etiology. The culture of these organisms is tedious, and it is absolutely necessary that there be complete clinical and laboratory cooperation. Direct anal smears and stool cultures without any period of drying out are essential. It is difficult to get to the bedside with a culture tube or plate before someone has poured "sulfa" drug into the patient. While the authors lament the percentage of negative cultures, I feel that they should be congratulated on the percentage of isolation of organisms. It speaks well for the control and cooperation within the group.

Therapy.—There are still almost as many therapies for diarrhea as physicians to prescribe them. Advances in understanding of fluid and mineral balance have been great, but there is still progress to be made. The elimination of castor oil from the regimen is in my opinion one of the greatest steps forward. I believe its use contributes more to the death rate than is realized, for there are still grandparents who grew up in that era which permitted its use. The drugstore shelves are still loaded with pink, white, and brown nostrums which serve usually to delay therapy until the patient is in poor straits.

The statistics which have been presented raise the question of whether it is proper to consider diarrhea as the same disease throughout the year. For example, the "summer complaint" was rampant in the city of San Antonio and among Latin-Americans, while the base showed no such peak. These cases are probably the true dysenteries and Salmonella infections.

The base study on the other hand presents a winter peak with a lower mortality. In Austin, we annually have a

winter peak that is troublesome, and it fits the description in the textbooks of what is called "winter vomiting disease." Cultures have yielded no results; the etiology is still unknown. I note that viruses were not isolated here so we should not call it virus. In many ways the outbreaks resemble toxin produced patterns such as occur in Staphylococcus toxin outbreaks. Whole families may come down in a matter of hours with vomiting and frequent stools. Further search for toxins is desirable.

An educational approach gives hope in this disease. The physician caring for children may render invaluable service by discussing early management of diarrhea with parents. I advise mothers that at the first evidence of diarrhea a starvation program should be initiated with elimination of all foods and drink except weak tea or carbonated beverages. If this program is complied with, no more than 5 to 10 per cent require further therapy. The problems are the cases home treated according to neighborhood consensus.

I cannot disagree with the idea of feeding as presented. As soon as vomiting is checked, patients tolerate food well with one exception. This exception, milk, is my one point of disagreement with the authors, for in my experience adequate management requires that milk be eliminated. I can give no reason for this. It is based on experience only. Time after time, the patient who is making excellent progress relapses immediately when milk is reintroduced.

In hospitalized cases, I advocate intravenous therapy on admission with glucose in distilled water. At the time of introduction of the needle, blood for carbon dioxide determination can be collected and the rehydration started. This permits time for planning the fluids to be used based upon the electrolyte needs.

CASE REPORTS

STRANGULATED LITTRÉ'S FEMORAL HERNIA

Case Report

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ALEXIS LITTRÉ in 1700 described 2 cases of inguinal hernia wherein an intestinal diverticulum was the sole component of the sac. Later, Riecke suggested such a hernia be termed "Littré's hernia." Littré's hernia is not to be confused with a mixed Meckel's hernia in which the sac contains a Meckel's diverticulum plus intestine or other viscera and a Richter's hernia, which is a partial enterocele of the bowel wall incarcerated or strangulated in a hernial sac. In order to meet the criteria of the condition described by Littré, a Meckel's diverticulum must be the sole occupant of the sac at any of the various hernial orifices.

From 1912 to 1944 Fishback[2] recorded only 15 cases found in the literature of a true Littré hernia.

We wish to report a case of a strangulated Littré's femoral hernia.

CASE REPORT

E. E. P., a 73 year old white woman, was admitted to the Mercy Hospital, Laredo, on January 6, 1954, with a complaint of a mass in the right side of the groin, which one day previously had become tender.

The patient had noted the presence of this mass "for many years," but it had never been tender. In addition, she was a compensated arteriosclerotic heart disease patient on maintenance digitalis. Family history was noncontributory.

Physical examination revealed an elderly alert white woman not appearing acutely ill. Her blood pressure was 150/90, and she had a pulse rate of 76 and a respiratory rate of 20. The heart and lungs were negative except for a loud blowing systolic murmur heard over the entire precordium. Examination of the abdomen revealed a large, tense, tender, reddened mass in the right side of the groin over the region of the external inguinal ring with a diameter of 2 inches. It did not transmit light. The remainder of the abdomen was soft and flat. Rectal and pelvic examinations were negative.

Laboratory examinations revealed a slight leukocytosis and a negative urine. Electrocardiographic examination revealed marked myocardial damage with a bundle branch block, first degree.

Shortly after admission to the hospital the patient was prepared for surgery. Under general nasotracheal anesthesia an oblique incision was made over the mass and the dissection promptly revealed the presence of a femoral hernia. The sac was of a reddish hue, and when opened it was found to contain a moderate amount of dark sanguinous fluid and a gangrenous infarcted blind pouch of small intestine. The neck of the sac was incised, and a normal terminal ileum was delivered into the operative field. The infarcted diverticulum was resected, and rhe intestinal defect was closed with an "open" technique using interrupted gastrointestinal and cotton sutures. The small intestine then was returned to the peritoneal cavity and the sac dissected free, transfixed, and amputated. Femoral herniorrhaphy was effected and the wound closed without drainage. The patient withstood surgery well. Her postoperative course was smooth and uneventful with dismissal from the hospital on the eighth postoperative day.

DISCUSSION

It is important to point out that an exact preoperative diagnosis is unlikely. To meet the neces-

sary criteria of a hernia of Littré, the occupant of the sac must be singularly and solely a diverticulum of Meckel.

SUMMARY

A case of strangulated Littré's femoral hernia is presented.

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SWIMMING POOL GRANULOMA

Report of a Case

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GRANULOMATOUS lesions rarely occur after a simple abrasion. However, there have been a few recent reports[1, 2, 3, 4, 5, 7, 9] of such lesions developing following abrasions sustained in and about swimming pools. We have observed the following case and consider it to be of sufficient general interest to record.

CASE REPORT

A. G., a 12 year old white boy, consulted us in November, 1953, concerning a lesion of his left elbow. While swimming six months previously, he had slipped on the concrete apron at the edge of a swimming pool and had abraded his elbow. The abrasion healed, but three weeks later there appeared a small growth which gradually increased in size. The lesion had caused little or no discomfort, and, according to the patient, there had been no enlargement of the regional lymph glands at any time.

Examination revealed a well nourished and apparently healthy young white boy. On the left elbow there was a superficial granulomatous lesion measuring 2 cm. in diameter composed of reddish-brown coalescing papules which were covered with a thick adherent scale (fig. 1). Adjacent to this lesion there was a small satellite papule which was similar to the larger one. Yellowish nodules were not discernible under diascopic pressure.

The patient's past history was not unusual although he had been in repeated contact with a relative suffering from active pulmonary tuberculosis. For this reason, roentgenograms of the chest were made both before and after the development of his skin condition. These examinations were consistently negative. A tuberculin patch test was applied at the time of initial observation of the patient, and it was strongly positive. He had not been tested previously.

The histopathologic findings on tissue removed for biopsy (fig. 2) were reported by Dr. Earl B. Ritchie, Galveston, as follows:

"The epidermis in addition to being intact throughout shows a marked acanthosis. Two large follicular orifices are plugged with dense hyperkeratotic and parakeratotic material. In the upper half of the dermis is a granulomatous reaction consisting of lymphocytic infiltration, histiocytes, epithelioid cells, giant cells both foreign body and Langhans' type, and numerous new vascular channels. One small well-defined area shows an intrinsic foreign body reaction surrounding a small epidermal inclusion. Aside from this, the remainder of the picture is that of a nonsuppurative, noncaseating granuloma in which the density of the lymphocytic infiltration almost completely obscures the epithelioid structure to some degree, but tuberculoid formation is apparent with typical Langhans' giant cells within these areas. No doubly refractive foreign particles were seen under polarized light and the Hotchkiss-McManus stain disclosed no fungus elements. The Ziehl-Neelsen stain for acid-fast bacilli was negative.

"The diagnosis is chronic granuloma possibly tuberculous."

Direct examination of scales from the lesion and cultures in Sabouraud's medium were negative for fungi. Cultures

FIG. 1. Swimming pool granuloma of the left elbow.

Presented before the Texas Dermatological Society, San Antonio, May 3, 1954.

(Dubose and Pizer) made from biopsy material were reported as negative.

The lesion was destroyed by curettage and electrodesiccation, and healing occurred with a soft, pliable scar.

COMMENT

A review of the literature reveals that several different types of granulomas have been recognized as complicating swimming pool injuries. Some of the lesions have resembled a form of cutaneous tuberculosis while others were of a nonspecific appearance. The cases recorded are summarized in table 1.

Hellerström,[3] in the initial report of this entity, described 6 cases with lesions of the lupus vulgaris type located on the bridge of the nose which developed subsequent to a swimming pool abrasion. The almost immediately developed the lupus vulgaris reaction in and around the original abrasion site. Also, tubercle bacilli were later isolated from one of the pools used by his patients.

More recently Brück[1] has observed a patient with a similar lupus vulgaris type of reaction. Tubercle bacilli were cultured, and animal inoculation was positive. Tolmach and Frank[9] were unable to demonstrate tubercle bacilli in their case and suggested silicates as a possible cause. However, repeated examinations with the polariscope in several reports, including our own, have failed to reveal the presence of refractive particles. Sulzberger and Baer,[8] in commenting on this case, mentioned the smegma bacillus as a possible causative agent. Symanski has produced tuberculoid lesions by inoculating smegma bacilli into the skin. Whether or not this has any etiologic significance in

TABLE 1.—*Summary of Reported Cases of Swimming Pool Granuloma.*

Author	No. Cases	Sex, Age (yr.)	Site	Diagnosis	Chest X-Ray	Tuberculin Reaction		T. B. Culture	Animal Inoculation
						Before Injury	After Injury		
Hellerström	6	M 12-29	Nose	Lupus vulgaris	Negative	Negative in 5, questionable in 1	Positive	Negative in 1	Negative in all
Brück	1	M 23	Midface	Lupus vulgaris	Negative	Questionable positive	Positive	Positive	Positive
Tolmach and Frank	1	M 19	Nose	Granuloma, possibly tuberculosis	Calcified areas hilar region	Unknown	Positive	Negative	Negative
Cleveland	4	2 M, 2 F 10-14	2 Chin 1 Nose 1 Finger	Consistent with tuberculosis cutis	Negative in 1	Unknown	Negative in 1	Not done	Not done
Rees and Bennett	9	6 M, 3 F 8-20	7 Knee 1 Finger 1 Ankle	Tuberculosis verrucosa cutis	Negative in 3, increased density in 1	Unknown	Positive in 6, negative in 2	Negative in 1	Negative in 4
Herlitz	80	77 Children 3 Adults	Elbow	Nonspecific granuloma	Unknown	24 Positive of 28 tested	26 Positive, 2 negative	20 Cultured, at 37C. all negative, at 31C. 3 positive	3 Negative in guinea pigs, positive in mice

clinical picture was similar in all instances; three to six weeks after the initial injury there appeared soft reddish-brown papules which soon coalesced and upon diascopic pressure had the distinctive color of lupus nodules. Although the microscopic picture was consistent with lupus vulgaris, guinea pig inoculations and pulmonary roentgen-ray examinations were negative. However, there was slight enlargement of the regional lymph nodes in 4 of his cases, and the tuberculin reaction was positive in all although the test had been negative in 5 of the patients prior to their injury. Hellerström considered this conversion of the tuberculin reaction as evidence in favor of his cases being tuberculous. He theorized that his patients passed rapidly through a primary tuberculous complex and the granulomas under question remains to be seen.

Cleveland[2] stressed the possibility of the contamination of public pools with bodily secretions from persons infected with incipient tuberculosis. In this connection, Rees[7] attempted to isolate tubercle bacilli from a public pool used by 8 of his 9 patients and was unsuccessful.

One of the most striking reports is that by Herlitz,[5] who observed 80 patients with nonspecific granulomas following swimming pool abrasions. Norden and Linell,[6] in an intensive study of his cases, were able in 3 instances to isolate acid-fast organisms indistinguishable from tubercle bacilli when the cultures were incubated at 31 C. The fact that this organism did not grow at 37C. and that it was pathogenic

for mice but not for guinea pigs resulted in the conclusion that the causative agent in their cases was probably a previously unrecognized Mycobacterium which differed biologically from the Mycobacterium tuberculosis. To substantiate further the idea that these

FIG. 2. Section of the lesion showing chronic granuloma. x 67.

lesions were produced by an infectious agent, it is their statement that no other cases occurred after the surfaces of the pool were tiled and the chlorine content of the water was increased.

Considering our case and those reviewed in the literature, it appears that this process is on an infectious basis, and it would seem worth while if, in the future, cultures were made upon several different types of media at varying temperatures. Others, as well as ourselves, have been unable to incriminate fungi in an etiologic role.

TREATMENT

There has been no uniformity as to the method of treatment employed in the recorded cases of swimming pool granuloma. Some have been treated as cutaneous tuberculosis with one or more of the following remedies employed: Finsen lamp, vitamin D_2, isoniazid, and para-aminosalicylic acid. In other cases the lesions have been treated with roentgen-ray, by surgical excision, or by curettage and electrodesiccation. We believe that the smaller lesion can be handled adequately by curettage and electrodesiccation or surgical excision.

SUMMARY

A granuloma of the elbow following a superficial swimming pool injury is reported.

The literature has been reviewed, and our case is similar to many which have been recorded.

REFERENCES

1. Brück, C.: Is There Possibility of Tuberculous Infection Through Injuries Sustained in Swimming Pools? Acta dermat.-venereol. *32:*443-448, 1952.

2. Cleveland, D. E. H.: Possible Tuberculous Skin Infection from Swimming Pool; Report of 4 Cases, Acta dermat.-venereol. *31:*147-152, 1951.

3. Hellerström, S.: Collected Cases of Inoculation Lupus Vulgaris, Acta dermat.-venereol. *31:*194-211, 1951.

4. Hellerström, S.: Water-Borne Tuberculous and Similar Infections of Skin in Swimming Pools, Acta dermat.-venereol. *32:*449-461, 1952.

5. Herlitz, S.: Cutaneous Infection Contracted in Swimming Pool and Resembling Tuberculosis, Acta dermat.-venereol. *33:*156-158, 1953.

6. Norden, A., and Linell, F.: New Type of Pathogenic Mycobacterium, Nature, London *168:*826 (Nov. 10) 1951.

7. Rees, R. B., and Bennett, J. H.: Granuloma Following Swimming Pool Abrasion, J.A.M.A. *152:*1606-1610 (Aug. 22) 1953.

8. Sulzberger, M. B., and Baer, R. L.: 1951 Year Book of Dermatology and Syphilology, Chicago, Year Book Publishers, 1951, p. 332.

9. Tolmach, J. A., and Frank S. B.: Granuloma of Skin with Tubercle Formation Following Swimming Pool Injury, J.A.M.A. *151:*724.726 (Feb. 28) 1953.

1017 Medical Arts Building.

ABSTRACT OF DISCUSSION

DR. MALCOLM W. HARRISON, Houston: This type of cutaneous granuloma obviously represents a new syndrome and should be recognized as such. Although of rare occurrence, the disease is nevertheless a public health problem because of the increasing popularity of both public and private swimming pools. There is a need for the accumulation of additional data to clarify the etiology of the disease.

We cannot contest the validity of the diagnosis of tuberculosis in the cases reported by Hellerström and Brück. These lesions should be considered as a separate group. The majority of the other reported lesions presented a different and more or less uniform morphologic appearance. The authors reporting these cases have had to consider the possibility of inoculation tuberculosis chiefly because of the histopathologic findings, but the evidence has not been conclusive.

For many years dermatologists have recognized two forms of inoculation tuberculosis of the skin, primary and secondary. Primary inoculation tuberculosis of the skin is analogous to the Ghon tubercle in the lung. The infections occur in young persons not previously infected with tuberculosis and are preceded by a negative tuberculin test which becomes positive six weeks to two months after the inoculation. These lesions are characterized by a primary focus and are always associated with a regional lymphadenopathy. In the secondary type of inoculation tuberculosis the patient has already had tuberculosis. The infection remains localized at the site of inoculation and may assume the picture of lupus vulgaris or a warty lesion called tuberculosis verrucosa cutis.

By comparison the lesions under consideration do not fulfill the requirements necessary for the diagnosis of the primary type of inoculation tuberculosis in spite of the fact that the infections occurred in young persons who would be ex-

pected to develop the primary complex. These lesions could be classified as a form of reinfection tuberculosis so far as the clinical appearance is concerned, but the histopathologic findings have not been uniformly typical of tuberculosis. If these granulomas are inoculation tuberculosis, they must represent a new form of the disease not previously recognized.

The sequence of events in the development of swimming pool granulomas, the morphology of the lesions, and the course of the infections follow a definite pattern in the majority of cases. This suggests a common etiology. Perhaps they are caused by some organism of the Mycobacterium group other than the Mycobacterium tuberculosis.

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, Fort Worth, April 25-27, 1955. Dr. F. J. L. Blasingame, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, Miami, Fla., Nov. 30-Dec. 3, 1954. Dr. Walter B. Martin, Norfolk, Va., Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice, Los Angeles, March 28-31, 1955. Dr. W. B. Hildebrand, Menasha, Wis., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. Bayard Carter, Durham, N. C., Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery. Dr. Emile F. Holman, San Francisco, Pres.; Dr. Paul C. Samson, 2938 McClure St., Oakland 9, Calif., Secy.

American Association of Genito-Urinary Surgeons. Dr. Vincent J. O'Conor, Chicago, Pres.; Dr. John A. Taylor, 2 E. 45th St., New York 22, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 9-11, 1954. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Chicago, April 25-30, 1955. Dr. Homer Prince, Houston, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, Philadelphia, April 25-29, 1955. Dr. C. C. Sturgis, Ann Arbor, Mich., Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Philadelphia, April 25-29, 1955. Dr. C. C. Sturgis, Ann Arbor, Mich., Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 4, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-18, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress on Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chairman.

American Congress of Physical Medicine and Rehabilitation, Washington, D. C., Sept. 6-11, 1954. Dr. William B. Snow, New York, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Belleair, Fla., April 17-21, 1955. Dr. Richard S. Weiss, St. Louis, Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association. Dr. J. M. Ruffin, Durham, N. C., Pres.; Dr. H. Marvin Pollard, 1313 E. Ann St., Ann Arbor, Mich., Secy.

American Gynecological Society. Dr. Richard W. TeLinde, Baltimore, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association. Dr. E. Cowles Andrus, Baltimore, Pres.; Dr. William H. Bunn, 44 E. 23d St., New York 10, Secy.

American Hospital Association, Chicago, Sept. 13-16, 1954. Mr. Ritz E. Heerman, Los Angeles, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society. Dr. LeRoy A. Schall, Boston, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association. Dr. Roland P. Mackay, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society. Dr. William L. Benedict, Rochester, Minn., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association. Dr. A. R. Shands, Jr., Wilmington, Del., Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society. Dr. Rustin McIntosh, New York, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society. Dr. Wendell Green, Toledo, Ohio, Pres.; Dr. Stuart T. Ross, 131 Fulton Ave., Hempstead, N. Y., Secy.

American Psychiatric Association. Dr. Kenneth E. Appel, Philadelphia, Pres.; Dr. R. Finley Gayle, 6300 Three Chopt Rd., Richmond 21, Va., Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Cincinnati, Oct. 25-30, 1954. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Washington, D. C., Sept. 6, 1954. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Philadelphia, April 27-29, 1955. Dr. John H. Gibbon, Jr., Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, Los Angeles, May 16-19, 1955. Dr. W. Joseph McMartin, Omaha, Neb., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Delegates Interim Meeting, Chicago, Oct. 1-2, 1954. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1954. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association. Mr. Mark H. Harrington, Denver, Pres.; Mr. Kemp D. Battle, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas. Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nashville, Pres.; Dr. George Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, Oct. 21, 1954. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Oklahoma City, Sept. 20-22, 1954. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secy.

Tri-State Medical Assembly, Fall, 1954. Dr. Joe D. Nichols, Atlanta, Pres.; Dr. Broox C. Garrett, 940 Margaret Pl., Shreveport, La., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice, Galveston, Sept. 9-11, 1954. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris, 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 11-12, 1954. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association. Dr. J. S. Minnett, Dallas, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians. Dr. Howard E. Smith, Austin, Pres.; Dr. John Wiggins, 1707 Medical Arts Bldg., Fort Worth, Secy.

Texas Club of Internists. Victor E. Schulze, San Angelo, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, Fort Worth, April 24-25, 1955. Dr. Paul H. Power, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, Fort Worth, April, 1955. Dr. George M. Jones, Dallas, Pres.; Dr. Hugo Engelhardt, P. O. Box 2180, Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas, Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Geriatric Society, Fall, 1954. Dr. Henry H. Niehuss, Longview, Pres.; Dr. Frank V. Mondrik, 214 Bramlette Bldg., Longview, Secy.

Texas Heart Association. Dr. George R. Herrmann, Galveston, Pres.; Mr. Edgar M. Brown, Jesse H. Jones Library Bldg., 1133 M. D. Anderson Blvd., Houston, Executive Director.

Texas Hospital Association, Houston, April 12-14, 1955. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, Galveston, Fall, 1955. Dr. Edgar S. Ezell, Fort Worth, Pres.; Dr. Bruce H. Beard, 1519 Pennsylvania, Fort Worth, Secy.

Texas Orthopedic Association. Dr. Brandon Carrell, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, Oct. 22-23, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society. Dr. Jack Kerr, Dallas, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 13-16, 1955. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Houston. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, Fort Worth, April, 1955. Dr. Raleigh White, Temple, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred W. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Mineral Wells, 1955. Dr. Charles N. Burrows, San Antonio, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 3, Executive Secy.

Texas Society of Anesthesiologists. Dr. Frank O. Barrett, El Paso, Pres.; Dr. Milton M. Rosenzweig, 200 Wildwood Dr. E., San Antonio, Secy.

Texas Society of Gastroenterologists and Proctologists. Dr. Charles Hardwicke, Austin, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, Dallas, Jan. 30, 1955. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Galveston, April 15-16, 1955. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Corpus Christi, 1954. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg., Corpus Christi, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society. Dr. John R. Mast, Midland, Pres.; Dr. M. J. Loring, 304 North N St., Temple, Secy.

Third District Society, Borger, April, 1955. Dr. M. C. Overton, Jr., Pampa, Pres.; Dr. William Klingensmith, 215 Fisk Bldg., Amarillo, Secy.

Fourth District Society, San Angelo, Oct. 14, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 8-18, 1954. Dr. Y. C. Smith, Sr., Corpus Christi, Pres.; Dr. E. Jackson Giles, 705 Medical-Professional Bldg., Corpus Christi, Secy.

Seventh District Society. Dr. William McLean, Austin, Pres.; Dr. John Rainey, 1709 San Antonio, Austin, Secy.

Eighth District Society, Victoria, September, 1954. Dr. Howard Z. Fretz, Wharton, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society. Dr. Thomas H. Giddings, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. John M. White, Port Arthur, Pres.; Dr. Rider Stockdale, Jasper, Secy.

Eleventh District Society, Jacksonville, Fall, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society, Corsicana, July 13, 1954. Dr. Neil Buie, Marlin, Pres.; Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society. Dr. Mal Rumph, Fort Worth, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society. Dr. J. W. Atchison, Gainesville, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Mount Pleasant, 1955. Dr. R. L. Johnson, Mount Pleasant, Pres.; Dr. R. L. Hardman, Mount Pleasant, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 14-17, 1955. Dr. Lawrence B. Sheldon, Dallas, Pres.; Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco. Dr. Ross Shipp, Waco, Pres.; Dr. Milton Spark, 3805 Herwal, Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Feb. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 7-10, 1955. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Sept. 22, 1954. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas, Houston, July 19-21, 1954. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls, April, 1955. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, Dec. 2-4, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

TEXAS ACADEMY OF GENERAL PRACTICE

The Texas Academy of General Practice will have its fifth annual assembly in Galveston, September 9-11. Physicians scheduled to speak are Dr. W. E. Kittridge and Dr. Arthur Neal Owens, New Orleans; Dr. Harold W. Lovell, New York City; Dr. H. Keith Fischer, Philadelphia; Dr. James L. Dennis, Galveston; Dr. William A. Sodeman, Columbia, Mo.; Dr. Philip Thorek, Chicago; Dr. M. Digby Leigh, Los Angeles; Dr. John G. Young, Dallas; and Dr. Ralph R. Braund, Memphis. John C. Krantz, Jr., Ph. D., Baltimore, will speak on pharmacology. All Texas Medical Association members are invited to attend.

Other than the scientific program there will be entertainment for the ladies, luncheons, and banquets. A door prize of a free trip to Mexico City for a doctor and his wife will be given.

University of Texas Medical Branch

The University of Texas Medical Branch, Galveston, was host to the Southern Society of Clinical Surgeons one day of the recent three-day Houston meeting.

Dr. Frank Fremont-Smith, director of the Josiah Macy, Jr., Foundation of New York City, was the featured speaker when 113 doctor of medicine degrees were conferred at the Medical Branch on June 4.

"Physiological Significance of Fibrillar Structures in Connective Tissues" was the subject of a May 11 seminar on which Dr. Isaac Costero, Instituto Nacional de Cardiologia, Mexico, D. F., spoke. Also on May 11, Dr. W. N. Powell, Temple, headed a clinical pathology conference.

A chapter of the Sigma Xi national scientific honor society has been established at the Medical Branch. Dean George Boyd, of the University of Georgia, Athens, conducted installation ceremonies.

On recommendation of a special committee, the Board of Regents of the Medical Branch has authorized the establishment of the James W. McLaughlin Fellowships for the investigation of infection and immunity. Funds will be available for predoctoral, postdoctoral, senior, and faculty fellowships.

PERSONALS

Dr. R. M. Moore, Galveston, was elected vice-president of the American Surgical Association at a late April meeting of the group.

Dr. T. G. Blocker, Jr., Galveston, was elected vice-president of the American Association of Plastic Surgeons recently.

Dr. G. V. Brindley, Temple, received a bronze medal for distinguished service for cancer control in Texas from the American Cancer Society in April.

Dr. Andrew S. Tomb, Victoria, recently spoke at a meeting of the Rhode Island Academy of General Practice in Providence.

Dr. Mavis P. Kelsy, Houston, is on a six-week trip to England, France, Switzerland, Holland, and Germany. He spoke to the Postgraduate School of Medicine, London, on June 10 on "Cancer of the Thyroid."

Speakers at the twenty-fourth annual meeting of the Texas X-Ray Technicians in San Antonio on April 23 included *Drs. Vincent Collins, Edward B. Singleton,* and *J. E. Martin,* Houston.

Dr. H. F. Connally has been named mayor of Waco.

Dr. C. C. Sheldon, was elected president of the new Sand Oaks Country Club, Greenville.

The *Alumni Bulletin* of the University of Texas Medical Branch, Galveston, lists as parents of new boys *Dr. and Mrs. M. L. Thornton,* San Antonio; *Dr. and Mrs. R. M. Adams,* Groves; and *Dr. and Mrs. C. R. Heare,* Stephenville. *Dr. and Mrs. H. F. Elmendorf, Jr.,* San Antonio, are the parents of twin boys.

BROOKE BIRTHDAY CELEBRATION

Thirty-two San Antonio physicians and one Houston physician, members of the visiting staff at Brooke Army Hospital, were invited to attend ceremonies on April 30 marking the seventy-third anniversary of the founding of the oldest unit at Brooke Army Medical Center.

The San Antonio physicians included Drs. John W. Winter, Thomas H. Diseker, C. Ferd Lehmann, J. Lewis Pipkin, Duncan O. Poth, William J. Block, Jr., W. W. Bondurant, Henry N. Leopold, David R. Sacks, Donald T. Dodge, and Alfred H. Hill.

Also included were Drs. S. Foster Moore, Jr., John L. Matthews, Wilfrid E. Muldoon, John J. Hinchey, Marion H. Morris, David R. Oliver, A. O. Severance, Sidney R. Kaliski, Dean B. Jones, Ervin F. Lyon, Jr., Albert W. Hartman, James W. Nixon, Ralph A. Munslow, Victor C. Tucker, Lawrence M. Shefts, Charles A. Hulse, William W. Sawtelle, James P. Aderhold, Albert N. Champion, Robert E. Parrish, and Dan A. Russell.

Dr. Hardy A. Kemp, Houston, was also invited.

LIBRARY SECTION

LECTURE SERIES

In cooperation with the Council on Medical Education and Hospitals of the Texas Medical Association, the Memorial Library now has available an additional service for Association members. With the purchase of the Audio-Digest Foundation's lecture series, the busy practitioner who is unable to attend many medical meetings can now hear programs by outstanding speakers. On-the-spot recordings at medical conventions, together with especially prepared lectures, will bring top medical names into the living room or office of the physician. Tapes by leading professors in the nation's seventy-nine medical schools will aid the physician in keeping abreast of advances of medicine. Many of the lectures are accompanied by slides to amplify the program.

The tapes will be loaned to any member of the Association for his own use or for group meetings. The only cost to the borrower is return mailing charges. The tapes may be secured on loan by writing the Memorial Library and stating the title (or titles) and date desired. The length of time and number of illustrations are noted in the listing. Additional titles will be listed as they are available.

TAPE RECORDINGS

Alvarez, Walter C.: Latest Trends in Therapeutics (26 min.).

Alvarez, Walter C.: The Neuroses (28 min.).

Boies, Lawrence R.: The Tonsil and Adenoid Controversy as Seen by the Laryngologist (20 min., 8 slides).

Boyd, Harold B.: Management of Hip Fractures in Aged (29 min.).

Boyd, Harold B.: Prevalent and Preventable Orthopedic Errors (29 min.).

Burch, George E.: Comments on the Low Salt Syndrome (25 min.).

Cattell, Richard B.: Diagnosis and Management of the Patient with Jaundice from Extra-Hepatic Diseases (21 min.).

Cattell, Richard B.: Management of Thyroid Disease (28 min.).

Dock, William: Present Status of Dietary vs. Endogenous Cholesterol in the Pathogenesis of Atheromatous Disease.

Dock, William: Uses and Abuses of Corticoid Steroids.

Dragstedt, Lester R.: New Light on the Physiology of Gastric Secretion and Its Relation to Peptic Ulcer (29 min.).

Dragstedt, Lester R.: Surgical Treatment of Gastric Ulcer, Duodenal Ulcer, and Gastrojejunal Ulcer (29 min.).

Erkenbeck, Col. Vernon J.: Recent Trends in Otolaryngology (23 min.).

Everett, Houston S.: Hematuria (28 min.).

Everett, Houston S.: Urological Obstruction Resulting from Gynecological Causes (23 min.).

Hayes, Maj. Gen. Silas B.: Traumatic Disease (29 min.).

Heck, Frank J.: Problem of Fever of Undetermined Origin (30 min.).

Hicken, N. Frederick: Diagnostic Problems of the Acute Abdomen (28 min.).

Hilger, Jerome A.: Chronic or Recurrent Head Pain (24 min.).

Hodges, Francis T.: Office Management (25 min.).

Holinger, Paul H.: Clinical Significance of Hoarseness (27 min., 28 slides).

Holinger, Paul H.: Foreign Bodies in Air and Food Passages (27 min.).

Huber, Carl P.: Dystocia (27 min.).

Huber, Carl P.: Early Diagnosis in Genital Cancer (27 min.).

Knapp, Miland E.: Rehabilitation in Severe Poliomyelitis (21 min.).

MacLaren, Walter R.: A Review of Allergy in 1952 (29 min.).

Miller, David: Pre- and Post-Operative Care of the Acute Abdomen (19 min.).

Orr, Louis M.: Appraisal of Use of Modern Antibiotics in Urology (29 min.).

Orr, Louis M.: Various Phases of Renal Failure and Its Treatment (29 min.).

Panel: Common Errors in Diagnosis (47 min.).

Panel: Low Back Pain (29 min.).

Panel: Peptic Ulcer (45 min.).

Panel: The Physicians' Public Relations (55 min.).

Panel: Postoperative Medical Complications (30 min.).

Panel: A Second Look at the Miracle Drugs (30 min.).

Slocum, Col. Harvey C.: The Effects of Malposition in Anesthesia (28 min.).

Slocum, Col. Harvey C.: Safety Factors During Anesthesia (29 min.).

Stephenson, George W.: Surgical Economics and Ethics (23 min.).

Wintrobe, Maxwell M.: Progress in Hematology and Laboratory Diagnosis (29 min.).

CONTRIBUTIONS TO THE LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library for the following recent gifts:

Austin-Travis County Health Unit, Austin, 348 journals.

Dr. James H. Herrod, Austin, 400 journals.

Dr. J. Edward Johnson, Austin, 54 reprints, 1 journal.

Dr. L. H. Reeves, Fort Worth, 1 journal.

Dr. Henry Renfert, Austin, 11 books.

Dr. N. L. Schiller, Austin, 11 journals, 10 reprints.

BOOKS RECEIVED IN JUNE

The Antiseptic, Golden Jubilee Issue, April, 1954.

Bauer, Louis H.: Seventy-Five Years of Medical Progress, Philadelphia, Lea and Febiger, 1954.

Benivieni, Antonio: De abditis nonnullis ac mirandis morborum et sanationum causis (translation by Charles Singer), Springfield, Ill., Charles C Thomas, 1954.

Blumgart, Herrman L.: Clinical Progress in Cardiovascular Disease, New York, Grune and Stratton, 1952.

Dublin, William Brooks: Fundamentals of Neuropathology, Springfield, Ill., Charles C Thomas, 1954.

Feinberg, J. G.: The Atom Story, New York, Philosophical Library, 1953.

Flocks, R. H.: Surgical Urology, Chicago, Year Book Publishers, 1954.

Galdston, Iago: The Meaning of Social Medicine, Cambridge, Harvard University Press, 1954.

Gradwohl, R. B. H.: Legal Medicine, St. Louis, C. V. Mosby, 1954.

Lee, J. Alfred: A Synopsis of Anaesthesia, ed. 3, Baltimore, Williams and Wilkins, 1953.

Liebolt, Frederick Lee: Illustrated Review of Fracture Treatment, Los Altos, Calif., Lange Medical Publications, 1954.

Nicolson, Gertrude H. B.: Clinical Electrocardiography in Children, New York, Macmillan Company, 1953.

Simmons, Fred A.: Diagnosis and Treatment of the Infertile Female, Springfield, Ill., Charles C Thomas, 1954.

Simons, R. D. G. Ph.: Handbook of Tropical Dermatology and Medical Mycology, vol. 2, Amsterdam, Elsevier Press, 1954.

Stanbury, John B.: Endemic Goiter, Cambridge, Harvard University Press, 1954.

Swartz, Jacob Hyams: Dermatology in General Practice, Baltimore, Williams and Wilkins, 1953.

Van Went, Johanna M.: Ultrasonic and Ultrashort Waves in Medicine, Houston, Elsevier Press, 1954.

Yearbook of Endocrinology, 1953-1954, Chicago, Year Book Publishers, 1954.

MOTION PICTURES FOR LOAN

On Our Own

16 mm., sound, 14 minutes.

This film shows the latest steps in the rehabilitation of patients with advanced poliomyelitis as practiced at the New York Rehabilitation Institute. The training of the patient to meet the demands of daily living is shown. The early steps in instruction in ambulation, the proper method of learning to apply one's own braces, the methods of getting in and out of chairs, and the various types of crutch gaits are demonstrated; and instructions in climbing curbs, crossing streets, entering buses, and ascending stairs are shown. This film can be used for lay audiences as well as student nurses.

Dwarfism

16 mm., sound, 40 minutes.

By Dr. S. Z. Levine, this film presents a clinic on dwarfism. Dr. Levine divides dwarfism into various clinical types including skeletal, endocrine, visceral, primordial, miscellaneous, unclassified, and delayed adolescence (not true dwarfism). He presents a number of case histories along with excellent photographs of patients. The subject is handled in an unusually able manner and should prove excellent for medical students, interns, residents, and pediatricians, as well as for general practitioners.

BOOK NOTICES

[1]Physiological Cardiology

ARTHUR RUSKIN, M. D., F.A.C.P., *Associate Professor of Internal Medicine, University of Texas Medical Branch, Galveston. 370 pages. $8. Springfield, Ill., Charles C Thomas, 1953.*

In this small, attractive, well-bound volume is presented a study of the heart with reference to its function and dysfunction resulting from disease or anomaly of itself or related organs.

The material, well outlined in the table of contents, is

[1]*Henry Tucker, M. D., Nacogdoches.*

arranged into twelve chapters, the title of each a pathologic condition of the heart or dependent system. A logical scheme is followed wherein normal and abnormal function, biochemical changes, functional alterations in respiration or renal excretion, and metabolism as they affect the heart are presented serially.

A feature of particular clinical interest is the diligent effort throughout to acquire practical correlation of the physiologic, pathologic, biochemic, and biophysic phenomena as they relate to the dependent therapeutic considerations.

While no elaborate chapters on laboratory studies nor electrocardiography appear in the treatise, essential findings are described as relevant.

In the chapter on congestive heart failure appear interesting figures in explanation of the "Starling law," of "forward and backward," and of "high output failure" and "low output failure." Physiologic actions of drugs are described in therapeutic considerations, but, as seems proper in such a work, no recommendations for specific use of drugs appear. Vascular and myocardial insufficiency in experimental disease of and drug effects on the heart with coronary disease are described.

Emphasized in treating of congenital heart disease are details of catheter data as diagnostic essentials and results to be expected from surgical treatment.

Acute pulmonary arterial hypertension such as follows thrombosis or similar chronic hypertension as an associate of emphysema is well pictured as an etiologic factor in right hypertensive heart failure, cor pulmonale.

Other hypertensive syndromes, valvular disease, myocarditis, compression, and endocrine and metabolic diseases affecting or affected by heart disorder are described in special chapters.

Throughout controversial points are dismissed by use of the question mark. Bibliography is notable in that references are sharply relevant and sufficient without profusion.

In the hands of physicians who do not merely read but study, an approach toward rational treatment of heart disease will be acquired, and the hope of the author that the book be "useful and stimulating" in a measure fulfilled.

[2]Annual Review of Medicine, Volume 2

Edited by WINDSOR C. CUTTING, M. D., *Stanford University School of Medicine, and* HENRY W. NEWMAN, M. D., *Stanford University School of Medicine. 485 pages. $6. Stanford, Annual Reviews, Inc., 1951.*

This volume is comprised of nineteen separate reviews by a total of twenty-five distinguished authors. The subjects reviewed in this volume are infectious diseases, diseases of the gastrointestinal tract, diseases of the cardiovascular system, diseases of the urinary system, diseases of the reticuloendothelial system and hematology, nutrition and nutritional diseases, endocrinology, allergy, neoplastic diseases, diseases of the reproductive system, diseases of the nervous system, psychiatry, diseases of bones and joints, diseases of the respiratory system, diseases due to physical agents and trauma, anesthesia, radiology, radioactivity, diseases of the eye, laboratory aids to diagnosis and therapy, therapeutics, and toxicology.

The individual reviews are, in the main, excellent summaries, although some of these are confined to rather narrow phases of the topics under discussion. On the whole they are representative of the recent work in the respective fields. An important feature of each of these reviews is the rather full bibliography which is placed at the end of each section.

[2]*L. O. Dutton, M. D., El Paso.*

Of special interest is the last topic section, an annotated list of reviews in medicine. Here is listed in a convenient place important reviews that appeared between November, 1949, and January, 1951.

The wide variety of topics discussed, of course, places this volume in the category of a general review with wide appeal. The one feature which detracts from the volume's general usefulness, however, is that in some of the reviews, the subject matter is too strictly confined to the author's particular small field of research interest and would not be too valuable for the general medical reader. Nevertheless, on the whole, the volume can be recommended because of its many excellent features.

Biochemistry and Human Metabolism

BURNHAM S. WALKER, M. D., Ph. D., *Professor of Biochemistry, Boston University School of Medicine;* WILLIAM C. BOYD, Ph. D., *Professor of Immunochemistry, Boston University School of Medicine; and* ISAAC ASIMOV, Ph. D., *Assistant Professor of Biochemistry, Boston University School of Medicine. Foreword by* JOHN T. EDSALL, M. D., *Professor of Biological Chemistry, Harvard University. 812 pages. $9. Baltimore, Williams and Wilkins Company, 1952.*

[3]Pregnancy Wastage

Edited by EARL T. ENGLE, Ph. D., *College of Physicians and Surgeons, Columbia University. 266 pages. $8.50. Springfield, Ill., Charles C Thomas, 1953.*

This book presents a collection of papers and discussions given at a conference held in behalf of the National Committee of Maternal Health, Inc., under the sponsorship of the Committee on Human Reproduction of the National Research Council. It is superbly edited. The material represents an acceptable distillation of significant knowledge pertaining to present-day concepts of facts and factors influencing pregnancy wastage. In essence, the book presents a beautiful description of the anatomy and dissection of the problems which evolve from the aggregate of pregnancy wastage and a statistical evaluation of the methods employed to solve these problems. The value of the book resides primarily in the fact that so much information pertinent to pregnancy wastage is gathered in so compact and accessible a form. The appended bibliographies are fully as valuable as the text presentations themselves. The book is printed on slick paper and the format is pleasing and the type readable. Typographical errors are rare. The book is recommended to all students, workers, and practitioners interested in the problem of human pregnancy wastage.

[4]Sectional Radiography of the Chest

IRVING J. KANE, M. D., *Consultant in Chest Diseases, United States Naval Hospital, St. Albans, N. Y.; Attending Physician, Chest Diseases, Lincoln Hospital, New York; and Associate Physician, Diagnostic Roentgenology, Montefiore Hospital, New York. 154 pages. $7.59. New York, Springer Publishing Company, Inc., 1953.*

This book is a fine effort in evaluating sectional radiography of the chest as a diagnostic procedure. It develops the history of the procedure and the various mechanical means that have been developed to get the desired information together with the relative merits of each. This includes such details as arcing the tube, preliminary travel, exposure factors, and hand operated as versus motor driven planography.

Important considerations such as the making of a test

[3]*William F. McLean, M. D., Austin.*
[4]*Joe C. Rude, M. D., Austin.*

film cannot be stressed too much, nor can variation in density, for it is important to know whether one is trying to show up a solid vascular element, a tumor, or a thin walled cavity surrounded by aerated lung.

The importance of 1 to 4 mm. of aluminum filtration to cut down on radiation exposure cannot be overstressed to protect both personnel and the patient. The intelligent placement of the patient using a minimum object film distance gets a maximum amount of sharpness of the resulting image, and a target film distance of not less than 36 inches should be used. Other important factors are breathing control, for the image will not be sharp if respiratory motion is in progress, and the use of low milliamperage and high kilovoltage to avoid extreme contrast. The best results are obtained by use of the motor drive with which the x-ray exposure is automatically synchronized.

In the matter of positioning, the recumbent attitude is advocated because a patient cannot stay in position well for any length of time upright. The advantages of using interoposterior, postero-anterior, lateral, and oblique sections are discussed. The use of postero-anterior and lateral films of the chest as a preliminary to body section radiography to help in localization for sections cannot be stressed too much as an intelligent, economical approach to the subject. It is important to know the normal anatomy of the trachea, bronchi, node chains, node groups, and great and hilar vessels as well as the various lung segments, for without this knowledge one will be unable to recognize pathologic lesions.

Although the importance of sectional radiography cannot be denied in relation to the heart and great vessels and in the demonstration of primary and secondary tumors of the lungs, as well as of metastatic nodes and abscesses, one still feels that its most frequent use will be in the field of tuberculosis. In this condition it has many uses such as the identification of cavities of fibrosed and contracted segments which may or may not contain cavities, of the extent of nodes, and of the extent of adhesions, and the investigation of compressed lung segments in cases of thoracoplasty.

It of course has many other uses such as determining the cause of atelectatic portions of lung for which the physician is unable to account, detecting of foreign bodies, and especially studying the trachea and major bronchi as an adjunct to the usual methods. This method has been highly developed in the study of the larynx, but it is not covered in this book and one would like to suggest that it be added to the next edition.

[5]Atomic Energy in Industry

Minutes of Special Conference, October 16-17, 1952, New York City. $10. New York, National Industrial Conference Board, Inc., 1952.

Today there are literally hundreds of industrial uses for atomic by-products, and more are being found each day. The millions of dollars invested in the atomic powered submarine, for example, indicate that nuclear power is some day expected to furnish electrical power.

Radioactive tracers are used in determining the wear on piston rings, to improve motor oil, and in separation of different products which are shipped through a common pipe line. By making cutting tool tips in machine shops radioactive, it is possible to measure the amount of wear the tips receive when machining different metals.

Not only in industry, but in agriculture tracers have been proved invaluable. For example, tracers in fertilizers are used to compare the uptake of the various fertilizers by plants.

[5]*Clark Hickman, Physicist, Brackenridge Hospital, Austin.*

Atomic by-products likewise have been used successfully in medicine. Of all the isotopes used as tracers, I^{131}, radioactive iodine, is the most widely used; its objective is that of determining thyroid function. Second to iodine and its measurement of thyroid function is measurement of volumes of different body fluids of spaces, such as plasma, red cells, total blood, and total extracellular fluids. Another popular use of tagged atoms is in the finding of the amount of blood a patient undergoing surgery loses during the operation.

Although there are more than 800 known isotopes, a small number, only five, have proved valuable as therapeutic agents. Many uses are found for these five isotopes as therapeutic agents, however. The first paper on the use of P^{32}, radioactive phosphorus, in the treatment of disease appeared in 1936; the first paper on the treatment with radioiodine appeared in 1938. Radiophosphorus is used in treatment of polycythemia vera, chronic leukemia, and diseases of the skin, benign and malignant. Radioiodine is used in the treatment of toxic hyperthyroidism, cancer of the thyroid gland, and advanced heart diseases. Radiogold is used in treatment of advanced cancer with excessive fluid in chest or abdomen and of cancer of the prostate gland. Radiostrontium is used in treatment of diseases of the eye, benign and malignant. Co^{60}, radioactive cobalt, is used externally in treatment of deep-seated internal cancer.

Recurrent Dislocation of the Shoulder

JAMES A. DICKSON, M. D., *Chief, Department of Orthopedic Surgery, Cleveland Clinic and Cleveland Clinic Hospital;* ALFRED W. HUMPHRIES, M. D., *Department of Orthopedic Surgery, Cleveland Clinic and Cleveland Clinic Hospital; and* HARRY W. O'DELL, M. D. *Chief, Department of Orthopedic Surgery, Akron Clinic. 159 pages. $4.50. Baltimore, Williams and Wilkins Company, 1953.*

There has been a wealth of material written on the procedures proposed for the treatment of recurrent dislocation of the shoulder. In this monograph the authors review the more than fifty various procedures without drawing any conclusion as to the best treatment. It is an attempt to compile all the pertinent data and present them in a better treatment. The first three chapters review the phylogenesis, ontogenesis, and anatomy of the shoulder. The chapters are well illustrated.

Pathology of the Heart

Edited by S. E. GOULD, M. D., D. Sc., *Clinical Professor of Pathology, Wayne University College of Medicine, Detroit; Editor, American Journal of Clinical Pathology. 1024 pages. $25.50. Springfield, Ill., Charles C Thomas, 1953.*

Up to the present time there has been no adequate English book on the pathology of the heart. The editor, Dr. Gould, has shown wisdom in his choice of collaborators and subjects. The book is marked by careful editing and planning; care is taken to let the practical aspects of the subject predominate, so that pathologists and clinicians will find a comprehensive survey of the information. There is an adequate chapter on congenital malformations by Jesse E. Edwards, followed by chapters on degenerative diseases, vascular lesions of the heart, rheumatic disease, parasitic disease, nonrheumatic disease, injuries, and neoplasms. A concise history of the pathology of the heart and the development and embryology are particularly well illustrated. The bibliography is arranged chronologically at the end of each chapter. There is an author and subject index. The book should be welcomed by the pathologist, internist, and medical student.

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION

1954 AMA Session in San Francisco

More than 12,000 physicians registered for the American Medical Association's one hundred and third annual meeting in San Francisco, June 21-25. Action was taken by the House of Delegates on fee splitting, the relationship between osteopathy and medicine, medical ethics, veterans' medical care, training of foreign medical graduates, and registration of hospitals.

The AMA House of Delegates took a firm stand against fee splitting, rebating, or payment of commissions. The American Medical Association has requested permission from the American Osteopathic Association for the AMA Committee for the Study of Relations between Osteopathy and Medicine to visit schools of osteopathy for such study. Action of this committee will be based on the action taken by the house of delegates of the American Osteopathic Association at its meeting this month.

The AMA House adopted two strong resolutions condemning the practice presently in use of treating nonservice connected disabilities under veterans' medical care. A resolution was adopted for the AMA to go all out to prevent the unscientific method of determination of service connected disabilities.

At the opening House session on Monday, Dr. William Wayne Babcock, Philadelphia, was elected to receive the 1954 Distinguished Service Award for his outstanding contributions to medicine and humanity. Dr. Babcock received the award from Dr. Walter B. Martin, then President, at the Tuesday evening inaugural ceremony.

President-Elect for the coming year is Dr. Elmer Hess, Erie, Pa. Dr. Hess was serving as a member of the House of Delegates and as Chairman of the Council of Medical Service at the time of his election. He will become President of the American Medical Association at the meeting in Atlantic City, June 6-10, 1955. At the opening session, speeches by Dr. Edward J. McCormick, Toledo, Ohio, then President, and Dr. Martin, then President-Elect, were heard.

Dr. F. J. L. Blasingame, Wharton, President of the Texas Medical Association, was reelected to the Board of Trustees, and Dr. Charles T. Stone, Sr., Galveston, was reelected to the Council on Medical Education and Hospitals. Dr. Robert L. Novy, Detroit, was elected to fill the vacancy created on the Council on Medical Service by Dr. Hess' resignation following his election as President-Elect. Dr. Andrew Bunter, Cheyenne, Wyo., was selected a new member of the Council on Medical Education and Hospitals. Others officers were reelected.

AMA PAMPHLETS AVAILABLE

Four American Medical Association pamphlets dealing with medical quackery, selection of a family doctor, medical progress, and the drug evaluation program of the AMA Council on Pharmacy and Chemistry are now available in quantity for distribution to Association members at the central office. The leaflets, entitled "Quack," "Why Wait?" "Health Today," and "On Guard," are suitable for distribution at fairs and health meetings, in reception rooms, and as enclosures with statements.

COUNTY SOCIETIES

Bell County Society

April 7, 1954

(Reported by F. M. Hammond, Secretary)

Nocardiosis—Marjorie Williams and Miss Mary P. Clapp, Temple. Discussion—W. N. Powell, Temple.

Bell County Medical Society met at Temple on April 7 for a business session. The society approved the use of the Salk poliomyelitis vaccine in Bell County. Hanes H. Brindley, Temple, president, appointed J. F. McKenney, Jr., Temple; A. R. Kirkley, Belton; and M. L. McRoberts, Killeen, to a Red Cross disaster committee.

Elected to membership in the society were D. J. Lynch, Temple; William Symon, Temple; J. P. Graves, Temple; T. R. Sunbury, Bartlett; and M. B. Goodwin (military), Fort Belvoir, Va.

Brazoria County Society

April 29, 1954

(Reported by Carlos E. Fuste, Jr., Secretary)

Diagnosis and Treatment of Otitis, Media and Externa—Claude C. Cody, III, Houston.

Brazoria County Medical Society met on April 29 in Freeport and heard the scientific program as outlined above.

Ralph E. Gray, Lake Jackson, was elected as delegate to the Texas Medical Association convention, and J. Milton Laughlin, Sweeney, was elected alternate.

Dallas County Society

April 13, 1954

(Reported by Glenn D. Carlson, Secretary)

Symposium on Specific Treatment of Shock States—Ben J. Wilson, Morris J. Fogelman, Jerry A. Stirman, M. T. Jenkins, Dallas.

Dallas County Medical Society met on April 13 in the Baylor Hospital Auditorium and heard the above scientific program.

The following newly-elected members were introduced: William Lloyd Hall, Jerry M. Lewis, Stanley Lee Stevenson, Harold M. Mims, Claude Wade Greathouse, Jr., Grover C. Winslow, Jr., Bedford Shelmire, Jr., John William Morris, George A. Freeman, Eldon Grady Mills, Phillip E. Whittlesey, Jr., and Frances L. Tompkins.

Howard-Martin-Glasscock Counties Society

March 30, 1954

Problems in Diagnostic Radiology—Ralph S. Clayton, Dallas.

Howard-Martin-Glasscock Counties Medical Society met on March 30 in Big Spring and heard Dr. Clayton, Southwestern Medical School of the University of Texas, Dallas, present the above scientific program.

Lubbock-Crosby Counties Society

April 6, 1954

(Reported by Richard K. O'Loughlin, Secretary)

Use of Radioactive Isotopes in Medicine—Julian Acker, Wichita Falls.

Dr. Acker spoke to the Lubbock-Crosby Counties Medical Society April 6 in Lubbock on the above topic. He included the diagnostic and therapeutic aspects of radioactive iodine, phosphorus, gold, and sodium in his presentation, and he outlined the requirements for establishing a radioactive treatment and diagnostic unit in a community the size of Lub-

bock. A discussion by Howard Hancock, John Selby, Harold Warshaw, O. R. Hand, A. G. Barsh, and William S. Croom, all of Lubbock, followed the speech.

A discussion of hospital insurance and of issues which are likely to be considered at the annual session of the Texas Medical Association composed the business part of the meeting.

May 4, 1954

(Reported by Richard K. O'Loughlin, Secretary)

Clinical Recognition of Depressions — Richard K. O'Loughlin, Lubbock.

Lubbock-Crosby Counties Medical Society met on May 4 in Lubbock and heard the above program. A discussion by R. Q. Lewis, Frederick P. Kallina, O. R. Hand, Clyde Elkins, Roy G. Loveless, Charles E. Ratcliff, and Frank C. Goodwin followed.

Nueces County Society

April 13, 1954

(Reported by G. S. Ahern, Secretary)

Doctor in Court—Hubert Winston Smith, M.B.A., LL.B., M. D., Austin.

Nueces County Medical Society met on April 13 in Corpus Christi. An executive officer of the Naval Hospital discussed the joint meeting of Navy and civilian physicians which was scheduled for May 11 at the Naval Air Station.

Stephen Youngberg and George Hudson were elected to membership. The program was given as outlined above with a short question and answer period following the speech.

Polk-San Jacinto Counties Society

March 9, 1954

Modern Treatment of High Blood Pressure—Hugh Hanson, Houston.
Acute Respiratory Infections of Children—David Schrum, Houston.

The Polk-San Jacinto Counties Medical Society met at Corrigan on March 9 in the home of Dr. P. C. A. Singleton.

The scientific program as outlined above was presented after a dinner given by Dr. and Mrs. Singleton.

Tarrant County Society

April 20, 1954

(Reported by S. W. Wilson, Secretary)

Recent Advances in Treatment of Leprosy—Robert G. Cochrane, New York.

Tarrant County Medical Society met in Fort Worth on April 20 and heard Dr. Cochrane, medical technical adviser to American Leprosy Missions, Inc., speak on the above subject.

R. G. Baker, Councilor of the Thirteenth District, met with the society and reported on medical legislation.

Tribute was paid to J. L. Spivey, honorary member from Fort Worth, who died on April 19, and J. A. Allison, honorary member from Grapevine, who died on April 20.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

April 13, 1954

(Reported by S. E. Thompson, Secretary)

Psychiatry in General Practice—George A. Constant, Victoria.

Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society met April 13 at Edna and heard the above speech.

Wichita County Society

March 9, 1954

At the Wichita County Medical Society March 9 meeting in Wichita Falls, the society endorsed the use of Salk poliomyelitis vaccine in Wichita County. The society also endorsed fluoridation of city water and appointed a committee to give information to the city council or other citizens about fluoridation.

Miss Henrietta Brocksmith of the American Red Cross explained the part of doctors, nurses, and hospitals in disaster relief; and Col. Steve Marchand, civilian defense director, told the society the over-all civilian defense and disaster relief organization and asked doctors to sponsor a medically equipped bus.

DISTRICT SOCIETIES

Second District Society

April 15, 1954

(Reported by Francis Hood, Secretary)

Cardiac Disease—Samuel A. Shelburne, Dallas.
Injuries to Hand—Eugene P. Legg, Dallas.
Injuries to Genitourinary Tract—William L. Bush, Dallas.
Injuries to Eye—W. Maxwell Thomas, Dallas.

The Second District Medical Society met on April 15 in Sweetwater and heard the above scientific program. F. J. L. Blasingame, Wharton, President-Elect of the Texas Medical Association, spoke at a banquet that evening.

Officers elected were John R. Mast, Midland, president; James W. Rainer, Odessa, vice-president; and M. J. Loring, Midland, secretary-treasurer.

Third District Society

April 13, 1954

(Reported by Mrs. Cassie Atherton, Executive Secretary)

More than 150 attended the Third District Medical Society meeting in Amarillo on April 13. In addition to the scientific program, there were fourteen technical exhibits and a social program planned by Potter County Medical Society, which was host.

M. C. Overton, Jr., Pampa, was installed as president; Marvin C. Schlecte, Plainview, is president-elect; and William R. Klingensmith, Amarillo, is secretary.

Guest speakers for the meeting were Maurice E. Snyder, Colorado Springs; Dumont Clark, Denver; William T. Foulk, Rochester, Minn.; Daniel Snydacker, Chicago; Luke W. Able, Houston; Mordant E. Peck, Denver; Joseph W. Kelso, Oklahoma City; and Edwin W. Cocke, Jr., Memphis. The scientific part of the meeting was divided into sections on eye, ear, nose, and throat; medicine; surgery; and obstetrics and gynecology.

The next meeting will be in Borger, April, 1955.

Fifteenth District Society

April 20, 1954

Newer Drugs and Treatment of Arterial Hypertension—M. S. Ragland, Gilmer.
  Discussion—D. C. Simmons, Kilgore.
Serious Otitis Media—W. B. Norman, Longview.
  Discussion—J. D. Roberts, Longview.
Are Cervical Polyps Important?—J. L. Goforth, Dallas.
Pediatric Techniques in General Practice—H. E. LeBus, Gladewater.
  Discussion—B. R. Clanton, Longview.
Modern Treatment of Hypertension—Richard Schneble, Texarkana.
  Discussion—Ben N. Wilson, Tyler.
Neuro-Surgical Treatment of Pain—Ira Jackson, Galveston.
Maxillo Facial Surgery—Sam Mack, Longview.
  Discussion—George W. Tate, Longview.
Control of the Diabetic at Surgery—M. H. Murphy, Marshall.
  Discussion—J. M. DeWare, Jefferson.

The Fifteenth District Medical Society met in Longview on April 20 and heard the program outlined above. F. J. L. Blasingame, Wharton, President-Elect of the Texas Medical Association, was the speaker at a dinner held with the woman's auxiliary that day. R. L. Johnson, Mount Pleasant, was elected president of the district. Other officers elected were M. H. Murphy, Marshall, vice-president, and R. L. Hardman, Mount Pleasant, Secretary.

AUXILIARY SECTION

TRANSACTIONS

THIRTY-SIXTH ANNUAL SESSION

of the

WOMAN'S AUXILIARY

to the

TEXAS MEDICAL ASSOCIATION

SAN ANTONIO, TEXAS, MAY, 2, 3, 4, and 5, 1954

PRE-CONVENTION EXECUTIVE BOARD MEETING

The Executive Board of the Woman's Auxiliary to the Texas Medical Association met in luncheon and business session, Sunday, May 2, 1954, at 1:00 p. m. in the Minuet Room of the Menger Hotel, San Antonio, Texas, with the President, Mrs. Edward W. Coyle, San Antonio, presiding. Mrs. Scott C. Applewhite, San Antonio, was chairman of the luncheon.

The invocation was given by Mrs. S. H. Watson, Waxahachie, Past State President.

The address of welcome was given by Mrs. John C. Parsons, San Antonio, president of the Woman's Auxiliary to the Bexar County Medical Society and General Chairman for the Convention:

Address of Welcome

We have looked forward to your coming—almost ever since you were here the last time! We shall always love having you, not alone because of our families and community of interest in the lives and duties we share, but also because of your gracious acquiescence in whatever plans we make for you.

The air is still surcharged with our annual Fiesta just recently passed, but we have kept alive the spirit of old San Antonio for your pleasure. This year we have added a new bangle on our hospitality chain, the garden tea and tour of old homes. It is to be on the very site where our city's earliest hospitality came to flower—and remains to this day to shed its warmth and charm on its visitors—the King William Street area.

It is one of our greatest joys to be able to say our whole town is alerted for the opportunity to contribute to your happiness while you are among us. There have been many who have expressed their pleasure in doing their part to make your welcome warm and your stay enjoyable.

The response to the welcome was given by Mrs. O. N. Mayo, Brownwood, president of the Woman's Auxiliary to the Brown-Comanche-Mills-San Saba Counties Medical Society:

Response to Address of Welcome

Thank you, Mrs. Coyle, for the lovely introduction. Since I am a comparative newcomer among you, and since I appreciate fully the ideals and scope of the State Auxiliary, I am keenly aware of the honor which is mine at having been chosen to speak on behalf of this distinguished group.

Coming to San Antonio is always a delightful experience. Hundreds of years have gone into making this the most unique city in our land. Where on this earth is there a river so beautiful as yours?

Many things cause the city to glow in high color—its rich history, its art, its literature. These would be enough, but there is yet another inherent quality which is noticeable here today, its social graces, lingering probably from the time of those great ladies from the Canary Islands.

Your cordial welcome, as expressed in so many ways and through the entertainment you have provided makes us all the more aware of the privilege we share in meeting and knowing each other within the framework and fellowship of the Auxiliary.

We shall love being neighbors with the Alamo while guests in this gracious hotel. As busy as the occasion will be, we shall certainly want to recall for just a moment our debt to those heroes lying there, whose bravery became the cornerstone which would bring Texas under the American flag. From our silent prayer we shall renew our determination to do everything we can to protect the principles for which they gave their lives. How proud we are when we realize the part the Auxiliary can and *is* playing in the preservation of those principles!

Again, we are happy to be here. Long after we have returned home we shall have both serious and frivolous memories of the thirty-sixth annual convention of our State Auxiliary. But they all will be pleasant ones.

Introduction of Past Presidents

Mrs. S. F. Harrington, Dallas, a Past President, paid tribute to all Past Presidents and greeted the seventeen who were present. Her greeting was:

"One of the pleasures we all have been looking forward to

all year is that of being together in San Antonio. When we think of the reasons we have for feeling proud of our Past Presidents in Texas, one of the first things that comes to mind is their love and their devotion to our Auxiliary—to their love of our husbands' profession and their love and devotion to each other."

Mrs. Harrington paid tribute to Past Presidents now deceased and asked to send greetings to those Past Presidents who were unable to be present. She expressed the appreciation of all the Past Presidents for the treasured Texas Past President's pin, a gift to them last year by the Auxiliary.

The President-Elect, Mrs. Mark H. Latimer, Houston, then brought the following message:

Message from President-Elect

This is the last intimate meeting of the official auxiliary family for 1953-1954. It is a time to reflect on our progress, our accomplishments, and the good fortune we have enjoyed in our leadership.

Under capable direction we have progressed. Our work is being more closely coordinated with that of the Texas Medical Association. We have long since passed the stage of being merely a woman's club. We are a working organization with vital objectives and duties to the medical profession, our communities, our America.

The keynote of the year's activities has been "Knowledge, Judgment, Action."

Tangible evidences of striving for workable knowledge are the splendid Handbook and the rewritten Constitution and By-Laws. These represent months of sheer work.

As women we are learning more of the meaning of sound business judgment. This again is evidenced by the ever increasing number of calls made on us by the Texas Medical Association.

Action? We have learned its true meaning and been inspired by watching our President at work. We serve happily and well when motivated by such untiring devotion as exemplified in our leader.

Last year we passed a great milestone, 100 per cent organization, due to the vision and ability of Mrs. Robert F. Thompson. This year our President has done much to mature, strengthen, and encourage these new auxiliaries.

Yes, "Together We Have Progressed." Why? Because all have worked under the vigilant leadership of our own Anita Coyle.

The President introduced Mrs. George Turner, El Paso, a Past President of the Woman's Auxiliary to the Texas Medical Association, wife of the President of the Texas Medical Association, and President-Elect of the Woman's Auxiliary to the American Medical Association.

Officers, committee chairmen and members, Convention chairmen, council women, county presidents, and guests were introduced.

The President read a telegram from Mrs. Paul Brindley, Galveston, Recording Secretary, who was unable to attend the Convention. Mrs. Newton F. Walker, El Paso, was appointed to act as Recording Secretary pro tem.

The Chair, by general consent, appointed the following committees:

Committee for Reading and Approving Minutes of Executive Board Meeting: Mrs. R. C. Bellamy, Liberty; Mrs. L. A. Feller, Fredericksburg; and Mrs. H. S. Renshaw, Fort Worth.

Reference Committee: Mrs. R. T. Travis, Jacksonville, to serve in the absence of Mrs. Max Woodward, Sherman.

Mrs. George D. Feldner, New Orleans, La., President of the Woman's Auxiliary to the Southern Medical Association, brought greetings from her organization:

Address of Mrs. George Feldner

Bueños tardes, amigos! Howdy stranger! Hello you all!

In any language—Spanish, Texan, or Louisianan—this friendly welcome has the same depth of sincerity as your welcome to me from the moment I arrived in your wonderful BIG state, for every moment everywhere I turn this welcome and cordial friendship is prevalent.

It is exciting being here in your Texas and particularly so in the enchanting and historic city of San Antonio, which has given so much to the history of our country and whose Alamo is such a hallowed shrine in our nation. It is only fitting that the Lone Star State gave to both the National and Southern Auxiliaries their first presidents, and I cannot help but feel there is a close bond of friendship, a tie that binds my native City of New Orleans and your state a little closer, because it was in New Orleans that the Southern Auxiliary was organized thirty years ago.

I would like to pay tribute to the five fine leaders you have given to Southern Auxiliary, of whom we are proud: Mrs. E. H. Cary, Dallas; Mrs. S. A. Collom, Texarkana; Mrs. Frank N. Haggard, San Antonio; Mrs. O. M. Marchman, Dallas; and Mrs. L. S. Thompson, Dallas.

Also, I would like for you to know the members from Texas who are serving as members of Southern's official family, Mrs. R. T. Travis, historian, and Mrs. O. W. Robinson, councilor.

Last, but by no means least, Southern shares with you your lovely, charming Mrs. George Turner of El Paso, President-Elect of the National Auxiliary. We are just as proud of her as you are and wish for her a happy and fruitful presidency.

I bring greetings to you from both the Southern Medical Auxiliary and the Association and extend a cordial welcome to you and your husbands to attend Southern's convention in St. Louis, November 8-11.

If some of you are wondering whether you are members, I would like to remind you that when your husband joins the Southern Medical Association you automatically become a member. There are no dues in our auxiliary, the Association appropriating an amount each year for our expenses.

To those of you whose husbands are not members, a special invitation to come to our convention is extended. Meet with us and enjoy good fellowship and fun, with other doctors and their wives from all over the Southland. In Southern Auxiliary we play and have time to visit with each other, yet have just enough interests with our three projects to "keep our finger in the pie."

This year you have participated in the observance of Doctor's Day in a larger scope than before, which makes me happy. By sharing this mutual interest and honoring your doctors, you accomplish a dual purpose, getting "to know the other member better" and creating the kind of good public relations for the medical profession that money cannot buy. We are the only group of organized women in the country which honors its husbands by setting a day aside each year. Of course, you and I know that every day is "Doctor's Day" in our lives.

As I look around me I can see the wealth of material which can be contributed to Southern's Research and Romance of Medicine files from your wonderful state. Your very own Dr. and Mrs. George Turner truly exemplify the "Romance of Medicine" with their important offices in the state and national medical organizations. So, I urge you to

write about them and many others who have contributed to the profession and the auxiliary.

"Adios, mi amigos."

Recommendations

The following recommendations, with the approval of the Finance and Reference Committees, were adopted:

1. Upon motion of Mrs. John H. Wootters, Houston, Chairman of the Student Loan Fund Committee: That suitable application blanks for boys applying for the student loans be printed and that these blanks be placed in the offices of the deans of the three Texas medical schools.

2. Upon motion of Mrs. James C. Terrell, Stephenville, Chairman of the Nurse Recruitment Committee: That the film "When You Choose Nursing" be purchased at a cost of $35 and placed in the film library of the Texas Medical Library.

3. Upon motion of Mrs. H. Leslie Moore, Dallas, Chairman of the Finance Committee: (a) That $300 be given the American Medical Educational Foundation Fund in memory of the following past presidents of the Texas Medical Association who died this year: Drs. E. H. Cary, H. R. Dudgeon, and M. L. Graves. (Wives of these doctors are all Past Presidents and active members of the Auxiliary.) (b) That the Auxiliary supplement the gift to the American Medical Educational Foundation Fund so that the aforementioned $300 and the $2,773.35 given by the county auxiliaries will total at least $3,500, this amount to be taken from the Special Fund. (c) That $200 be given to our Memorial Fund in memory of the deceased Past Presidents of the Woman's Auxiliary to the Texas Medical Association.

4. Upon motion of Mrs. H. Leslie Moore, Dallas: That the vote on the proposed revised Constitution and By-Laws be taken Tuesday morning, May 4, as the first order of business.

There being no further business the meeting was adjourned.

MRS. NEWTON F. WALKER, El Paso,
Recording Secretary Pro Tem.

OPENING EXERCISES, MEMORIAL SERVICES, AND GENERAL MEETING

On Monday, May 3, 1954, at 8:45 a. m., the Woman's Auxiliary met in joint session with the Texas Medical Association for its Opening Exercises, Memorial Services and General Meeting in Room A of the Municipal Auditorium, San Antonio.

The detailed program, including the Auxiliary's report to the Texas Medical Association given by the President, Mrs. Edward W. Coyle, San Antonio, is printed with that of the Texas Medical Association in the June issue of the TEXAS STATE JOURNAL OF MEDICINE (pages 409-412) with the exception of the Memorial Address by Mrs. G. V. Brindley, Temple, Memorial Chairman, which follows:

Memorial Address

At this time we pause to pay loving tribute to the following members who have preceded us to the Great Beyond:

Mrs. W. H. Barnett, Abilene
Mrs. W. H. Brandau, Beaumont
Mrs. J. W. Cathcart, El Paso
Mrs. R. A. Dathe, Dallas
Mrs. I. D. Ellis, Troy
Mrs. W. J. Harlan, Bartlett
Mrs. P. S. Joseph, Alice
Mrs. Peter Keating, San Antonio
Mrs. Victor Keidel, Fredericksburg
Mrs. A. G. Marshall, El Paso
Mrs. R. H. McMeans, Houston
Mrs. V. B. McMillan, Overton
Mrs. Paul Ramey, Fort Worth
Mrs. L. B. Reppert, San Antonio
Mrs. Dalton Richardson, Austin
Mrs. A. E. Starnes, Hughes Springs
Mrs. W. O. Stephenson, Dallas
Mrs. A. T. Talley, Houston
Mrs. J. K. Webster, Athens

"Say not of her, 'She is Dead' or 'She is asleep,'
For well I know her eyes are closed only to keep
The vision of the world shut out
So that she may distinctly hear
The Wondrous voice of God
When He whispers in her ear."

—Flora Moon.

We come to the hour of this Memorial Service. It is a special day of remembrance, a heart's communion in song, meditation, and prayer, a day dedicated to our departed loved ones. We honor them in this sacred service, surrounded by loving friends and lovely flowers.

This is a day when we would recall through the mists our friends and the remembrance of many sweet and happy times spent together. We would take note of the wonderful influence they have left for good in this world. We are all better people because they have lived and touched our lives, and that influence, as it is passed on, will live till the end of time. These fine women, wherever they lived, went about doing good. Some of them have lived long and useful lives; others have been cut down in youth, but of none of them do we dare say, they left their work unfinished. These noble women have been the candle bearers for whatsoever things were true and of good report. They lighted the Candles of Service, Courage, Devotion, Faith, and Sacrifice. They have been to their husbands a helpmate, a sweetheart, a friend, and a steadfast guiding star, among all the tumult of life. They have met the cares and problems of life bravely, knowing that "All things work together for good to those who love the Lord." And, now they have gone to hear the Master say, "Well done, thou good and faithful servant, enter into the joys of thy Lord."

"When earth's last picture is painted, and the tubes are twisted and dried,
When the oldest colors have faded, and the youngest critic has died,
We shall rest, and, faith, we shall need it—lie down for an aeon or two,
Till the Master of All Good Workmen shall put us to work anew!

"And those that were good shall be happy: they shall sit in a golden chair;
They shall splash at a ten-league canvas with brushes of comets' hair;
They shall find real saints to draw from—Magdalene, Peter, and Paul;
They shall work for an age at a sitting and never be tired at all!

"And only The Master shall praise us, and only The Master shall blame;
And no one shall work for money, and no one shall work for fame,
But each for the joy of the working, and each, in his separate star,
Shall draw the Things as he sees It for the God of all Things as They are!"

—Rudyard Kipling: "L'Envoi."

FIRST BUSINESS SESSION

The Woman's Auxiliary to the Texas Medical Association met for the first general business session of the thirty-sixth annual convention, Monday, May 3, 1954, at 10:00 a. m. in the Minuet Room of the Menger Hotel, San Antonio, with the President, Mrs. Edward W. Coyle, San Antonio, presiding.

The invocation was given by the Rev. Hugh Robertson, D. D., San Antonio, pastor of the Alamo Heights Presbyterian Church.

The address of welcome was given by Mrs. John C. Parsons, San Antonio, president of the Woman's Auxiliary to the Bexar County Medical Society and General Chairman of the Convention:

Address of Welcome

We have anticipated with real pleasure your being here. Planning for the events before us had all the hum and buzz of a holiday home coming. And now that you are here we are excited.

We feel it a privilege to be your host auxiliary. Each one of us is carrying an Aladdin's lamp—you have only to let us know your wishes. We hope that you will not hurry away as soon as the meetings are over. Stay awhile. Rest and enjoy to the fullest this warm-hearted little *City of Mañana!*

The response to the welcome was given by Mrs. William Hibbitts, Texarkana, Past State President:

Response to Address of Welcome

We have so many happy memories of our past visits with you that we have been eagerly looking forward to this one. We have been your guests many times and, having sampled your hospitality, know that it is good.

Some of our members have come to this meeting as brides, anxious to share this new adventure with their husbands. These brides may still be startled by their new name and position in their communities, but they are proud to be eligible for membership in the medical auxiliary.

Others of our membership have come after solving many problems at home such as getting baby-sitters or grandparents to keep their children and their family pets. These young women have boundless energy and the enthusiasm to carry through all projects. After a year of activity, they want to be present to report the excellent work that their auxiliary has done.

Then the grandmothers come. We never let anything interfere with our visits, for we must renew old and cherished friendships and learn about the welfare of the Auxiliary, which we have worked so many years to build. Physically we may be slowing down a bit but our interest never wanes. We are here to give our support and to encourage our successors.

Today, we are all gathered together under one roof. We are grateful for another opportunity to enjoy and profit from the good things you have planned for us and to share with you in your beautiful city one more enriching experience.

The President led the Auxiliary in repeating in unison the Pledge of Loyalty to the Woman's Auxiliary to the American Medical Association and the Credo of a Doctor's Wife.

On the motion of Mrs. Scott C. Applewhite, San Antonio, the Convention program as printed and the following Convention rules were adopted:

1. When obtaining the floor, a member shall announce her name and the name of her auxiliary.

2. Reports of all officers except that of the President and Treasurer, and reports of committee chairman, council women, and county presidents excepting those presidents of auxiliaries with more than 100 members shall be limited to two minutes. Reports from those auxiliaries of over 100 membership shall be limited to three minutes.

3. A time keeper shall notify each speaker when the allotted time is up.

4. The President may require that a motion be in writing, signed by the mover and presented to the Recording Secretary.

5. Recommendations may be considered only when presented by the Reference Committee.

6. All visitors are welcome at the general meetings and are asked to register.

The President by general consent appointed the follow ing committees:

Committee for Reading and Approving Minutes: Mrs. R. C. Bellamy, Liberty; Mrs. L. A. Feller, Fredericksburg; and Mrs. H. S. Renshaw, Fort Worth.

Reference Committee: Mrs. R. T. Travis, Jacksonville, to serve in the absence of Mrs. Max Woodward, Sherman.

Time Keepers: Mrs. Andrew Tomb, Victoria, and Mrs. J. L. Jinkins, Galveston, assisted by the members of the Bexar County Auxiliary who served as pages and ushers.

The business was interrupted to allow the President to introduce Dr. George Turner, El Paso, President of the Texas Medical Association, who made the following address:

Address of Dr. George Turner

First, I wish to say that it has been indeed a pleasure to have had the privilege of working with you during the past year as President of the Texas Medical Association. On behalf of the doctors of TMA, I wish to express our gratitude for your accomplishments. The statement that our Woman's Auxiliary is the greatest contributing force of the Association in accomplishing the many and complex problems confronting organized medicine in Texas again has been shown abundantly. You are indeed our help and support in the preservation of our free enterprise system of medical care. Your work is of supreme value in all areas of public relations, and you have gone far to engender in the public mind a feeling of confidence, trust, and security that the undivided effort of the medical profession is focused on furnishing the best medical care for all people.

Your co-sponsorship of the AAPS essay contest in stimulating thinking and writing at the high school level on why freedom of thought and action on the part of the physician produces the best medical service has been outstanding. Through this expression of loyalty and devotion to the principles of freedom the real prize winner in this contest is the American people.

The work of the legislative committee has been greatly facilitated by the increased efficiency of the AMA Wash-

ington office. Information concerning the exact status of any pending national medical legislation can be had for the asking from this source at any time. At our Texas level your work among state legislators and other community leaders constitutes one of our best sources of information on pending state medical legislation. Proposed legislation to levy a 1.1 per cent tax on all gross Blue Cross and Blue Shield premiums collected is being made ready to introduce. It is estimated that this law would produce approximately $178,000 in tax money each year. This would, of course, discourage our voluntary health insurance program which is being operated on a non-profit basis.

Your work in the newer project of distributing material and participating in programs in the field of mental health is well worth-while. A long list of specific projects and most commendable accomplishments in each field could be detailed but I will mention only a few of them. I refer to your work in rural health, nurse recruitment, assisting in raising philanthropic funds for the American Medical Education Foundation, library endowment, student loan fund, *News Letter,* public relations projects, and many others.

These activities and achievements are proof that in the Woman's Auxiliary, the Texas Medical Association has a powerful ally. Its basic policies and its years of experience in meeting new and challenging issues will enable it to face the problems and responsibilities that may come as the result of changing economic and social conditions in the world. There is every reason to believe that the Auxiliary will continue to broaden its program of service and that its participation in the affairs of the future will far exceed that of the past. With increased interest and sincerity, the Woman's Auxiliary continuously strives to maintain the high ideals of the medical profession and to serve the purpose for which it was organized.

General officers and guests were introduced. In the absence of Mrs. Paul Brindley, Galveston, Recording Secretary, Mrs. Newton F. Walker, El Paso, was appointed to serve as Recording Secretary pro tem.

Recommendations

The following recommendations from the Executive Board were adopted:

1. Upon motion of Mrs. H. Leslie Moore, Dallas: That suitable application blanks for boys applying for student loans be printed and that these blanks be placed in the offices of the deans of the three Texas medical schools.

2. Upon motion of Mrs. Joseph Foster, Houston: That the film "When You Choose Nursing" be purchased at a cost of $35 and placed in the film library of the Texas Medical Association.

3. Upon motion of Mrs. Jacob F. Schultz, Houston: That $300 be given the American Medical Educational Foundation Fund in memory of the following past presidents of the Texas Medical Association who died this year: Drs. E. H. Cary, H. R. Dudgeon, and M. L. Graves.

4. Upon motion of Mrs. J. L. Jinkins, Galveston: That the Auxiliary supplement the gift to the American Medical Educational Foundation Fund so that the aforementioned $300 and the $2,773.35 given by the county auxiliaries will total at least $3,500, this amount to be taken from the Special Fund.

5. Upon motion of Mrs. Charles L. McGehee, San Antonio: That $200 be given to our Memorial Fund in memory of the deceased Past Presidents of the Woman's Auxiliary to the Texas Medical Association.

6. Upon motion of Mrs. A. H. Neighbors, Jr., Austin: That the vote on the proposed revised Constitution and By-Laws be taken Tuesday morning, May 4, as the first order of business.

Mrs. Travis Smith, Abilene, Historian, presented the following recommendation and upon her motion it was adopted: That for the awards the auxiliaries be regrouped according to membership, particularly the top membership groups.

Mrs. Newton F. Walker, El Paso, presented the following recommendation with the approval of the Reference Committee, and upon motion of Mrs. Scott C. Applewhite, San Antonio, it was unanimously adopted:

The members of the Woman's Auxiliary to the El Paso County Medical Society wish to present the name of Mrs. George Turner for your consideration as an Honorary Life President of the Woman's Auxiliary to the Texas Medical Association. Mrs. Turner has served the Auxiliary in many offices with continued loyalty and effort for over thirty years.

In 1936-1937 she was president of the Woman's Auxiliary to the El Paso County Medical Society. She continues her interest and activity in her county auxiliary. She has held many offices and chairmanships and is a charter member.

In 1946-1947 she was President of the Woman's Auxiliary to the Texas Medical Association. Prior to that she was Recording Secretary, Council Woman, and Chairman of the Finance Committee. Since then she has continued her service as an advisory officer. Her comprehensive understanding of all phases of auxiliary activity has been demonstrated in numerous original projects she has initiated for county and state organizations. Among them are county and state schools of instruction, outlines of program materials, organization study, and evaluation of auxiliary activities.

Mrs. Turner, who is now President-Elect of the Woman's Auxiliary to the American Medical Association, has served with equal distinction the national organization. She was Constitutional Secretary for two years, 1947-1949, and Treasurer for three years, 1949-1952, and as President-Elect was the presiding officer of the 1953 Conference of State Presidents and Presidents-Elect and National Committee Chairmen.

Whatever commendable remarks might be said, and truthfully, of her stature as an auxiliary officer would not exceed that which might be related of her warmth of affection, unselfish giving of self, her sense of humor, and loyalty.

The members of the Woman's Auxiliary to the El Paso County Medical Society take pride in presenting her name to you for your consideration.

Mrs. L. A. Feller, Fredericksburg, presented the following recommendation with the approval of the Reference Committee, and upon motion of Mrs. Mark H. Latimer, Houston, it was unanimously adopted:

The Woman's Auxiliary to the Kerr-Kendall-Gillespie-Bandera Counties Medical Society recommends that an Honorary Life Presidency be conferred upon Mrs. Sam E. Thompson of Kerrville by the 1954 annual Convention.

Mrs. Thompson is a charter member and four times president of the Kerr-Kendall-Gillespie-Bandera Counties Auxiliary. She has served as council woman and on many various state committees. In 1944-1945 she served with distinction as State President.

In 1952, Dr. and Mrs. Thompson presented a gift of $50,000 to the Texas Memorial Medical Library Association, and the large meeting room in the State Medical Association Library building in Austin has been named the Sam Thompson Room in their honor.

Recently Dr. and Mrs. Thompson gave their entire library, with the exception of a few personal volumes, to the Association's Memorial Library.

Since 1931 Mrs. Thompson has been an active and faithful member of the four-county auxiliary. She has served for many years and is at present chairman of the tuberculosis seal sale, one of the outstanding projects of the auxiliary.

Mrs. Thompson is known for her hospitality at "Steepside" in Kerrville. Her life has been one of love, service, and dedication to the Medical Auxiliary.

For her many outstanding traits of leadership, unselfish service, and dedication to duty, we recommend that she be accorded this honor.

The Reference Committee reporting on the recommendation of the Third Vice-President and Chairman of *Today's Health*, Mrs. Ralph B. Payne, Amarillo, that *Today's Health* be sent to all members of the Texas Legislature and to the Texas members of the United States Congress, suggested that this be considered on the county level rather than the state level and that the recommendation be passed on to the 1954-1955 administration. No action was taken.

The Reference Committee reporting on two recommendations presented by El Paso Auxiliary suggested that these be referred to the incoming Nurse Recruitment Committee for further study. No action was taken on these recommendations, which follow:

Whereas, Most girls begin to plan their careers during the first years of high school; and

Whereas, Specific information on nursing as a career or on the requirements of schools of nursing is difficult to obtain without writing many schools of nursing; and

Whereas, Most young girls will become interested in things which they know something about;

BE IT RESOLVED: That the Woman's Auxiliary to the Texas Medical Association consider the placing of brochures containing information on all the schools of nursing in Texas in the public high schools of Texas if this prove to be financially possible.

Whereas, One of the most difficult problems in recruiting students interested in nursing as a career is to convince the parents of the girls that nursing is a desirable career; and

Whereas, There is no literature available to present to parents showing the salaries paid to nurses, the hours of work, the possibilities for advancement, and the high respect in which a career of nursing is held by the community;

BE IT RESOLVED: That the Woman's Auxiliary to the Texas Medical Association develop attractive literature to cover this need and distribute it to auxiliaries to county medical societies in Texas.

Mrs. Thomas H. Sharp, San Antonio, Chairman of Registration, reported that as of 11:30 a. m., Monday, May 3, 375 had registered.

REPORTS OF COUNTY AUXILIARIES

The reports of county presidents were begun in the morning and concluded following luncheon. County presidents gave the highlights of the year's activities. The following are the reports which have been filed:

Andrews-Ector-Midland Counties

Andrews-Ector-Midland Counties Medical Auxiliary was organized at the beginning of the 1954 year. We now have 54 paid members and there are 6 more eligible for membership. Our dues of $5 covered our philanthropic donations ($80) as well as dues to the National and State Auxiliaries. We meet with the medical society once a month for dinner and have a meeting of our own afterward. Our programs this year included speakers on juvenile delinquency, medical legislation, medical missionary work in Africa, vocational rehabilitation, state legislature, hospital administration, and socialized medicine reports. We observed Doctor's Day and gave the doctors boutonnieres. Response to the AAPS essay contest was gratifying. The Midland doctors' wives have given engraved sterling silver pitchers, graduating in size, for the first, second, and third prizes. Nurse recruitment will be stressed this spring. We will be sending a student to nursing school this fall through the efforts of a fashion show using the doctors' wives as models. Our women work in all sorts of civic organizations and our relations with the community are good.

MRS. H. P. MCCRIMMON, Odessa.

Angelina County

The Woman's Auxiliary to Angelina County Medical Society has held three meetings this year. All were interesting and featured guest speakers.

All active members subscribe to *Today's Health.* We were interested in sponsoring the AAPS essay contest and had funds for prize money, but we were told that the students had so much other work to do that it would be impossible to allow them to enter the contest. We appreciate the *News Letter.* It is full of news that we need to know.

MRS. M. A. ESTEP, Lufkin.

Armstrong-Donley-Childress-Collingsworth-Hall Counties

The Hattie Hunt Auxiliary (Armstrong-Donley-Childress-Collingsworth-Hall Counties) increased its attendance record to almost 100 per cent this year. We feel that this was accomplished by printing a yearbook and having planned programs for each meeting. Members drive thirty miles to attend, often in bad weather, but in spite of this our programs have been successful. Book reviews, papers on nurse recruitment, legislative programs, and our answering roll call on assigned subjects proved interesting and stimulating.

A nurse recruitment drive began with dressing mannequins in a store window as student and graduate nurses and a poster urging students to study nursing. This was followed up by a coke party given for sixty local and rural pupils who had indicated they were interested in studying nursing. A movie was shown, "Girls in White," and a lecture given at St. Joseph's Hospital in Wellington. Mrs. F. H. Cariker of Childress donated the Cherry Ames books to the Childress school library.

Doctor's Day was observed in December with a Christmas dinner; each doctor was sent a red carnation to wear that day.

We are 100 per cent subscribers to *Today's Health* and have sold sixty-seven subscriptions.

Mrs. Carter Holcomb, Wellington, assisted at the school in an immunization program for the children of Collingsworth County.

We have been proud this year to have one of our members, Mrs. E. K. Jones of Wellington, to serve as council woman for District 3. Through her activities and interest, we have maintained an enthusiasm in auxiliary work in our area.

Officers will be elected at our April meeting, and our final project will be our annual picnic for the doctors and their families.

We think we have had a successful year—with only 18 members and a distance of thirty miles separating us.

MRS. DALE WATKINS, Wellington.

Atascosa County

The Woman's Auxiliary to the Atascosa County Medical Society has 6 members and had 2 meetings. The State President, Mrs. E. W. Coyle of San Antonio, and the district 5 council woman, Mrs. John L. Pridgen, San Antonio, visited at the last meeting. All members take part in civic affairs through church, schools, and women's clubs. Each member has undertaken to give a subscription to *Today's Health* to one of the schools in the county.

MRS. U. B. OGDEN, Pleasanton.

Bastrop-Lee Counties

The Woman's Auxiliary to the Bastrop-Lee Counties Medical Society has 11 members, an increase of 2 over last year. Meetings are held quarterly and most of the members take part in civic affairs. Two members work on health committees, and health examinations in the schools have been promoted. Funds and services have been given to Red Cross, polio, and cancer drives. Members read the State Auxiliary *News Letter* and the Auxiliary section in the JOURNAL.

MRS. ROBERT B. BURNS, Giddings.

Bell County

The Woman's Auxiliary to the Bell County Medical Society holds its regular meetings the second Friday of each month October through May at the City Federation Club House with a tea and social hour following.

A membership coffee was given in September for all new members and intern and resident wives. The membership committee and officers of the auxiliary were hostesses.

Our first meeting in October was a community service program showing the film "Your Doctor," with the home demonstration agent and PTA president and program chairman as invited guests.

A book review of *Forty Odd* was given by Mrs. A. R. Waggoner, special speech teacher at the Temple Elementary Schools, at the November meeting. Resident and intern wives were given special invitations to attend.

The December meeting was a luncheon–business meeting at the Stage Coach Inn, Salado, honoring our State President, Mrs. E. W. Coyle, San Antonio. Mrs. Milton Spark, Waco, council woman of District 12, was also a guest. Our auxiliary provided money, clothing, and food for a family of nine for Christmas.

The January meeting was held at the Temple High School Home Making Department with the junior and senior high school girls of Bell County invited to see the film "Girls in White." Refreshments were served and forty girls attended. The film also was shown later to the Negro high school girls with thirty present. Literature was distributed and radio publicity was obtained preceding this meeting.

An open meeting on preventive mental health was given in February by Mr. Charles F. Mitchell, acting director of the State Mental Health Division at Austin. A discussion period followed as to what were our local mental health problems. Also, a survey of Temple has been made concerning the number of handicapped children and what is being done in our community to aid them. A report has been sent to the State Auxiliary Mental Health Committee.

"The American Medical Education Foundation and Its Meaning" was the program topic for our March meeting. Dr. S. W. Thorn, Houston, Chairman of the Texas Medical Association Committee on the American Medical Education Foundation, was guest speaker. Each member was asked to contribute to the Foundation and allowed to bring a guest.

We observed Doctor's Day in April with a barbecue supper held at the country home of Dr. and Mrs. R. K. Harlan, Temple, honoring our husbands.

At our May meeting Judge J. K. Evetts of Belton will speak on juvenile delinquency. Reports from all committees and the historian as well as a report on the state convention will be given and officers will be installed.

Our special project for the year has been that of sponsoring volunteer workers to the Bell County Health Unit two days a month in the maternity clinic. We have provided cakes for three USO Saturday night dances. We also have a representative to the City Welfare board meetings. Twenty-two members have given service and a total of 270 hours on community projects, including United Fund, USO, McCloskey Volunteer Service, mobile x-ray unit, tuberculosis association, and the crippled children's society. Two members are serving with the Community Concert Association. The president of the City Federation of Women's Clubs is one of our members and we have sixteen members holding offices or on committees in the Federated Club. Eleven members are serving on PTA committees and another member is a Democratic council woman and a member of the Executive Board.

Six films have been shown at schools, and eye, hearing, and chest x-ray tests were promoted at the Catholic school.

MRS. R. N. BARTELS, Temple.

Bexar County

Bexar County Medical Auxiliary started the year with 385 members; at present we have 374. We have had 15 new members and 2 deaths this year.

Each regular monthly meeting has consisted of a business session, a program, and a coffee or luncheon. We feel that the programs have been enjoyed inasmuch as the average attendance has increased. The theme of the year was "Keep the Fires of Purpose Blazing." Committee activities include the following:

Membership.—This committee contacted each auxiliary member to obtain her correct address and the like. Each new member was introduced to the auxiliary. Parties for new members, one for the husbands and wives, one for the ladies only, were held. All eligible members have been invited to join and their names recorded.

Social.—We have had two auxiliary parties. One was a ranch party at Lost Valley Ranch, Bandera, honoring new members of the auxiliary and the medical society. We honored our doctors at a formal dinner-dance in December. When the International Medical Assembly met here in January this committee had charge of the ladies' entertainment. A style show was presented by Frost Bros. and was followed by luncheon. There were 153 guests.

Program and Yearbook.—The programs were planned around our projects. The programs "Demonstration by Children from the Sunshine Cottage, School for the Deaf," "Guidance Institute," "Safety in the Home," and "Juvenile Delinquency" were planned with the idea that we might be active in these projects next year.

The civic and philanthropic committee was broken down under subcommittees, each with a project, including

The Children's Shelter.—This children's home was the main project of the civic and philanthropic committee. Here we assumed the responsibility for the finances and personnel of the nursery (infants through 2 years of age). We also furnished supplies, clothing, and drugs, and volun-

teers did personal work such as baby sitting, feeding, dressing, bathing, and the like. Sixty auxiliary members spent approximately 800 hours on the project.

Mental Health.—Movies were made available to PTA groups and all other civic clubs. In January, we participated in the financial campaign of the Bexar County Mental Health Society and Guidance Institute. Forty members solicited for funds, with 300 hours given.

Geriatrics.—This was a new subcommittee. Twelve homes for the aged were visited and the Mathews Nursing Home was adopted by the auxiliary. There are about sixteen old folks at this home ranging in age from 69 to 100 who have no known living relatives. Christmas gifts were taken to these old folks; also, Easter gifts will be taken. Magazines, games, and clothing have been given and personal social visits made. Ten auxiliary members gave sixty hours to this project.

Community Services.—Six committee members gave approximately 100 hours of service in contacting the schools to promote interest in the essay contest and in notifying them of the movies and programs available on safety. This committee also furnished members for the health educational booth at the Live Stock Show.

This committee assisted in the collection of dolls for the Christmas Clearance Bureau of San Antonio. Our Auxiliary was asked to coordinate the collection of dolls from all the women's clubs. We collected approximately 300 new dolls.

Health Education.—The health education, community service, and civic and philanthropic committees sponsored a booth at the San Antonio Live Stock Exposition for ten days in February. This booth was donated by the Live Stock Commission; expenses of approximately $175 were paid by the medical society; seventy auxiliary women and thirty-three doctors gave 400 hours to manning this booth. Approximately 25,000 pieces of literature were distributed; it is impossible to estimate how many people visited the booth. We used the exhibit 'You and Your Body," which was furnished by the American Medical Association, as a successful eye-catcher.

Publicity.—We have had a very active publicity secretary. All meetings and activities have been reported to the local papers, the STATE JOURNAL OF MEDICINE, and the *News Letter.* To the local papers have gone 28 social notices, 12 news stories, 17 pictures, and 5 reports; and 450 clippings to date have gone to the Texas Medical Association.

Physical Examinations.—Members were urged by cards to have physical examinations. Numbers reported include doctors 83, wives 106, children 210, servants 51, total 450.

Legislative.—This committee of twenty-two members endeavored to disseminate among the auxiliary members information on legislative matters relative to the medical profession. A column in our monthly "Auxiliary News Letter" is devoted to legislative information. Our members were urged to pay their poll taxes and vote.

Publications.—Two members gave fifty hours to this committee. Letters were sent to all auxiliary and medical society members concerning *Today's Health.* A total of 950 copies of the magazine was distributed to laymen through the Live Stock Show Booth, City Federation of Clubs, and other channels.

Nurse Recruitment. — This committee consists of five members. They made brochures available to all high school libraries and councilors. They worked in cooperation with the Nurses Association of San Antonio in organizing Future Nurses of America clubs. They assisted in the distribution of nurse recruitment literature at the Live Stock Show booth. We have available $495.26 to be used by third or fourth year nursing students as a loan fund. Nursing schools have been notified of this.

Historian.—At the request of the State Medical Auxiliary Historian, a report on Bexar County Auxiliary activities for 1953-1954 has been mailed to Austin to be filed. A history of Bexar County Auxiliary has been prepared and will be placed in our book of publicity clippings.

Philanthropic Contributions.—Bexar County Auxiliary has contributed to the Library Fund, Memorial Fund, and Student Loan Fund, both as an organization and as individuals. We contributed to the American Medical Educational Foundation 100 per cent, the first auxiliary to contribute 100 per cent in the entire state!

President's News Letter. — There are many interested members who are unable regularly to attend auxiliary meetings because of other pressing obligations; to keep these members informed of projects and actions, we are sending a monthly letter of committee reports, social announcements, new members, births, deaths, and general news. An Addressograph has been purchased to be used for this letter and all notifications to members.

Bexar County Auxiliary will be hostess to the state convention in May. As local president, I will act as general chairman. Plans are now being made by our local convention chairmen.

Bexar County Auxiliary is proud to claim the Auxiliary's State President, Mrs. E. W. Coyle, as one of our most beloved members. Others in our Auxiliary have served the State Auxiliary in various capacities this year.

MRS. JOHN C. PARSONS, San Antonio.

Bosque County

The Woman's Auxiliary to the Bosque County Medical Society has 9 members. We have no regular meeting date but we have had five meetings with an average of 6 in attendance. Members are taking part in the civil defense program which is underway in this area. One of the members is county president of the tuberculosis association and several work each year in the Red Cross drive and also assist twice a year in two towns with the Red Cross blood bank. As members of the PTA, several members were active in the polio drive. Heart and cancer drives also were given funds and services. We have read the State Auxiliary *News Letter* and the Auxiliary section of the JOURNAL.

MRS. S. L. WITCHER, Clifton.

Bowie-Miller Counties

The Woman's Auxiliary to the Bowie-Miller Counties Medical Societies started its fall meetings in September with a luncheon meeting devoted to organizing the year's activities. We were fortunate at our October luncheon in having as guest speakers Mrs. A. A. Little (a member of our auxiliary), Arkansas State President, and Mrs. Mark H. Latimer, Houston, Texas State President-Elect.

In November, we were entertained by a drama group from one of the high schools and devoted the rest of the program to legislative discussion. We celebrated in December with a Christmas dinner party, and in January we met at luncheon with a program on dental health, presented by James Clark, D.D.S., a local dentist. Instead of a routine meeting in February, we gave a tea in the home of one of our members honoring prospective student nurses and their faculty advisors. We invited girls from the senior classes of the four high schools who were interested in nursing careers and also a graduate nurse from both local hospitals to talk informally with the girls about nursing.

In March on Doctor's Day we entertained our doctors

with a dinner party followed by bingo, with many attractive prizes donated by the local druggists. In April we plan to meet at luncheon at Red River Arsenal and the commanding officer will escort us on a tour of the arsenal, which is one of the largest in the nation. We feel that this tour will increase our consciousness of civil defense. In May we will install our new officers and hope to have our new District 15 council woman as speaker. We will end the year's activities in June with a family picnic and swimming party.

During the year, we have worked on an essay contest, mental health survey, publicity for the medical societies' radio program, and as individuals on numerous fund drives and at the Temple Memorial Crippled Children's Home. We have sent contributions to the Library and Student Loan Funds in both Texas and Arkansas and have contributed to the American Medical Education Foundation Fund.

MRS. CHARLES V. BINTLIFF, Texarkana.

Brazoria County . .

The Woman's Auxiliary to Brazoria County Medical Society has had a successful year with excellent cooperation among its 26 active and 8 associate members. We welcomed 5 new members to our group.

Nurse recruitment is our main project. We achieved our goal of raising $600 to defray expenses of the two nurses now using our loan fund. A talk and film shown to the Future Nurses Club at the local high school was received enthusiastically.

Our members worked hard to stimulate interest in the AAPS essay contest, with over sixty students participating despite apparent lack of interest by educators. Publicity in local papers will be given the winners.

We have been 100 per cent in donations to the AMEF fund and 100 per cent in subscriptions to *Today's Health*. Over half of our members subscribe to and read the *Bulletin*.

We have kept abreast of legislative affairs and gave particular attention to the Bricker Amendment.

Our doctors were honored with a lovely Valentine dance and a red carnation and remembrance card will be presented to each on Doctor's Day.

The civil defense program just now is being organized in our various communities and the auxiliary has offered its services. We continue active in public relations with publicity and service.

Our social meetings have been very successful, with an excellent mental health speaker and a promising book review to come. The high point of our year was the delightful meeting in El Campo with our State President, Mrs. E. W. Coyle, San Antonio, and our district auxiliary members.

MRS. ROBERT C. MILLER, Lake Jackson.

Brooks-Duval-Jim Wells Counties

The Woman's Auxiliary to the Brooks-Duval-Jim Wells Counties Medical Society has 10 members, an increase of 4 over last year. Meetings are held monthly on the last Thursday. A joint meeting of the auxiliary and the medical society was held in the form of a barbecue supper. Another supper was also held with great success. Members have been active in the civil defense program which is under way in this area. Members belong to various civic clubs and about eight have worked on health committees. Health talks have been sponsored and members have contributed funds and services to Red Cross, polio, cancer, crippled children and Community Chest. Members read the State Auxiliary *News Letter*, and the Auxiliary Section in the JOURNAL.

MRS. G. G. WYCHE, SR., Alice.

Brown-Comanche-Mills-San Saba Counties

The Woman's Auxiliary to the Brown-Comanche-Mills-San Saba Counties Medical Society has during the year 1953-1954 grown from a small newly organized group into one which is firmly established. As a result of its development, interest has grown to the extent that average attendance has increased 60 per cent over our first year of organization.

There are 24 members and a possibility of gaining several more before the new auxiliary year begins. Everyone who is eligible has been contacted.

The films "How to Catch a Cold" and "Here's Health the American Way" were shown at PTA meetings. Another activity connected with the high schools is that of nurse recruitment. A film, "Girls in White," was shown to junior and senior girls, accompanied by an informative talk on the subject by a registered nurse who appeared in uniform. Plans are under way for establishing a Future Nurses Club and nurses scholarships.

The AAPS essay contest was conducted in the high schools of the area. Prizes were given by the county medical society and in several cases smaller prizes were given in each town.

The civil defense program in Brown County is well organized and has the full cooperation of the medical society and the auxiliary. For years there has been an emergency unit in operation, giving assistance in time of flood, fire, and all other disasters. Courses are held from time to time to keep workers up to date on civil defense. Members of the auxiliary attend the workshops and are ready to assist in any emergency.

At each visit of the blood mobile to Brown County, the auxiliary has been asked to help. Lunch was served to the workers and members also assisted in various other ways.

Volunteers from the auxiliary served as assistants when the tuberculosis x-ray unit was in Brownwood and supported and worked with the various other drives conducted in the community such as the March of Dimes, the heart fund, the Red Cross, and others.

The program theme "Know Your Community" has been used with emphasis on our county health program and the Brown County School for the Physically Handicapped Child.

The social aspect of the auxiliary was certainly not neglected. In fact, each meeting was a social event in itself, since each one was held in the form of a dinner in the home of a member. Brownwood was host to the district meeting in October and special activities were planned for auxiliary members.

In November we were honored by a visit from Mrs. E. W. Coyle, San Antonio, President of the Woman's Auxiliary to the Texas Medical Association. Another social vent that was of special interest was a party given in honor of the doctors in the home of Mrs. O. N. Mayo, Brownwood, president of the auxiliary.

Our year has been a full one, but it has served also as an inspiration to strive for higher goals in the coming year.

MRS. O. N. MAYO, Brownwood.

Caldwell County

In a small town the doctors' wives play an important role in all civic projects. Those "who can and will" are called upon frequently. Because of the many demands put upon time, interests, and energy, we have not had as many meetings of the auxiliary. Instead, we have transacted business by telephone and the like and feel that we are contributing more in this way. We have 6 paid members, giving us a 100 per cent membership.

The president subscribes to the *Bulletin* and there have

been four subscriptions to *Today's Health*. Each member telephoned others in the community urging them to pay their poll taxes, and legislators have been contacted whenever requested.

All members participated in the Red Cross drive, and five members, four of whom are nurses and helped in that capacity, worked with the blood mobile. The auxiliary also had 100 per cent participation in the polio, heart, and tuberculosis chest x-ray drives and the Cancer Crusade.

Mrs. A. A. Ross served on the State Auxiliary's Public Relations Committee and as lay woman of District 7 of the Texas Division, American Cancer Society. In the latter capacity she has for the past three years had charge of public education in cancer control for District 7.

Members and their husbands have served with the Youth Canteen, as presidents and members of the Parents Band Club, with church youth fellowship groups, as members of the PTA, and also as a program leader for the church council women.

School nurses have given talks and shown films in the interest of nurse recruitment, and several girls have entered schools of nursing. Physical examinations reported numbered 29. One member made a talk on civil defense to the high school PTA. "The Warning Shadow," a film on lung cancer, was shown to members of home demonstration groups. An individual contribution of $2 was made to the American Medical Education Foundation.

MRS. A. A. ROSS, Lockhart.

Cameron-Willacy Counties

The main objective for this calendar year has been to promote good will, thereby obtaining the end result of "good work." We have endeavored to follow the program outlined by the State Auxiliary to the best of our ability, keeping in mind, however, that "it is better to do *one job well* than to do a poor job of many things." We concentrated our energies on nurse recruitment. Late last spring the film "Girls in White" was shown to the girls of five high schools in this bi-county area, reaching about 400 girls. In Harlingen, two doctors' daughters dressed as student nurses, and one doctor's son, as an intern, passed out candy pills and "took care of" the high school students and their guests of San Benito high school. Plans were discussed in each school regarding the formation of a Future Nurses Club there.

This fall, following the general pattern of our Harlingen Future Nurses Club organized last year, four new clubs were started. Los Fresnos has an active club under the leadership of the school nurse and has participated in many projects, including setting up first aid kits for each schoolroom, studying films on tuberculosis, assisting with the school immunization program, helping at the Well-Baby Clinic, and taking Red Cross first aid courses.

The Raymondville group was later organizing, but under the guidance of Mrs. Helen Goerger, president-elect of our auxiliary, and the school nurse, is now doing nurse-aid work at the hospital for its project. In Brownsville, the club, under the Public Health nurse, is doing volunteer work at the local hospital and also helping at the Public Health Unit.

The club at Rio Hondo was unable to continue due to lack of support by the superintendent of schools. (This is the only exception. All the other schools have been most receptive.) The Harlingen Club has continued its project of last year—volunteer hospital service—with many new girls participating.

Most of the clubs meet twice monthly, once for a business meeting and once for an informative program. We have had talks by Public Health nurses, Air Force nurses, hospital nurses, and nurse instructors, as well as programs on the different types of nursing schools, requirements for admission, and any scholarships available.

Each club member who gives twenty or more hours of volunteer service on any of the club projects is awarded a Future Nurses Club pin, furnished by the auxiliary. These pins will be awarded by our president at our "All Valley Meet" to be held on April 24, 1954, at Whalen Park. Plans for the day include games, talks (one by one of our student nurse loan fund recipients), entertainment, and food. This promises to be a most enjoyable event.

During our nurse recruiting we found so many worthy girls needing financial help that we made this known to our medical society, which responded most generously with donations with which we formed a student nurse loan fund. In addition, it also voted to give $150 each year out of its society treasury to this fund. We have at present two girls in nursing schools through loans from this fund.

MRS. JOHN A. WELTY, Harlingen.

Cass-Marion Counties

Again, our auxiliary has enjoyed a year of fellowship among its members, which has been our best reason for functioning. Since our auxiliary is composed of groups from five towns in two counties, we have used our meetings at times to become better acquainted and enjoy one another's company. We meet 6 times a year, rotating our meeting places from town to town. We have dinner with the doctors and then retire to a separate place for business.

We have made donations to the Library, Memorial, Student Loan, and American Education Foundation Funds. We have several young people in nurses training, have stressed physical examinations, and observed Doctor's Day.

All of our members are very active in all civic work of the various communities. Many are serving as chairmen of heart fund, Red Cross, March of Dimes, and cancer drives. All are active in PTA and church work.

All reports have been mailed as directed.

MRS. O. R. TAYLOR, Linden.

Cherokee County

The Cherokee County Medical Auxiliary has had a busy and successful year.

Attendance average at meetings is 86 per cent. *Today's Health* sales are 139 per cent. We have contributed to the Library, Memorial, and American Medical Educational Funds, with contributions to AMEF being secured by passing a "kitty" at each meeting.

Auxiliary member Mrs. W. E. Gebbertt of Rusk was chairman of county tubercular drive. More contributions were secured than during any previous drive. Individual members worked on establishing a "Well Baby Clinic" through the Lions Club. Members contributed hours and funds toward establishing a Youth Center in Jacksonville. The Center is in operation and very successful. Members worked on and contributed to heart, polio, tuberculosis, and cancer drives. Members have given magazines and reading material to the library at the state mental hospital at Rusk.

Our outstanding meeting was a joint meeting with the county medical society at the Rusk State Mental Hospital. The patients put on the program and we took as guests business men, civic leaders, and those whom we felt would be interested in the problems of our state mental hospitals.

Our public relations tea was a success, with a large number of guests attending. A health film and talk was given by Dr. J. C. Rucker, Jacksonville. On Doctor's Day, our

local radio station paid tribute to the doctors with talks and skits on medicine. Climaxing the day, the auxiliary honored the doctors with a dinner with Dr. Hardy Kemp of Baylor Medical School, Houston, as guest speaker.

Officers for 1954-1955 have been elected and will be installed in April.

MRS. COLLIER RUCKER, Jacksonville.

Clay-Montague-Wise Counties

The Clay-Montague-Wise Auxiliary is one year old at this report time. We feel that our year has been a successful one, although our activities have been, through necessity, based on the individual efforts of each member in her own community.

Members in each city have contributed their time or money to the appeals by the American Heart Association, March of Dimes, American Cancer Society, and the American Red Cross. The Decatur members have, through their Federated Clubs, presented a mental health program, sponsored a school immunization program, and presented a civil defense program and a program for improvement of racial relationships. The Bridgeport members helped to organize and sponsor several Cub Scout dens and promoted physical examinations of members in their Federated Clubs. The Bowie members have done much through their Federated Clubs to provide a Youth Center, have helped raise funds for a swimming pool, and two are members of the North Texas Area Council of Camp Fire Girls. The Nocona members arranged for the showing of the film "Self-Examination of the Breast" to approximately 150 women in the community, secured as a Federated Club program a talk on mental health by a local physician, and served on the board of directors of the Nocona Youth Center. The members in Bridgeport, Decatur, and Nocona sponsored the AAPS essay contest in their high schools.

Our September meeting was a barbecue dinner honoring our husbands, held at the country retreat of one of the Bowie members. At our other meetings we first have dinner with our husbands, then while the doctors hold their meeting, we adjourn to the home of one of the Bowie members for our business meeting. In this way we have become acquainted, not only with the members of our auxiliary, but with the doctors in the medical society, too.

MRS. J. W. MAJOR, Nocona.

Coleman County

The Woman's Auxiliary to the Coleman County Medical Society met this year for the first time in some while. Last year there were 6 members but now there are 8 and 1 new member. We meet for combined social and business meetings. Contributions were made to the American Medical Education Fund and to the Library Fund. Two subscriptions to *Today's Health* were obtained and one to the *Bulletin*. Next year we hope to be more active.

MRS. J. C. YOUNG, Coleman.

Comal County

The Comal County Medical Auxiliary held a luncheon meeting last summer to elect officers and meet Mrs. E. W. Coyle, State President, and Mrs. Charles McGehee, State Auxiliary Corresponding Secretary, both of San Antonio. Mrs. Coyle spoke regarding the aims and organizations of the Auxiliary. At that time it was resolved that this auxiliary would remain more or less inactive, with the members participating in civic activities as individuals rather than as a group. However, in May the medical auxiliary, in conjunction with the hospital auxiliary, acted as hostesses at the open house held in observance of National Hospital Day. We plan to meet again soon to elect officers and discuss plans for the coming year.

MRS. WILLIAM W. SULLIVAN, New Braunfels,
Secretary-Treasurer.

Cooke County

The Cooke County Medical Auxiliary has a roster of 13 members, 2 honorary members, and 6 associate members. We meet once a month with doctors for a social and business meeting.

Our projects for 1953-1954 were to provide cancer dressings to those who needed them, and to spread cheer and bring joy to those confined to the State Training School for Girls and the County Poor Farm. We again assisted with the tuberculosis x-ray drive, and members worked on the tuberculosis and Red Cross fund raising drives. The members who are also nurses assist the county health nurse in school health checks. The AAPS essay contest is being sponsored and prizes of $22.50 will be given.

Carnations were sent to our husbands on Doctor's Day and a dinner dance was given at Christmas time.

The mental health survey was made in Cooke County and, with the help from Tarrant County Auxiliary, great strides are being made with one family. Collectively our auxiliary cannot list too much activity, but each member is a worker in many related fields and I am proud to say they are a fine group of hard working women.

MRS. VINCENT C. CIRONE, Gainesville.

Coryell County

The Woman's Auxiliary to the Coryell County Medical Society has 5 members. Three meetings have been held with an average of 4 attending. One meeting was business, one a program, and one a social for the doctors and the members of the Bosque County Medical Society and Auxiliary. The various women's clubs of the city were invited to the program meeting when "Self-Examination of the Breast" was shown. The members have read the State Auxiliary *News Letter*.

MRS. O. W. LOWREY, Gatesville.

Dallas County

Meetings were held the first Wednesday of each month, with executive board meetings being held on the Tuesdays preceding. The average attendance at our general meetings has been 175. Identification cards were made for each individual member. Green ribbons attached to the cards were used to designate new members and white ribbons were used for hostesses. All committees in the social group have been most active.

Dues were collected for 583 active and associate members. In addition we have 1 honorary life member, 6 honorary members, and 18 members whose husbands are in military service. In August letters were sent out enclosing printed check drafts and suggesting that dues be paid prior to the first meeting. This resulted in 403 members paying dues in advance of the due date.

The auxiliary is affiliated with the City Federation of Women's Clubs, the Health Council of Social Agencies, the Health Museum Guild, and the City-County Hospital Auxiliary, and sends a representative to each meeting.

Public relations has been emphasized in auxiliary programs and work throughout the year. Members have been urged to participate in all religious and civic activities of the community as a means of building good public rela-

tions. Our PR committee chairman attended the AMA's Rural Health Conference held in Dallas in March.

We have a health service committee composed of a general chairman and five co-chairmen who serve in various city organizations. They have reported the following contributions and services: 170 hours work given at the West Dallas City Maternity Clinic, as well as clothing and $30 worth of canned goods; 35 hours spent assisting the school nurse at Thomas A. Edison School; $350 contributed for fans for patients and view boxes for physicians at Woodlawn Hospital and 140 periodicals donated, plus 20 hours service helping the physical therapist; and 3 gallons of cod liver oil and books, magazines, clothing, and volunteer service contributed to the city-county welfare agency.

A meeting of the health education committee chairmen was held in the summer. A letter was composed listing all the health services by the auxiliary. This was mailed to all school principals, PTA presidents, and Dad's Club presidents in Dallas and the Park Cities. Three speakers were placed directly and others were referred to the speakers bureau of the Dallas County Medical Society. We can report 1,766 physical examinations of members, their families, and servants. The executive board was 100 per cent in subscriptions to the *Bulletin* and *Today's Health*. Total *Today's Health* subscriptions received numbered 310, with the auxiliary donating 39 subscriptions to civic groups, schools, and hospitals. Members also staffed the *Today's Health* booths at the state dental convention, the Southern Clinical Society meeting, and the AMA's rural health meeting.

Notices were sent to the schools and PTA groups encouraging them to make trips to the Health Museum. Parentcraft classes for expectant fathers and mothers have been held weekly at the Museum under our group's sponsorship. The purpose of the series of fourteen classes is to teach the intelligent, practical preparation for parenthood. The weekly average attendance has been twelve, but in the past six weeks there has been a 50 per cent increase. The parentcraft committee has accomplished the following:

1. Provided books and teaching equipment.
2. Wrote letters to all obstetricians to inform them that this course of lessons is available for their patients.
3. Distributed 1,200 referral cards to the physicians.
4. Placed descriptive literature, approximately 850 leaflets, in waiting rooms.
5. Mailed "Prepared Parents" diplomas to all who completed the course.
6. Arranged for a television program to inform the public about the course.
7. Obtained special speakers.

Three films (two new ones and one other) have been shown to 1,200 people. In addition, the visual education committee has made eight appointments for March showings, and it is estimated that 1,000 persons will view the films at that time. In cooperation with the mental health committee, the films "Human Growth" and "The Story of Menstruation" have been shown once each week to the children of the Dallas County Juvenile Home. Also in the field of mental health, a survey of physically handicapped children under 18 years of age in Dallas County was made. School superintendents were contacted and reports secured from the school census. We learned that the schools have a special education department for the handicapped children and have facilities to accommodate 40 per cent more children than are enrolled this year. The private agencies which teach the blind, deaf, speech retarded, cerebral palsy, and crippled children filled out work sheets to assist in the survey.

We also made a survey of the facilities, both private and public, in the county for caring for the aged and are prepared to cooperate with the city in this matter.

Our voluntary placement committee was responsible for securing members who gave a total of 268 hours to the polio and heart fund drives. Poll tax receipts were sold in conjunction with the polio drive, and for three weeks during the heart fund drive members staffed a downtown booth where they ran a projector and oscillograph and distributed literature.

Gifts totalling $250 have been received for the State Library Fund. Our American Medical Education Foundation committee chairman mailed out 600 cards to members, and $200 for the AMEF was obtained. Also, $364 for the Memorial Fund had been received as of March 1.

The nurse recruitment committee has been very active since June of 1953. The following is a summary of its accomplishments during 1953-1954:

1. Established a coordinated plan in cooperation with all other groups interested in student nurse education.
2. Sponsored a contest to select the student nurse of Dallas in cooperation with the motion picture industry.
3. Promoted a "Student Nurse Recruitment Week" through proclamations issued by the mayors of Dallas and Grand Prairie. At this time there were ninety window displays in department and dress stores and in drug stores. Also, 3,600 brochures and posters were distributed and radio, television, and newspaper publicity was obtained.
4. Organized eleven Future Nurses Clubs in the high schools of Dallas, with an enrollment of 246 students.
5. Established the Edith Cavell scholarship fund, which at present has $378.88 in funds.
6. Sponsored a tea for the future nurses at hospitals.

The AAPS essay contest has received publicity both in the Dallas newspapers and throughout the county. Literature was sent to all county high schools, and the auxiliary voted to give $125 in prize money.

Our research chairman has obtained the biographies of four Dallas physicians who have done outstanding work in the medical world, and these will be mailed to the State Research Chairman.

All members were contacted and urged to write their representatives and senators on behalf of the Bricker Amendment. A paper on this amendment was read on guest day and pamphlets explaining its purpose handed to members and guests.

MRS. SIDNEY S. BAIRD, Dallas.

Dawson-Lynn-Terry-Gaines-Yoakum Counties

The Woman's Auxiliary to the Dawson-Lynn-Terry-Gaines-Yoakum Counties Medical Society has 14 members and meets alternately at Lamesa and Brownfield. There have been 9 meetings during the present term. Members have been urged to take part in civic affairs. Contributions were made to the Waco and San Angelo Tornado Disaster Funds.

MRS. F. E. SEALE, Lamesa.

Denton County

We have stressed public relations and nurse recruitment this year. Each member has donated her time and talents to all local drives and undertakings and, as a group, we assisted in and donated to the United Fund, Red Cross, Warm Springs Foundation, heart and cancer drives, patch tests for tuberculosis, blood bank, and the like.

We also sponsored the x-ray mobile unit. We made an award to the Negro Girl Scouts and a prize to the Negro school for its work for the tuberculosis drive.

Another scholarship was presented to the Kress Foundation School for Practical Nurses, and several talks, field trips, and films were arranged by the auxiliary for prospective nurses in the high schools of the county. I am proud to report excellent results with several actual recruits. We continue to place books in our public library and also *Today's Health.*

A guest luncheon and book review was given in March. Our annual benefit party, by which means we obtain the funds for our various projects, was held in April. This as always was quite successful.

The 1953-1954 year is being closed with our Doctor's Day celebration. We have an editorial in our local paper, boutonnieres for our husbands, and a picnic in the evening planned.

At the present our members are planning and looking forward with great enthusiasm to the District 14 meeting to be held in Denton this year.

MRS. HARRY FARBER, Denton.

Dewitt-Lavaca Counties

The Dewitt-Lavaca Counties Auxiliary is a small group. We have 24 members in 5 towns. Because of the long distance between our towns, frequent meetings are not held. We should meet quarterly, as stated in our constitution. We will have met 3 times this year.

Our Auxiliary has sponsored the AAPS essay contest, but only one town and two schools therein participated. We have stressed that old medical journals be sent to Korea for use in the schools there. Donations from the auxiliary have been made to the following: American Medical Edution Foundation, Library Fund, Memorial Fund, and Student Loan Fund.

Though the year has not shown remarkable movement, the group has moved onward and is together.

MRS. J. M. BUTTERY, Hallettsville.

Eastland-Callahan-Stephens-Shackelford-Throckmorton Counties

The Woman's Auxiliary to the Eastland-Callahan-Stephens-Shackelford-Throckmorton Counties Medical Society meets bi-monthly throughout the year. There are 15 members, with an average attendance of 8 to 10. A combination business and social meeting is held followed by dinner with the husbands in the homes of various members.

Our programs included a film and lecture from the American Cancer Society, a book review, and a group discussion of the Bricker Amendment and other legislative matters. Nurse recruitment has been stressed in each town and supervisors from nearby hospitals have made talks in the schools.

MRS. CARROLL FORD, Breckenridge.

Ellis County

The Woman's Auxiliary to the Ellis County Medical Society in the past year has completed three major projects, as follows:

1. We have written and adopted a constitution and by-laws.

2. We have instituted regular quarterly luncheon meetings and an annual Doctor's Day dinner.

3. We have sponsored locally the AAPS essay contest, awarding prizes from the county level in the aggregate amount of $50.

MRS. B. C. WALLACE, JR., Waxahachie.

El Paso County

The Woman's Auxiliary to the El Paso County Medical Society planned and executed the year's work with our State President's theme in mind, "Knowledge, Judgment and Action in Health Leadership."

Initiating our year's work we presented a program on "Know Your AMA" by Dr. Robert Homan, El Paso, a member of the AMA's Council on Medical Service; "Know Your Auxiliary" by Mrs. George Turner, President-Elect of the Woman's Auxiliary to the AMA; and "Know Your Community" by Mrs. L. W. Breck, one of our past presidents and a member of both the board of governors of the El Paso General Hospital and the commission to rewrite the City Charter.

At our public relations meeting in November, representatives of fifty women's organizations were our guests at luncheon. Dr. H. D. Garrett, a dermatologist, gave a talk on cosmetics and the care of the skin, entitled, "The Basis of Glamour." The film "Scrub Game" was shown and five PTA groups and one Girl Scout Troop requested it for showing. Each guest received the AMA brochure for program chairmen of lay groups, "Better Health—A Project in Living."

In January the mental health committee presented a talk on personality development by one of our psychiatrists, Dr. George Schlenker. Our year was highlighted by the visit in February of our State President, Mrs. E. W. Coyle, and the district council woman, Mrs. Harold Lindley. Twenty-four of our members attended the District 1 meeting in Pecos.

The nurse recruitment committee has worked closely with the nurse recruitment committee of the Nurses Association. All local high schools have nurse clubs, one a boys' club in nursing. To these clubs we distribute paper nurses caps with "Future Nurse" printed on them and assisted with their programs. We have carried out the following projects: (1) At the annual Social Welfare Fair sponsored by the Central Council of Social Agencies, we had a walk-in trailer set up as a nurse recruitment center. Representatives from the nursing schools gave out information on all types of nursing. Members of the auxiliary and representatives of the Future Nurse Clubs acted as hostesses. (2) We are setting up a file of nursing scholarships and loan funds available in El Paso and have started a program to encourage other organizations to set aside money for this purpose. (3) We are developing literature beamed at the parents to convince them that nursing is a good career for girls. We feel this is so important that we are recommending that the State Auxiliary develop this type of literature. (4) We have compiled a brochure on schools of nursing designed to be used as reference material for girls interested in nursing to be kept in the offices of the school nurses in the high schools. We are giving one to each high school in El Paso County and one to the State Auxiliary with the recommendation that the State consider a similar project on the state level to be distributed through other auxiliaries to all Texas high schools. (5) On March 25 we will have a tea and program for members of Future Nurse Clubs and other interested students and their mothers. The brochures will be presented at that time and a skit, "Stars of Nursing" will be given by auxiliary members. A nurse scholarship of $125 was given in September.

Our legislative committee initiated an intense program in favor of the Bricker Resolution. Mimeographed material was given to the auxiliary, medical society, and dental aux-

iliary and Pro-America and Current Topics Clubs. Members responded to a request to wire Senator Lyndon Johnson.

The civil defense committee prepared a card file of our membership giving the various professional, domestic, technical, and business abilities and training of members, and this was presented to the local civil defense headquarters. Through the chairman a similar file of the membership of Young Matron's Auxiliary of the Woman's Club was presented to the civil defense headquarters. On February 1 the Auxiliary began a thirteen-week series of television programs, "Nurse, Please," originated by the Tarrant County Auxiliary. We have had many requests for the "Six Survival Secrets" which we offered viewers. One Boy Scout troop has requested them for study. One teacher is using the program as home work for her health class.

We have had excellent publicity in the local papers featuring meetings, special events, and projects, and monthly articles in the *Southwest Clubwoman* and the TEXAS STATE JOURNAL OF MEDICINE. The publicity chairman assisted the county medical society in preparing a history of the society and biographical sketches of pioneer doctors for the centennial editions in our newspapers. These editions carried a history of the auxiliary, a copy of which has been sent to the State Historian.

We sponsored the AAPS essay contest in eight high schools, public, private, and parochial. Eighty-seven papers were written. Local prizes totalled $120.

Three hundred and thirty-three physical examinations were reported. One hundred members of the Young Matron's Auxiliary of the Woman's Club were contacted and urged to have physical examinations.

Thirty-five members subscribe to the *Bulletin* and thirty subscriptions to *Today's Health* have been given.

The mental health committee conducted the survey with the State Auxiliary Mental Health Committee and the results were sent to the State Chairman. A student-centered safety program dealing with all aspects of safety was carried on during the year. We have made a preliminary health survey of El Paso County, with a copy being sent to the State Historian.

The public relations committee sent 153 letters during the summer to women's organizations of El Paso County. We have given eight talks, including two before Home Demonstration clubs, and shown seven films at five high schools. The film, "Know Your Doctor" which our medical society bought was shown to three PTA groups. The American Theater Wing Production, "Scattered Showers," was given by members at a PTA meeting and the Trans-Pecos teachers' convention.

Our members are active in all civic organizations and on all boards in the city. One of our members is president of the Young Matron's Auxiliary of the Woman's Club, one is Chairman-Director of the Woman's Department of the Chamber of Commerce, and one was Chairman of the Sun Queen's Court of the Sun Carnival Association. We have served the Lighthouse for the Blind; addressed envelopes for the Easter seal drive; manned booths in department stores and also collected nylon for the cancer society; filled bags for the Goodwill Industries; collected samples from doctors for El Paso General Hospital and clinics; and cooperated with the ministerial association in the "Go to Church" campaign. Members worked on the YMCA Building Fund Drive as well as on all fund campaigns. We contribute to the Red Cross, Community Chest, American Cancer Society, and the tuberculosis association. We have contributed to all state auxiliary funds including the American Medical Education Foundation. Auxiliary members furnished hospitality to delegates to the Southern Association of Student Councils when 800 students from fourteen states met in El Paso. The goodwill created has been rewarding.

One of our members was chosen El Paso's Woman of the Year. Five members were "Women of the Week" and two of our newest doctors' wives have been featured as "Arrivals of the Month."

We hope that by learning and by doing we have come to know our community better and that our community has come to know us.

MRS. NEWTON F. WALKER, El Paso.

Falls County

Due to the fact that the Woman's Auxiliary to the Falls County Medical Society has been inactive for several years and few meetings have been held, officers were not elected for 1953-1954 until October. However, I am pleased to report that since that date we have met regularly every month, have worked up several projects, and there is definitely a marked increase in enthusiasm among the members and a keen desire to accomplish something worth while.

In November a committee from the auxiliary attractively decorated a window for National Book Week illustrating *The Horse and Buggy Doctor,* by E. Hertzler, M. D.

In December we entertained the doctors at a delightful Christmas party, and again in January the auxiliary and medical society met for a social hour following their respective meetings.

In January a nominating committee was appointed, and new officers for 1954-1955 were voted on in February. The following were elected: president, Mrs. Clarence R. Miller (re-elected); vice-president, Mrs. Tom Glass; secretary, Mrs. Roy G. Giles; treasurer, Mrs. J. C. Hohf; reporter, Mrs. John B. Barnett; and historian, Mrs. Milton A. Davison, all of Marlin.

In March the nurse recruitment committee arranged for the auxiliary to entertain eighty-five members of the Marlin High School senior class at a tea at the Veterans Administration Hospital. A donation of $50 was sent to the American Medical Education Foundation.

More elaborate plans for next year are in the making. Now that we seem to be better organized, it is earnestly hoped that our concerted efforts will result in more activity in the different phases of the work outlined for the county auxiliaries.

MRS. CLARENCE R. MILLER, Marlin.

Fannin County

The Woman's Auxiliary to the Fannin County Medical Society voted to be members-at-large as there were only 3 members. All work as individuals in civic affairs.

MRS. L. E. MORGAN, Bonham.

Freestone County

The Freestone County Auxiliary was organized last year and is composed of 3 members, 2 in Teague and 1 in Fairfield. We are necessarily circumscribed in our activities. However, I feel that we form a nucleus of informed members who can work on an individual basis for better community health and public relations. Through organization we can keep in touch with other communities over the state and be ready to grow when the opportunity presents itself. Although we do not meet regularly, we did present one film on cancer this year to a group of club women, and more are planned. What we can do with *Today's Health* remains to be seen. I should be happy to hear what other small auxiliaries over the state are doing.

MRS. JACK R. COX, Teague.

Galveston County

A full and satisfying year is coming to a close with all our projects completed. We centered our attention on nurse recruitment by organizing seven Future Nurses Clubs throughout all high schools in Galveston County. We gave a $300 nurse scholarship by assessing each member $5. The sponsors of all clubs were auxiliary members, all of whom are registered nurses except one. The girls were taken on tours of various hospitals in our county and also in Houston. Some of them even visited the Anatomy Laboratory at the University of Texas School of Medicine.

We plan a style show in April to portray the different phases of nursing in honor of our Future Nurses Club members. We also feel it will be good public relations to have their mothers there as our guests. This phase of auxiliary work could not be done without the splendid cooperation of our members, the superintendents of our two schools of nursing, and the District Nurses Association.

Next, we quietly mentioned in September that we were converting the radio series "Healthy Living in Our County" into television programs, as requested by our school principals. This we did, on a one-program-a-month basis, which proved successful. We felt at this point we were putting into effect our own State President's slogan, "Knowledge, Judgment and Action in Health Leadership." Of course, the success of the television series fell mainly on our teachers. They have been wonderful. One program was a skit on "Johnny's Toothache." It was so good on television that we presented it at our open meeting in February, and members and guests both enjoyed it.

We were able to accomplish the AAPS essay contest this year. A parochial school student won it and will be presented her award at the April meeting of the county medical society. Fourteen high schools were contacted for this project. One of the essay chairmen agreed to take the project again next year because she realizes the need to inform young citizens of tomorrow of the dangers of socialism in medicine.

Civil defense is not completely organized in Galveston itself but is in outlying communities. Texas City has a chairman for all of Galveston County and, because of the industrial plants, is well organized in disaster preparedness. In our own community of Dickinson where I live we have sent out questionnaires to every family, and with the help of several other registered nurses I assumed chairmanship of the blood typing of all of our school children. This will be completed in April or May.

We contributed to the Memorial, Library, and Student Loan Funds. Our "birthday plan" of 10 cents for every year of your age worked out very well in obtaining individual donations to AMEF. Our auxiliary made a contribution to AMEF in honor of our husbands on our Doctor's Day program which was a dinner-dance in December.

At this time we have an active membership of 122 plus 20 junior members. We feel with this ratio of members we have accomplished a year full of success and happiness among ourselves.

MRS. ANDREW J. MAGLIOLO, Dickinson.

Gonzales County

The Woman's Auxiliary to the Gonzales County Medical Society has a membership of 4, an increase of 1 over last year. We have no regular meetings but all members work in civic affairs.

By personal contact in the high school we participated in the nurse recruitment program. Home nursing classes were taught, and funds and services were given to Red Cross, March of Dimes and heart drives. We served on the board of the Red Cross and as chairman of the chest survey. One hundred per cent of the doctors had physical examinations. Two *Today's Health* subscriptions were sold, and members read the State Auxiliary *News Letter.*

MRS. DAVID M. SHELBY, Gonzales.

Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson Counties

The Top O' Texas Medical Auxiliary has 38 members in a nine county area. Meetings are alternated between Pampa and Borger which are more centrally located. Some members drive as far as 150 miles to attend these monthly meetings. Except for the hostess town members, others travel from 54 to 65 miles each meeting Though handicapped by distance we have an active group.

This year we concentrated on three projects: Student Loan Fund, *Today's Health* and nurse recruitment. Public relations through community service was stressed.

Our auxiliary contributed $50 to the Student Loan Fund. Each member subscribed to *Today's Health.* In our nurse recruitment program over 250 contacts were made. Four films were shown and five talks were given. A book on nursing was placed in the Pampa High School library together with pamphlets and posters. In Hutchinson County all high school seniors were contacted, in Negro schools as well as others. Pamphlets were distributed to students and put in school libraries. Of the 250 girls attending films, eleven are planning on entering nurses training next fall.

As many members as possible plan to attend the District Medical Auxiliary meeting and luncheon at the Amarillo Country Club, April 13, to hear our State president, Mrs. E. W. Coyle, San Antonio.

MRS. W. C. BARKSDALE, Borger.

Grayson County

We have provided a rather diversified program this year trying to meet the interest of all our members and thereby creating more interest in all phases of Auxiliary work.

This year we added one new office to our Executive Board—that of president-elect—in order to acquaint the incoming president with her duties and responsibilities. We feel this will add a great deal to our over-all efficiency.

In November, we sponsored a style show and tea open to the public in an effort to raise money for the American Medical Educational Fund. We have also tried to interest other organizations in the project.

Throughout the year we have had programs or discussions on mental health, civil defense, nurse recruitment, AAPS essay contest, and such legislative measures as are of primary interest to the Auxiliary and medical profession.

We have assisted our doctors in every project in which they have been interested, such as: heart fund, diabetic control, camps for underprivileged children in our area, cancer fund, medical conventions, and others. Our doctors have given generously of their time to make health talks in our schools and social organizations.

In addition to honoring our husbands with a dinner-dance at Christmas time, we are sponsoring an official Doctor's Day in our county. The newspapers, pharmacies, and merchants all are participating.

At this time our auxiliary is attempting to organize a visiting nurse association. We realize this is quite an undertaking, but the need in our own county is so great that we are willing and anxious to try it. We feel that, with the cooperation of the doctors, the organization of such a

group will be one of the most beneficial things we could ever do for our community.

MRS. STANLEY L. CLAYTON, Denison.

Gregg County

At the first monthly meeting of our auxiliary, we were honored by a visit from our State President, Mrs. E. W. Coyle, San Antonio. Her visit with us was both pleasant and inspiring for our auxiliary.

This year, we have spent a large part of our time working on a new public relations venture, in the form of a television program. So far, we have presented only two programs, both films, with a five minute live program preceding our first one, but we have arranged for more time, beginning in May, during which we plan to present a series of programs. Most of our programs will be films, but we hope gradually to work up a few live programs also. Many members were rather dubious about the success of this kind of program, but after the first one was presented, we all felt that we could do it successfully.

We plan to work with other organizations in presenting some of these programs, particularly drives, such as cancer, heart, tuberculosis, crippled children, and others.

This year, we made our first loan from our Student Loan Fund to a nurse. We have more money available and hope to use it soon for another loan. This fund is available to girls entering any field of medicine.

Our annual linen shower for the Cerebral Palsy Center was successful, and the center was grateful for much needed linens.

This is our first year to sponsor the essay contest, and we only had one entry. We are discouraged about that, because we feel that we now know much more about how to handle it than when we began. This year's essay chairmen asked for the chairmanships for another year in order to be able to follow up the work they have already done. We expect much more next year.

Near the end of the year, we decided that there is a definite need of an information file on our members. Though we have a relatively small membership—65—we found that there is much talent and ability in the group that is not known. An example of this is that, almost too late, we found that one member had majored in radio in college, and had had experience in the radio field before her marriage. She proved a valuable asset in working up our TV programs.

We plan to make files on each member listing her professional training and experience, her major interests, and other facts that will aid the president in placing the right person on the right committee. Of course, we knew that Mrs. Mark Latimer, Houston, State President-Elect, is preparing a similar file of state members, but we did not realize what a nice idea it was for county organizations until we began to find women with talents and training that we had not known of previously.

We feel that our year has been successful in that we have made some ventures new to our auxiliary. In those, we have done little more than lay the groundwork on which to build in future years. If we can add one new activity each year and do a good job on that, we shall feel good.

MRS. RALPH C. CRAWFORD, Longview.

Grimes County

The Woman's Auxiliary to the Grimes County Medical Society has a membership of 7, the same as last year. Members are taking part in the civil defense program in this area. Financial aid and personal service have been given to the following: Red Cross, polio, tuberculosis, heart, cancer, and crippled children.

Members also have participated in health programs on cancer, heart, tuberculosis, first aid, safety, and home nursing. They have enjoyed the State Auxiliary *News Letter*. New officers are Mrs. H. L. Stewart, Navasota, president, and Mrs. E. T. Ketchum, Navasota, treasurer.

MRS. E. T. KETCHUM, Navasota.

Hardeman-Cottle-Foard-Motley Counties

The Woman's Auxiliary to the Hardeman-Cottle-Foard-Motley Counties Medical Society has 6 paid members. Since we live so far apart, we work as individuals and try to meet quarterly. We are glad to see the Auxiliary work progress.

MRS. C. C. PATE, Paducah.

Hardin-Tyler Counties

The first two meetings of our auxiliary were held in September and October, 1953, for the purpose of organization and electing officers. Officers elected included a president, vice-president, legislative chairman, and secretary-treasurer.

Meetings are held the third Tuesday evening at 7:30 p. m. We have held 9 meetings, with an average attendance of 4. At each meeting we allow our legislative chairman ten minutes in which to keep us posted on events taking place in Washington and elsewhere pertaining to the practice of medicine. The secretary of our auxiliary wrote letters to Senator Lyndon Johnson and Senator Price Daniels in regard to the Bricker Amendment and the legislature for physicians' retirement plans.

Members work with PTA and contribute to Red Cross, Easter seals, Christmas seals, heart and cancer funds. Six doctors, 6 wives, 4 children, and 2 servants have had physical examinations.

We voted on the dues for each member per year to be $5, with $3 to be used for worth-while projects. We contributed $5 to the AMEF Fund. Six members paid their dues for the year 1954 at our February meeting, and it was decided that the present officers should hold their respective offices until September, 1954.

We have planned a steak dinner for the doctors of the two counties to be held in May of this year.

All members voted to subscribe to *Today's Health* (ten subscriptions were bought with four being given to schools) and to try in the separate communities to establish better public relations with the medical profession and the communities.

MRS. JOHN H. TATE, Kountze.

Harris County

The Woman's Auxiliary to the Harris County Medical Society incorporated the themes of our National and State Presidents in planning and executing our year's work. Emphasis has been placed on membership and organization. A personal letter of welcome was sent by the president in September to each member to establish friendly relations and to create interest in the activities of the auxiliary. We have tried to make each member, regardless of service years, feel equally important to our organization.

Our auxiliary has 693 members. Of this number, 649 are regular members, 30 are chapter, 3 honorary, and 11 associate members. Ninety-six new members have been received into membership. New members, as they affiliated, were entertained at informal coffees by the visiting com-

mittee. Notes of welcome and taking them to meetings are projects of the courtesy committee. All new members will be honored at a tea in May. More than 50 per cent of the total membership are on various committees.

An auxiliary Newsletter has been mailed to each member to keep them informed. Handbooks for board members, to clarify obligations and supply information from predecessors' reports, were compiled and distributed by the president.

Mr. Robert A. Dedman, President of Facts Forum, Dalias, spoke on "America Is Worth Fighting For" at an open meeting followed by brunch in October. Invitations were extended to all local women's organizations.

The November meeting honored our State President, Mrs. E. W. Coyle, San Antonio, who made us conscious of "The Individual's Importance in the Community." Our chairman of nurse recruitment presented a progtam on "The Nursing Profession," highlighted with the recipient of our nurses scholarship, a student nurse and a director of education from each school of nursing—all as participating guests. New members and their husbands were honored at our Christmas dinner-dance in December.

"Feed the Kitty for AMEF" was the theme of the January program. Dr. Stanley W. Olson, Dean, Baylor University College of Medicine, spoke on "Medicine in Mid-Century"—an interesting resumé of advances in the medical field and causes of the tremendous cost of medical education. His talk seemed the perfect background for remarks of our State AMEF Chairman, Mrs. J. L. Jenkins of Galveston, and stimulated interest in and donations to this fund.

In February, Miss Jasmine L. Sadler as guest speaker spoke on "Torch Bearers of Tomorrow," which was a juvenile delinquency challenge to us. Doctor's Day, March 29, honored our doctors at a luncheon and program entitled "Laugh With Your Lady." Morris Frank, popular newspaper columnist, fulfilled the title in his witticism and pertinent remarks providing laughs for doctors with their ladies. For the first time, we honored a doctor, one of our members and a lecturer in pathology at Baylor University College of Medicine, Dr. Elizabeth Powell.

"Hobbies and Mental Health" was the topic of our speaker, Mrs. Norborne Powell, M. D., in April. Eighteen displays of varied handcrafts and collection hobbies were displayed by our members in such an expert fashion that the meeting has been considered our most outstanding and successful one this year.

Mrs. Mark H. Latimer, one of our members and incoming State President, will be honored at an executive board tea on May 12. Each auxiliary member will receive a personally written invitation, our custom this year for social events which has proven worth-while.

The Auxiliary has contributed to the Library, Memorial and Student Loan Funds. We reported 1,860 health examinations for our doctors, their families and servants, submitted a Mental Health Survey and nine articles with publicity items to the State Research Chairman, and compiled and submitted a thirty-five year history of our auxiliary.

Legislative activities include (1) monthly study groups for members; (2) twelve legislative talks at executive board and regular meetings; (3) 154 wires, calls, or letters to senators and legislators; (4) distribution of 3,580 pieces of literature; (5) endorsement for Bricker Amendment by securing signatures; (6) poll tax sales; and (7) co-sponsorship for two open meetings—one with the Harris County Medical Society for which we were commended for the attendance of 450 people.

Public relations has been stressed as one of our three point program. An outstanding project was the collecting, packing and shipping of 4,000 medical periodicals and 500 textbooks to the medical schools in South Korea. Our members, in assisting our medical society, each gave eight hours in the preparation for mailing of 10,650 "Focus On Health" programs. "Focus on Health," an important PR project, lists our medical society and woman's auxiliary with the organizations co-sponsoring with Houston Public Schools the thirteen weeks series of TV programs on health. Two auxiliary members for many months have been committee members in original planning for this program.

Sixty-eight auxiliary members, as a cancer hospital-bandage folding committee, devote one Friday morning each month to making bandages at the M. D. Anderson Hospital. As of April 30, 409 workers have given 375 hours to the making of 17,255 bandages and wrapping an additional 2,000. Children's Hospital receives our support through cooperating in sale of Pine Oaks tickets—an annual event in June the proceeds of which are given to Children's Hospital.

Since our auxiliary's organization, the Tuberculosis Hospital has received our continued interest and support. The adoption several years ago of a ward consisting of an average of 26 women patients has our concentrated attention at present. The auxiliary contributes no less than $250 to this work yearly; additional money, items needed, and gifts are solicited. Our chief objective is giving these patients that which is not supplied by the hospital and thus keeping them happy and contented.

We sponsored the AAPS essay contest with twelve schools participating and 109 essays submitted. The auxiliary financed the needed kit materials and through our medical society's generosity, $600 was awarded in prizes. This amount, however, did not include the all-Harris County prizes given.

Achievements in nurse recruitment, our most important public relations project, have been outstanding. A $300 auxiliary scholarship was awarded to a student nurse in August, and she has been in training this year at the Central College of Nursing. A scholarship was secured for another applicant through contacting another organization. Applications are being received for next year's scholarship now; to date, eleven applications have been received. The committee, with next year's nurse recruitment chairman, will become acquainted with all applicants at a coffee in May. Sixteen schools were given talks by a member with a student nurse; approximately 750 girls were actually contacted. The fifth, and last, Future Nurses Club was organized recently by the committee; each club has a member as its sponsor. We have appeared on one radio and two TV programs on nursing; originated a Student Award Day with the schools; distributed literature; and actively worked with the city nursing scholarship committee and with other organizations.

Today's Health subscriptions total 602 credits. Harris County Medical Society gave us 134 gift subscriptions, one year each, for schools and libraries. The auxiliary, and individual members, gave thirty-seven gift subscriptions to hospitals, beauty shops, women editors of newspapers, and various charity organizations. Fifty *Bulletin* subscriptions—100 per cent for Executive Board members—were secured.

American Medical Education Foundation, promoted for the first time by our auxiliary, shows $700 contributions, which is over 100 per cent. This committee assisted Harris County Medical Society with the preparation for mailing AMEF literature to 1,000 physicians. Civil defense activities were curtailed due to our local situation. Talks by committee chairman were given at meetings, and a list of nurses and typists was compiled from our membership file.

MRS. JACOB F. SCHULTZ, Houston.

East Harris County Chapter

We of the East Harris County Chapter are just completing the fourth year of our organization. We have 30 active members, including 3 new members, and are happy to report that we have had good attendance at our regular meetings.

Most of our meetings have been business meetings, with a Christmas tea and a cocktail party for the doctors included. At the business meetings programs on health and legislation as well as the prescribed ones on mental health, juvenile delinquency and safety were given. For our legislative program we had a particular treat in the person of our State Legislative Chairman, Mrs. John King Glen, Houston. She gave us all the facts concerning the Bricker Amendment as well as other related items such as the NATO Status of Forces Treaty.

We can report twenty-four subscriptions to *Today's Health* and thirty subscriptions to the *Bulletin*. This year, for the second time, we have placed *Today's Health* in all the public schools and in the public library.

For Doctor's Day, March 30, we hope to surprise our doctors by having each presented, at his place of business, a red carnation.

A good percentage of our auxiliary, working through other organizations, has devoted a considerable number of hours to the Red Cross, cancer, tuberculosis, geriatrics, welfare and other organizations. Quite a few, too, have worked with Future Nurses Club, and the auxiliary as a whole has cooperated and furnished means of transportation for these girls to do some visiting. In October, they took a tour of John Sealy Hospital in Galveston and in March they attended a tea sponsored by the University of Houston.

We again worked on the AAPS essay contest and received a fairly good response from the schools. Five schools participated and fifty-one essays were submitted. These are in the process of being judged at the present time.

We contributed to the American Medical Education Foundation, Library, Memorial, and Student Loan Funds.

MRS. H. O. SAPPINGTON, Baytown.

Harrison County

The Harrison County Medical Auxiliary meets the first Tuesday in each month, September through May. There were 16 active members this year with an average attendance of about 80 per cent. One eligible member was unable to be active because of illness, and another possible member has just moved to town and plans to be active next year.

This is the first time in many years that this auxiliary has had a yearbook. The advantages are obvious. Our attendance is up considerably due to the fact we now have a planned program and a definite time and place to meet. The group as a whole has shown more interest in all the phases of our work.

In December we had a Doctor's Day dinner honoring our husbands. Games were played and a raffle was held. The proceeds from the party helped to make our contributions to the Library, Memorial, Student Loan, and the American Medical Education Foundation Funds, the Red Cross, cancer, heart fund, and the Harrison County School for Exceptional Children.

Members of our group contributed to all the following and worked on all the drives of the Red Cross, heart, polio, cancer, Community Chest, tuberculosis, and crippled children. Letters were gotten out to all women's organizations concerning the open heart forum held in Marshall in February.

One of the most outstanding and interesting programs was given to our group by a mother and teacher in the Harrison County School for Exceptional Children. This school was one of the first of its kind in the country. There are now about 700, with many using this school as an example. Children with an IQ below 50 are accepted. The school thus is taking care of those who are trainable but not educable. As a result of this program another woman's organization in Marshall is underwriting transportation for those children who would not otherwise be able to attend.

In February Mrs. E. W. Coyle, San Antonio, our State President, was here for a luncheon meeting with us and gave an informative and enjoyable talk. We have had four social gatherings of doctors and wives. These were usually given to entertain a guest speaker of the county medical society.

Harrison County Medical Auxiliary offered its services for civil defense, but the county itself has not yet been successfully organized. Talks have been given to Camp Fire Girls' groups on nursing and several of these groups are observing at the hospital.

In March the hospital brought to our attention the grave deficit in the blood bank. We plan to try immediately to sponsor a drive to secure replacements and to try to set up some sort of permanent plan of replacement for the blood bank.

MRS. H. O. PADGETT, Marshall.

Hidalgo-Starr Counties

Our auxiliary is just beginning to get back on its feet this year. For several years the interest was not there and the ladies began to drop out quite steadily. In September our elected president resigned and since I was first vice-president I was asked to step up into her place.

This being my second year in any auxiliary it was all very new to me. However we all got busy to make our programs more interesting in order to get our members back. Throughout the year each town is responsible for one program, and this seems to be working in getting the ladies interested in coming.

In October Mrs. McMahon, who is from Hungary, gave us a good talk about her homeland. Since her talk, we as a group have written several messages to the wives of Hungary through the Radio Free Europe program. I believe every town has done an outstanding job in getting good programs. For the coming year we have a yearbook committee and we will have yearbooks. We also are planning a nurse recruitment program for the next year as well as a committee to work on *Today's Health* subscriptions.

This year I am somewhat ashamed of our report, but we did hold together and the interest is much better, and I believe next year we will be ready to start off in full swing.

MRS. J. F. FITCH, McAllen.

Howard-Martin-Glasscock Counties

The Woman's Auxiliary to the Permian Basin Medical Society has had an unusual year in that we were all "old auxiliary members" but were yet a new auxiliary. This was due to the division of the Odessa-Midland-Big Spring group. This division has made the work of the auxiliary somewhat simpler in that it has been concentrated, for the most part, in one area.

Since we are a small and a new group, and since most of our members are active in study clubs, PTA, and the like, we as an auxiliary decided to concentrate our efforts on a few things and to try to do them well. Our major project was the AAPS essay contest, and, thanks to the cooperation of both students and faculty, we consider it to be highly successful. The medical society donated $90 for prizes.

We have given subscriptions of *Today's Health* to the high school and junior high school. Several members have made personal subscriptions. We have contributed to the American Medical Education Foundation and to the Memorial Fund.

Our members have played a prominent part in various civic drives—the March of Dimes and the United Fund—and have helped plan and lead discussion programs on health topics in their study clubs.

Our auxiliary will continue to grow and improve. We have a long way to go before we become a "perfect auxiliary," if there is such a thing, but as time goes on we hope to do more and to be able to help our husbands in more and better ways.

MRS. MILTON W. TALBOT, JR., Big Spring.

Hunt-Rockwall-Rains-Delta Counties

Everyone in our auxiliary and medical society looks forward to "Reassembly Day" in October. We met this year in the home of Dr. and Mrs. J. W. Ward, Greenville, and had a program especially planned for the doctors' entertainment. We served dinner and gave a skit entitled "A Day in the Life of Marmaduke Snodgrass, M. D." Later in the month the Junior Pallas Club (Federated Women's Club) asked us to give this skit at one of their meetings.

Our November meeting was given an excellent write-up in the *Greenville Morning Herald.* Mrs. J. M. Spurlock gave a review of *Women In the Bible,* and tied it with health quotations from the Bible.

The Christmas dinner for the doctors was an enjoyable social hour. Dr. C. D. Savage, past county president, and Dr. John Vallancy, 1954 president, asked us if we could make it our project to get the doctors in this society to come to the county medical society meetings. In the past three years attendance had not been good. Our roll call for the January meeting was 'Why Our Husbands Do Not Attend County Medical Meetings." Since our interest has been aroused we have been told the attendance is greatly improved!

The film shown at our March meeting, "Here's Health, the American Way" was enjoyed by all who attended, and one of our delegates showed it at a Civic Federation meeting also.

Mrs. Fred Horton, a nurse at a local hospital, agreed to discuss "Nursing as a Vocation" with the high school seniors. Wolfe City entered the AAPS essay contest. Greenville High School was not interested in doing it this year since the material and title was the same as last year.

We have as an auxiliary contributed in time and money to such drives as the tuberculosis seal sale, heart campaign, and Red Cross. And in all things have enjoyed being "the doctors' wives."

MRS. C. D. SAVAGE, Greenville.

Jasper-Newton Counties

The Jasper-Newton Auxiliary has an enrollment of 10 active and 2 associate members. We have held 9 meetings, with every meeting being preceded by a dinner. We have had the following types of meetings:

Civil Defense: Film, "You Can Lick The Atom Bomb."

Juvenile Delinquency: Speaker, Mr. Ward Markley, County Attorney.

Personal Hygiene: Film, "What Every Woman Should Know."

Enjoyment: Book Review, *So Sure of Life,* by Mrs. Estell McLeod.

Medical Knowledge: Fractures, George G. Gill, M. D.

Our project for the year was to feed one underprivileged child at school for the entire term.

We have had a successful and fruitful year.

MRS. JOHN T. MOORE, Kirbyville.

Jefferson County

This has been a successful year for the Jefferson County Medical Auxiliary.

The membership consists of 175 paid members, 16 honorary members, and 15 new members.

This auxiliary has two chapters, each chapter holding its own meetings except for the first and last. This year our first joint meeting was held in Beaumont with Robert Akers, editor of the *Beaumont Enterprise* speaking on "Our Responsibility in Current Events." This year, too, we had a combined meeting when Mrs. E. W. Coyle, our State President, was guest.

Our Public Relations Day program was held in November, with guests from civic organizations in our city. That also was our mental health program, with Mr. John H. Lane, Jr., Field Representative for Texas Society for Mental Health, as speaker. In December we had a Christmas musicale with our own membership participating on the program.

The Port Arthur Chapter entertained their senior nurses and the Future Nurses Club with Christmas parties.

We enjoyed Mrs. Coyle's visit in January. One of our members sold poll tax receipts at this meeting. "Meeting Our Hospital Auxiliaries" was the theme of our next program, a panel discussion on the order of the television program, "What's My Line." Our own auxiliary members were on the panel. Hospital auxiliary members and presidents were special guests.

A "Medical Auxiliary Think-Nic" is planned for April, when we plan to have final reports for the year with each committee chairman submitting suggestions to the new chairman and officers.

As has been our custom for several years, both chapters collect sample drugs from our doctors' offices for the Out Patient Clinic of the Municipal Hospital in Beaumont.

The Auxiliary was 100 per cent in contributions to the AMEF, with a total of $215. We also made contributions to the Library and Memorial Funds on the State level, locally to polio, tuberculosis, and crippled children. Twenty-four members worked in a downtown station selling tuberculosis bangles and collected $181, which was the highest amount collected by such a team. One of our members was general chairman of this sale in the city. Another of our members serves as chairman of the Junior Red Cross. Port Arthur Chapter sponsors a Camp Fire Group, with an auxiliary member as leader.

We are sponsoring the AAPS essay contest with six schools participating and twenty-four entries. The medical society furnishes $100 for prizes, $50 for each chapter.

This year we have three $100 nurses scholarships and an award of $50 to the outstanding student nurse. We also sponsor two Future Nurses Clubs.

Our mental health committee headed by Mrs. Winston Cochran, who is past president of the Mental Health Society, in cooperation with the State Auxiliary, made a survey of physically handicapped children in our county, who number approximately 1,400.

The Port Arthur Chapter is 100 per cent in subscriptions to *Today's Health* and the *Bulletin.* Total subscriptions to *Today's Health* are 142, including 23 gift subscriptions to schools in the county. Total *Bulletin* subscriptions are 67.

One hundred and eight physicians, 127 wives, 280 children and 89 servants had physical examinations.

We entertained our doctors with an informal barbecue in March and on Doctor's Day served coffee and doughnuts at all hospitals in the morning. Port Arthur Chapter had boutonnieres for their doctors.

On October 3, 1953, we entertained the Tenth District in Port Arthur. Mrs. Mark Latimer, Houston, State President Elect, was our guest.

Our courtesy committee entertained new members with an informal get together and wrote notes to members who were ill or had illness or death in the family.

We have a wonderful new slate of officers and are looking forward to an exciting new year in auxiliary work.

MRS. S. V. GRANATA, Beaumont.

Johnson County

The Woman's Auxiliary to the Johnson County Medical Society was not as active during this year as hoped by the program committee. The committee chairmen for the various assignments did not perform their duties and many of the anticipated projects were necessarily dropped.

The annual silver tea for the benefit of the Johnson County polio fund was held in November and approximately $100 was collected.

Through our Coca Cola fund, the auxiliary purchased two open-end oxygen tents and apparatus for use in the Johnson County Memorial Hospital. The auxiliary members assisted the x-ray mobile unit by spending a full day acting as secretaries.

The program was specifically social this year to aid in interesting more members to participate actively in the auxiliary.

MRS. E. L. CLARK, Cleburne.

Kerr-Kendall-Gillespie-Bandera Counties

The Woman's Auxiliary to the Kerr-Kendall-Gillespie-Bandera Counties Medical Society submits the following report:

The present membership is 35, with an average attendance of 20 members. All members are notified of meetings by the telephone committee. Nine meetings were held on the first Friday of the month in the homes of auxiliary members. Each was a combination social and business meeting.

The sum of $70 was sent to the State Treasurer for dues, and $15 was contributed to the Library Fund. Recently Mrs. Sam E. Thompson, Kerrville, donated $50 to the Past Presidents' Fund to be used to purchase rare books.

Publicity reports were sent to all local newspapers and to the TEXAS STATE JOURNAL OF MEDICINE by our secretary.

Kerr County sponsored the tuberculosis seal sale. Patch tests given 1,610 school children in Kerr County; 352 x-rays of food handlers were paid for by the tuberculosis association; and the mobile x-ray unit with a total of 3,359 x-rays made, was sponsored.

Total subscriptions to *Today's Health* magazine was 72. Nine were gifts to schools from our auxiliary and 12 were gifts to the country schools from individual doctors.

Nurse recruitment was stressed and the main project was establishing the student nurse loan fund. Two young women chosen by a selective board entered the Baptist Memorial Hospital School of Nursing in San Antonio in September, 1953. The loan provides the entire tuition and will become a gift if upon graduation the nurses return to their respective communities and practice their profession for two years.

The outstanding social affair was the President's Day tea given in the home of Mrs. Sam Thompson. We were honored to have as our guests the State President, Mrs. E. W. Coyle; Past State President, Mrs. Frank Haggard; and council woman of District 5, Mrs. John L. Pridgen, all of San Antonio.

The end of our auxiliary year will be marked by an outdoor meeting and barbecue supper in June honoring the doctors of the four counties.

MRS. L. A. FELLER, Fredericksburg.

Lamar County

Our year opened auspiciously with the visit of the State President, Mrs. E. W. Coyle, San Antonio, for our first meeting in October. Her suggestions were helpful and timely, and her enthusiasm was contagious.

During the summer, eight of our members assisted with the registration of the mass chest x-ray in Lamar County. We also started plans for cooperating with the Lamar County Medical Society on a medical exhibit for the Lamar County Fair. In October, the exhibit was obtained through the AMA and was visited by 10,176 people. We felt it was especially worthwhile, because it reached many rural residents who ordinarily have little opportunity to see what modern medicine is accomplishing.

Our monthly meetings, held in the homes of our various members, have been three-fold in purpose. We have tried to combine business and education with a social hour.

In November, Dr. Donald Lewis, Paris physician and company surgeon for the Babcock-Wilcox plant in Paris, spoke on "Industrial Medicine in our Community."

In December, the Lamar County Medical Society gave its annual dinner party honoring the medical auxiliary at the Paris Golf Club. We expressed our appreciation by pinning a red carnation on each doctor that night.

At our March meeting Mrs. Perry Booth, counselor at Paris High School, discussed "The Guidance Program as an Aid to Mental Hygiene."

In April, Dr. W. W. Fitzpatrick, Paris physician who has been interested for many years in the health and adjustment problems of older people, will speak on geriatrics.

Under the leadership of Mrs. Malcolm Johnson, nurse recruitment chairman, two Future Nurses Clubs were formed in the Lamar County Medical District—one at Paris High School and one in Cooper. The auxiliary furnished refreshments for the club meetings at Paris High, and served tea for the joint meetings of the Paris and Cooper clubs. About sixty-four girls were contacted during the year. In April, a representative from St. Paul's Hospital in Dallas is coming to talk to the clubs, and in May the senior girls are to be taken to Dallas to see the nurses' training program at some of the Dallas hospitals.

Our auxiliary consists of 23 active members, 6 associate members, and 5 honorary members. Our group had their yearly physical examinations and reported that a representative number of their husbands, children, and servants had been examined as well. We contributed to the AMEF through gifts put in a "Pot of Gold" at each meeting.

Our members have been active in various civic organizations. One of our members, Mrs. O. W. Robinson of Paris, is district director of the Texas Division, American Cancer Society, and another, Mrs. W. W. Fitzpatrick, is co-chairman of the service committee of that organization. Our auxiliary has voted to sponsor a loan closet for the local cancer society and has already secured two wheelchairs.

We have contributed to the Auxiliary Memorial Library and Student Loan Funds, and have turned in fifteen subscriptions to *Today's Health.*

MRS. GEORGE S. WOODFIN, Paris.

Liberty-Chambers Counties

We have had our usual busy, informative year. Our monthly programs have consisted of monthly reports of pending federal legislation with special reports and discussions for self-education on such topics as the American Medical Education Foundation, which resulted in the first 100 per cent contribution reported in the state; mental health; public service as concerns the medical auxiliary; civil defense preparation in Texas; and polio facts relevant to our community.

Our special projects were as follows: *Bulletin* subscription 100 per cent; contribution of $2 per member to the Library, Student Loan, and Memorial Funds; a $5 contribution to the local tuberculosis seal drive; a luncheon for the State President; a Christmas luncheon for our auxiliary; Doctor's Day observance in the form of a supper for the doctors and their families; a public relations tea with a guest list of 500 entertained with a book review; and the showing of nursing film, "Keepers of The Lamp," to five of our county high schools.

In addition to our scheduled program our members are active participants in the local PTA, the numerous charity-fund drives; Boy and Girl Scouting; and the Red Cross blood drives; and we have members who serve on the various boards of the cancer, crippled children, muscular dystrophy, and similar foundations.

Our auxiliary includes two counties, and of our 14 members only 12 are able to participate actively in our yearly program.

MRS. O. W. HARRIS, Liberty.

Lubbock-Crosby Counties

We feel proud of the work of our auxiliary this year, although our total accomplishments will not be reflected in our statistical reports. It has been largely in a change of emphasis and in reorganization of responsibilities, and we feel that these changes will certainly improve and extend the influence of our auxiliary within the communities of the Lubbock-Crosby area.

We began by formation of an executive committee, and our business sessions at our luncheons have been more pointed and shortened by the executive committee having specific recommendations to present for consideration.

Some of the innovations have included the use of permanent and legible name tags worn at each luncheon. We found this helpful since our membership is largely new. Our membership chairman, Mrs. A. G. Barsh, has used double postcards to notify the membership and to make reservations for each luncheon instead of telephoning. This is not only time-saving but more effective in reaching out-of-town doctors' wives and those not easily accessible by phone, such as members at Reese Air Force Base. We believe this is the reason for our increased attendance from these groups as well as the Veterans Administration doctors' wives.

We have increased the number of our committee chairmen this year. Our geriatrics committee, Mrs. C. E. Payne, chairman, was new and did fine work in setting up a plan of visitation by teams of two doctors' wives to the Garrett Convalescent Home. Members visited, gave small gifts, ran errands, and invited some of the elderly people to dinner in their homes. We also instituted a "Project Finding Committee" to consider a permanent project for our auxiliary. We have found that many of the proposed projects for auxiliaries are already being done capably by other groups in our community. In the field of nurse recruitment, for example, the Lubbock Memorial Hospital Auxiliary which includes lay women has been active. So we have been considering several possibilities where we could make a real contribution without overlapping.

We also have had an active constitution committee which has written a new constitution and by-laws, and we are waiting to adopt it until the new state constitution is passed.

We have had a more concerted effort in public relations, having discovered to our sadness that the newspaper was not even aware we had monthly meetings. We asked the editor of the Woman's Page to speak to us and have seen to it that she had adequate news of our activities. We had an attractive yearbook this year.

We were privileged to have our county medical society president, Dr. Wallace Hess, speak to us on the work of our medical society. Because we discovered we were really uninformed about its work, we now have in our meetings a liaison member of the society's executive committee, Dr. Marie Shaw, so we can know how we can best cooperate.

This year we also have initiated a requirement for our officers and committee chairmen to submit written reports at the end of the year for our auxiliary archives. We are asking this year that they also include a list and time schedule of their duties and suggestions for more effective work of their committees. We are hoping to compile from these a handbook for our future officers.

This year for the first time we have included a president-elect in our slate of officers. We also had an informative program at each monthly meeting; and also for the first time, we contributed $100 to the American Medical Education Foundation and $25 each to the Memorial, Library, and Student Loan Funds. In January the county society and auxiliary together had a dinner and dance—a purely social affair—which we felt was a huge success, and we hope we have thereby begun a yearly tradition.

MRS. WILLIAM C. SMITH, Lubbock, First Vice-President.

McLennan County

Our main need this year was to get the interest of the members and increase our attendance. The program committee, with this in mind, decided on varied programs, some of which were sure to interest everyone.

The first meeting was a brief business meeting followed by a style show with auxiliary members as models. Guests were invited and our year began with a large meeting and good public relations. Other meetings were on: civil defense, gardening, a luncheon honoring the State President, mental health and a book review given by an auxiliary member, Mrs. C. G. Shellenberger.

Before anyone could catch their breath after the first meeting, we began work on a booth at the Heart-O-Texas Fair. The medical society gave us the space and we were to do the work. Never having done anything like this before we "rushed in where angels fear to tread" and started gathering things together. We did not hesitate to ask anyone for anything and much to our surprise everyone responded with a great deal of interest. With the exception of a very few who were physically unable, every member helped. Posters were made to be used as a backdrop in the booth, members were signed up to man the booth for a week, wires and letters were sent, and material was sorted and worked into the overall plan. The theme was mainly that of the free services offered the people of McLennan County by the medical society. In addition to the posters on the main theme, we used an exhibit from the AMA called "Food Facts and Fallacies," a showcase of old and new instruments, and, as a drawing attraction, we borrowed a skeleton

from Medical Plastics Laboratory in Gatesville. The skeleton proved to be the best eye-catcher we could have found because it attracted children as well as adults and brought forth numerous questions. To help man the booth the schools of nursing sent students in uniform and literature for distribution. The booth received excellent publicity and, I believe, gave the members a feeling of having done something along the line of public relations to help the doctors.

This year we have continued to sell subscriptions to *Today's Health*. At the time of this report we have credit for 1,921 copies. Some of these, as they were last year, are to schools where they are used in the health classes and others to individuals.

To help the tuberculosis association, the auxiliary gave one day to register people for the free x-rays. Then at Christmas we furnished the dinner for the patients at the tuberculosis hospital.

We have not dealt too much with nurse recruitment. However we do have a small fund set up to be used for small personal loans by students of both local schools.

This has been a full year and I feel that by each member having done some job, a new or renewed interest has been created. Our attendance, though still not what it should be, has increased. At least we can say that every member has done some one thing during the year.

MRS. ELDON B. FINE, Waco.

Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties

The Woman's Auxiliary to the Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Medical Society had 22 members last year and now has 23, 4 of whom are new members, and 3 associate members.

The second Friday of March, June, September, and December are our meeting dates. An average of 6 to 10 members are present usually.

In September Mrs. A. P. Utterback, Brackettville, president, spoke on mental health and socialized medicine. Mrs. Julia Dorian spoke on public relations in December. At the same meeting officers were elected and a discussion of the project was held. A polio film was shown and "Touring a Ceramic Shop" were on the program at one meeting. A social meeting with the doctors is held each meeting date.

MRS. A. P. UTTERBACK, Brackettville.

Nacogdoches County

The Nacogdoches County Medical Auxiliary has 16 active members. Nine meetings are held annually in the homes of the members, with an average attendance of 12 members.

The AAPS essay contest was sponsored locally by the Nacogdoches Medical Society. Our essay chairman placed package libraries in approximately eleven high schools. Four schools participated, turning in sixteen essays.

Our annual Silver Tea was held in November and the money contributed was used to complete payment on an air-conditioner placed in the doctors' obstetrics waiting room at City Memorial Hospital.

We have been active in selling *Today's Health* and fourteen subscriptions have been sold to date. We contributed to the Library Student Loan and Memorial Funds, and the Junior Chamber of Commerce's Christmas Cheer Fund. We have worked with the Red Cross and March of Dimes drive.

Activity has continued concerning legislative matters; thirty-six cards have been mailed to legislators.

We observe Doctor's Day on May 15 by giving a boutonniere to each doctor and placing floral sprays at the cemeteries.

MRS. EUGENE S. ROGERS, Nacogdoches,
Secretary-Treasurer.

Navarro County

Our programs have emphasized different phases of auxiliary work. We had three different programs with out-of-town participants. Mrs. E. W. Coyle, San Antonio, State Auxiliary President, and Mrs. Milton Spark, Waco, District 12 council woman, visited in October. Mrs. W. F. Armstrong, Fort Worth AMEF Committee member, reviewed *Medicine and Magic in Childbirth* for us. Dr. Robert Kimbro, Cleburne, chairman of the Board of Trustees of the Texas Medical Association, was our speaker for our Doctors' Day banquet.

Our chief achievement in public relations was in sponsoring the Navarro County Heart Fund Drive. We not only collected over $600 for the heart drive, but also distributed much instructive literature on heart disease. Our benefit coffees stimulated outside interest in our auxiliary. We showed the heart film "Be Your Age" to our own group and to a men's luncheon club. We remembered each aged person in our Twilight Home with a gaily wrapped Christmas gift.

Radio station KAND has continued its weekly health broadcasts from programs of the American Medical Association. Our members assumed a large portion of the clerical work connected with the chest survey done by the mobile x-ray unit. We were well represented by members active in Red Cross blood collection, the polio drive, PTA, and civil defense.

Our membership consists of all eligible wives in this county and numbers 25. Our average attendance at our monthly meetings is 16. We are 100 per cent subscribers to *Today's Health* and have a total subscription list of 62. Nine members take the *Bulletin*.

Our contributions to the Auxiliary Benevolent Funds are the following: Library, $16; Student Loan, $5; AMEF, $5; and Memorial, $284.40.

We had only one school to have entries in the AAPS essay contest. Copies of our yearbook and history were mailed to the State Historian. We plan to bring our scrapbook to the state meeting.

Our report on physical examinations in our families shows much progress over last year's. Our legislative chairman kept us informed on bills in Congress, and we wrote our legislators regarding the Bricker Amendment. The only work on nurse recruitment has been to assist the health nurse in showing the film "Keepers of the Lamp" to the high schools in the county.

MRS. PAUL H. MITCHELL, Corsicana.

Nolan-Fisher-Mitchell Counties

The Woman's Auxiliary to the Nolan-Fisher-Mitchell Counties Medical Society meet twice a year for a social meeting. All members participate in community activities, support all health work and drives, work in clubs, PTA, and other organizations. The Public Health unit distributes information, shows films, and the like.

MRS. T. D. YOUNG, Sweetwater.

Nueces County

To give an annual report of the activities of the Woman's Auxiliary to the Nueces County Medical Society for the year 1953-1954, it seems appropriate to begin with the ob-

ject of our organization: "The object of this organization shall be to bring into closer fellowship the families of members of the Nueces County Medical Society and to engage in any educational, philanthropic and social work upon which the body may decide." In pursuance of the first part of this object, the auxiliary has held five social meetings: a dinner which celebrated Doctor's Day, a covered dish luncheon, a picnic to which the doctors were invited, a morning coffee honoring the new members, and a Christmas open house which was shared by the doctors. There were also four luncheon meetings with the following programs: a movie and lecture on the American Cancer Society, speakers from the four local hospital auxiliaries, a regular business meeting, and a final meeting presenting the annual reports and installation of the new officers. In pursuance of the second part of our object, our auxiliary contributed the financial means for the completion of a three years education in nurse's training for one student and further paid the expenses for her graduation from the St. Joseph's Hospital in Fort Worth. The auxiliary was represented at a meeting of the National Tuberculosis Association by Mrs. George Schuster and Mrs. Rex House. Under the capable chairmanship of Mrs. J. V. Blair and Mrs. W. C. Triplett, the auxiliary furnished forty volunteers for registration for the tuberculosis x-ray program.

The auxiliary contributed $5 each to the Student Loan, Library, and Memorial Funds, and $20 to the American Medical Education Foundation.

There are 129 members, with only 3 wives of members of the Nueces County Society not members of the auxiliary.

Seventy-one subscriptions of *Today's Health* were purchased by auxiliary members. Many of these subscriptions were sent to libraries, schools, beauty shops, and hospitals.

The auxiliary was represented at the 1953 State Auxiliary Convention in Houston by Mrs. Harold E. Griffin and by our Sixth District council woman, Mrs. June Yates. The president and Mrs. Yates attended the Executive Board meeting of the State Auxiliary held in Austin in September, 1953.

At the July meeting of the Fifth and Sixth Medical Districts, members aided the doctors by taking complete charge of the registration of all delegates. The Nueces County Auxiliary was hostess to those auxiliary members of Districts 5 and 6 present at a luncheon and style show at the Corpus Christi Country Club. At this meeting it was our privilege to hear a talk by the President of the State Auxiliary, Mrs. E. W. Coyle of San Antonio.

The most outstanding work done by our auxiliary in the past year has been in the field of public relations. Since it was the feeling of the president and the executive board that the auxiliary can best help the doctors by creating good public relations in the community, a program was set up whereby fifty outstanding men and women who are leaders in Corpus Christi were invited to attend clinics where the doctors give their services in an effort to promote good health and thereby improve conditions in our city. Mrs. L. W. O. Janssen, as chairman of the public relations committee, assisted by Mrs. James Sharp, Mrs. King Gill, and Mrs. A. J. Ashmore formulated this program, and auxiliary members conducted lay people to the clinics. There they were able to see the organization of the clinics, the social service departments, the nursing care, the services of volunteers, and the doctors who were giving their valuable time and services to benefit the community welfare. The program was extended over a period of a week, with visitors going to the Driscoll Foundation Hospital, Crippled Children's Hospital, and Memorial Hospital. After the people were conducted through the clinics they were invited for coffee in the morning and tea in the afternoon at the home of some member of the auxiliary. This social period afterwards allowed an exchange of ideas between the visitors and the auxiliary members. It was felt this educational program was successful because the people who participated showed intense interest in the clinics and expressed amazement at how much service the doctors give to improve the community.

I wish to thank all the members of the executive board and the chairmen of all committees for their capable assistance which has made serving as president of this organization a pleasure.

MRS. SAM POWELL, Corpus Christi.

Orange County

The Woman's Auxiliary of the Orange County Medical Society has a roster of 20 paid members and 5 honorary members. The auxiliary's main project for the year was to sponsor a spastic center in connection with the polio therapeutic ward at Orange City Hospital. We are working to raise money for more equipment and also are encouraging parents with spastic children to show that these children can be made into useful citizens.

The auxiliary has several members active in the League of Women Voters and Mrs. O. C. Seastrunk is president of the Orange Women's Club. The Women's Club chose for their main theme "Mental Health," and two of our doctors have been guest speakers. The auxiliary has also had a mental health program this year.

The auxiliary and medical society jointly sponsored the AAPS essay contest, giving three prizes of $25, $15, and $10.

We furnished *Today's Health* subscriptions to each of the schools and these were greatly appreciated.

MRS. DAVID BENNETT, Orange.

Pecos-Jeff Davis-Presidio-Brewster Counties

The Auxiliary had charge of all preparations and management of the blood mobile when it was in Fort Stockton August 5, 1953. We were notified that of the towns having the blood mobile in the town for only one day, we ranked third in the state for having the most donors. This was our year's project.

The members of our auxiliary donated $10 to be sent to the State Memorial Fund.

All members as individuals give to needy families during the year. We do not have the Community Chest here. Heart, cancer, polio, and other drives are donated to on an individual basis. Members of the auxiliary help on each of these drives.

Mrs. John W. Pate of Sanderson is financing the education of one girl in nurse training school. We asked Mrs. Charles Honaker, registered nurse and supervisor at Memorial Hospital, Fort Stockton, to talk to the girls in an assembly at school on nurses' training. The doctors' wives have a party each Christmas for the nurses of Memorial Hospital.

We have had twelve members of our auxiliary, or members of their families, to have complete physical examinations.

In December we were hostesses to the doctors' wives who attended with their husbands the medical seminar in Fort Stockton. We arranged a luncheon, style show, and bridge party for the ladies during the day, and a cocktail party and dinner for the doctors and their wives that night.

We have 13 paid members, but, I am sorry to say, we have only four active members. Therefore, it is difficult to achieve much. Our main goal is to stay organized! With

so few active members we only have two offices, president, Mrs. Charles E. Oswalt, Jr., and secretary, Mrs. George Hoffman, both of Fort Stockton.

MRS. CHARLES E. OSWALT, JR., Fort Stockton.

Polk-San Jacinto Counties

The Woman's Auxiliary to the Polk-San Jacinto Counties Medical Society has 7 members. The members work as individuals in civic affairs.

MRS. T. L. GARDNER, Livingston.

Potter County

There were two outstanding results in the activities of the Woman's Auxiliary to the Potter County Medical Society: (1) Through complete cooperation with the county medical society, we were able to achieve 100 per cent paid membership—including new members and formerly delinquent members. This was accomplished by the collection of our dues from the doctors at the time they paid their society dues. (2) The mental health play "Scattered Showers" was performed by our own members at the regular March meeting of the auxiliary. It elicited enthusiastic response and resulted in numerous invitations for performance before lay groups, including a women's circle meeting at the First Presbyterian Church, a child study club, a regular meeting of the local mental health society, and an elementary school PTA meeting.

We participated in

1. sponsoring the AAPS essay contest in four high schools and receiving 35 entries, and awarding prizes in the amount of $200, the first prize being $100;

2. promoting a considerable increase in new subscriptions of *Today's Health* including gift subscriptions to three junior high school libraries;

3. observing Doctor's Day by decorating the dinner tables at the regular March county medical society meeting with flowers, a physician's bag of one of the first Panhandle practitioners, and also numerous amusing cartoons and anecdotes at individual places—producing a pleasant, informal, jocular atmosphere;

4. holding a Christmas tea in a private home as a strictly social function to which wives of doctors at the Veterans Administration hospital and the Amarillo Air Force Base and dentists' wives were invited as one of our public relations activities;

5. contributing to the Library, Memorial, and Student Loan Funds; and

6. giving, on an individual basis, numerous hours of volunteer service in community service.

Other programs on regular meeting days included talks on: juvenile delinquency, given by the former district attorney; religion and health, given by a specially qualified pastor; and life in Germany, given by a young lady with the Special Services Division of the United States Air Force.

This auxiliary was hostess auxiliary to the Panhandle District Meeting in April. A luncheon was held in the Amarillo Country Club, with excellent attendance and representation from many areas of District 3. Our State President, Mrs. E. W. Coyle, was an honored guest and the principal speaker. We feel that this was a most successful meeting because of her informative speech and the excellent response in attendance.

MRS. WILBERT E. SCOTT, Amarillo.

Red River County

The Woman's Auxiliary to the Red River County Medical Society was 4 members. Films and speakers were furnished for PTA meetings. The meetings are held on a social basis but we discuss ways in which to help in civic affairs. Members worked in Red Cross, polio, tuberculosis, heart, cancer, and crippled children drives and in church work.

MRS. J. L. WRIGHT, Clarksville.

Reeves-Ward-Winkler-Loving-Hudspeth-Culberson Counties

Our meetings are held in conjunction with those of the medical society on the third Thursday of each month. Members from Kermit, Monahans, and Pecos alternate being hosts for the meetings.

The highlight of this year's activity occurred on February 12, 1954, when the District 1 medical meeting was held in Pecos. We felt honored to have among our guests Mrs. George Turner of El Paso, National Auxiliary President-Elect, Mrs. E. W. Coyle of San Antonio, State Auxiliary President, and Mrs. Robert Thompson of El Paso, past State Auxiliary President. The business meeting was presided over by Mrs. Harold Lindley of Pecos, District 1 council woman who, in turn, introduced the main speaker, Mrs. Coyle. Much was learned of Auxiliary objectives and achievements from Mrs. Coyle and a congenial atmosphere was enjoyed by the entire group. Members from each town in our auxiliary did much to make this meeting a success.

"Angry Boy" was shown to junior and senior high school PTA groups as a project on mental health. A tea and film on nursing as a career are planned for interested high school girls on April 22. Members also have contributed much time and effort toward various community projects, including the Community Chest drive.

MRS. H. W. MARTIN, Pecos.

Runnels County

The Runnels County Medical Auxiliary has a total of 6 members. We have been inactive as a group. New officers are appointed every two years, election being in the odd years.

MRS. LLOYD DOWNING, Ballinger.

Rusk-Panola Counties

The Rusk-Panola Counties Medical Auxiliary has an enrollment of 18 active members who meet every third Tuesday of each month with their husbands for dinner either in Henderson or Carthage. After dinner the doctors withdraw for their meeting and the ladies to theirs.

Clearly the two outstanding programs this year which the auxiliary has presented have been the meeting for civil defense and the work done on the AAPS essay contests.

The program on civil defense was held at the first meeting in September, at which time two directors of civil defense from Smith County and the county judge of Rusk County were asked to be the guests of both the doctors and their wives. The film from the State Medical Library, "They Also Serve," was shown. Following the showing of the film, the guests were asked to speak. These talks were so stimulating that further work on civil defense was accomplished by setting up a program for defense by the county judge assisted by members of the medical auxiliary. Outstanding men throughout the county were appointed to fill pertinent places, and once a month meetings were held at the Rusk County Courthouse.

A great deal of interest has been shown in Rusk County in the fight against socialized medicine, and this year twenty-nine students of Henderson High School entered the essay contest. The local doctors contributed $100 toward the

prizes, and after the judges had selected the three outstanding essays, an auditorium program was arranged by the superintendent of schools, Mr. Earl Adams. At this time, a member of the press was present and the local radio cooperated with a direct broadcast. Pertinent parts of the essays were read by the contestants and the prizes awarded. The essays will be published in full by the local paper.

The superintendent of the local hospital is cooperating with a program of nurse recruitment and in the last summer enlisted the interest of fifteen young girls through the sponsorship of the superintendent of the senior department of the First Methodist Church of Henderson. The girls were given such work to do in departments of the hospital as wheeling patients outside, reading to children and elderly patients, taking care of the flowers, helping in the kitchen, carrying trays, and the like. This program has been the means of creating much interest in nursing.

MRS. JESSE E. ROSS, Henderson.

San Patricio-Aransas-Refugio Counties

The Woman's Auxiliary to the San Patricio-Aransas-Refugio Counties Medical Society has increased its membership from 5 members-at-large to 20 active members. We are minus 1 member of having 100 per cent. Subscription credits for twelve *Bulletins* and eight *Today's Health* have been gained.

Five students have entered nurses' training schools and four have entered vocational nurses schools. The highlight of our year was a visit on March 9 from Mrs. E. W. Coyle, State President, with the Kleberg-Kenedy Auxiliary as our guests.

MRS. J. L. PIERCE, JR., Sinton.

Smith County

Since its inception, the Woman's Auxiliary to the Smith County Medical Society has placed particular emphasis on fostering good fellowship among its members and their husbands. Along with "internal friendliness," public relations also is stressed. With these two objectives in mind, our opening meeting, an evening dinner meeting attended by our husbands and featuring Mrs. E. W. Coyle of San Antonio, State President, as special honor guest and speaker, and our April guest day tea, to which each auxiliary member brings several lay guests, were planned. Knowing each other, we learn that it is indeed only "the little things that create differences, that in the big things of life we are as one."

Feeling a strong need to familiarize ourselves with our state institutions, we based our programs for the year on "A Survey of State Institutions." Talks provided by well-qualified speakers each were followed by a lively question and answer period, revealing a strong desire on the part of our membership to be informed. We had one unscheduled called meeting at our nurses home, when it seemed that there was an urgent need for our women to learn much about the progress of our infant Texas Eastern School of Nursing, now in its third year. All our meetings have been well attended throughout the year. We have had a thirty-minute social period at each meeting, further advancing our objective of knowing each other.

We have attempted to give thought and attention to the many sober objectives of our parent organization. We have again sponsored the AAPS essay contest, offering the same prizes as last year. We are sponsoring a student nurse through our nurses loan fund. Our standing committee chairmen have performed their duties well. We also this year revised our constitution and by-laws which were in its original form of 1934 when our Auxiliary was chartered. Many of our members are active in a wide range of civic and community affairs and projects, and we are proud of their eagerness to accept responsibility. My year as president has been a satisfying and rewarding one.

Incoming officers of our auxiliary are: president, Mrs. E. H. Caldwell; vice-president, Mrs. R. E. G. Baldwin; recording secretary, Mrs. William Rowe; treasurer, Mrs. Albert McCulloh; and historian, Mrs. C. E. Willingham.

MRS. JESSE GOLDFEDER, Tyler.

Tarrant County

The Tarrant County Auxiliary accepted the State President's challenge in making her theme for the year, "Knowledge, Judgment and Action in Health Leadership," our guiding light for the year's work. We decided to cooperate in all lines of state endeavor, putting special emphasis on bettering public relations through community service and on the recruiting of nurses.

Our programs have been varied in an attempt to appeal to all interests and encourage attendance at the meetings. Some have been educational, some entertaining. For entertainment there have been a book review, *Forty Odd* by Mary Bard, and a travelogue, "Island Hopping in the Caribbean." To appeal to those who enjoy working with their hands we had programs at Christmastime on "Candle Making" and "Christmas Decorations," and for our May program we have planned "Corsage Making" with each member participating by working along with the demonstration. We had Dr. Mary Karriker, director of the Crippled Children's Center, speak on "Speech Therapy." We had two guest meetings, one at Christmas and a style show luncheon in March.

A summer series of television shows, "Help Yourself to Health," presented by the public relations committee, was sponsored by the auxiliary. These thirteen weekly shows gave information to housewives and mothers on recognizing danger signals, what to do until the doctor comes, first aid, and baby care. Graduate nurse members of our group demonstrated procedures as they were discussed. The medical society cooperated by providing doctors for discussions on polio and the services provided by the medical society. One program was a style show of uniforms worn in several fields of nursing and was given in the interest of nurse recruitment.

The public relations committee provided the program at our regular meeting in April and presented a talk by the director of the local Red Cross chapter entitled "Your Public Relations Are Showing," a discussion of individual public relations.

The nurse recruiting committee has worked with a local camera club in producing a film in sound and color to be used in interesting girls in the nursing profession. Hospital auxiliaries, the Red Cross, the medical society, and the District Graduate Nurses' Association provided the funds to be used and our committee furnished the technical information, arranged for locations for taking the pictures, and supervised the complete operation.

One full scholarship has been provided for a nursing student this year by the auxiliary. A benefit variety show was given by the doctors and wives to provide money for the scholarship fund in order that another student may begin training in August. About fifty of our group participated in the show. We also provided clothing for two student nurses receiving scholarship aid from other organizations.

The social service committee has worked with the Foun-

dation for Visually Handicapped Children, providing clerical help and the money for a record player to be used in the work with blind children.

Publicity, which has been one of our problems in the past, has been excellent this year. We have provided much material to the Woman's Page editors of the newspapers by sending our monthly newsletter to them. Beginning with a full page in the spring on the community service work done by the auxiliary, frequent articles have been in print about the families and activities of individual doctors as well as the organization as a whole.

The legislative committee has reported each month, either at the regular meeting or in the newsletter, on items of interest in government on the local and national level. As a result of interest so stimulated, the Tarrant County group had reported 976 communications with congressmen and senators and 52 personal calls on them. A resolution was passed in favor of the Bricker Amendment and our representatives so notified. Payment of poll taxes was stressed.

The mental health chairman reported on the result of the county survey on mental health conditions and means for taking care of problems resulting from these illnesses.

To further our aim of closer fellowship, the auxiliary has continued the custom of small coke parties in each district of the city before the first meeting in the fall. Special efforts were made to see that the previous year's new members attended in order that old and new members might become acquainted before the general meeting. We also have sent out a monthly newsletter containing announcements, committee reports, and personal items so that all our members will be informed on the activities of the group.

Doctor's Day was observed with a dinner given by the medical society and the presentation of the "Gold Headed Cane" Award to the outstanding local physician of the year.

Two parties were given by the auxiliary—a masquerade dance and breakfast at Halloween and an informal supper at the Boat Club in the spring. Each committee was entertained by its chairman during the year. The variety show was staged cabaret style and dancing was enjoyed after the show.

A full and interesting year has been enjoyed by all our members. We have had 34 new members. One hundred and eighty-five of our members have served on committees. One of the nurse administrators summed it up very well when she commented, "You really have an active medical auxiliary here, don't you?"

MRS. W. N. JENKINS, Fort Worth.

Taylor-Jones Counties

The Woman's Auxiliary to the Taylor-Jones Counties Medical Society began its work in September with a coke party for senior high school girls in the interest of nurse recruitment.

In November it was our pleasure to have our State President, Mrs. E. W. Coyle, with us. She gave us a stimulating talk on the plans for the year's work.

The Christmas party was a dinner-dance entertaining our doctor-husbands. The auxiliary voted to take out membership in the mental health society. Also it voted to contribute to the American Medical Education Foundation, members making individual contributions. Twenty-five dollars was given to the student nurses at Hendrick Hospital toward improvement of their recreation room.

Subscriptions were taken to *Today's Health* magazine and the *Bulletin*.

The AAPS essay contest was sponsored, the chairman having contacted each of the sixteen high schools in Taylor and Jones Counties.

Hostesses were supplied for the mobile x-ray program of the Texas Tuberculosis Association while it was in our city. Several members devote regular time to the rehabilitation and education program for cerebral palsy and crippled children at the Taylor County Crippled Children's Center.

Health talks on cancer were given by members. They also participated on mental health panels.

Our March meeting was devoted to public relations and legislation. Mr. Robert Kennedy, public relations representative for our local utilities company, gave the auxiliary an invigorating talk on how, in her manner and speech, the doctor's wife is a walking example of public relations in her community.

Doctor's Day is planned for May.

MRS. SOL B. ESTES, Abilene.

Tom Green-Eight County

The Tom Green-Eight County Medical Auxiliary, with 48 members, has tried to bring individual service into our everyday lives. In May, we will have had nine meetings: 4 business and social, 3 of varied social themes, 1 joint meeting with the county medical society, and 1 strictly social honoring husbands.

We have followed a policy of being informed on local activities, both civic and political affairs, and having a working knowledge of state and national problems.

Our members are active in various activities locally, having given approximately 3,000 hours to volunteer services including Community Chest drive, cancer drive, baby clinic, handicapped children clinic, transportation for Young Women Service League clinic, tuberculosis bungle sale, United Council of Church Women, and League of Women Voters.

Of special note is the work of the welfare committee in helping to plan for improved conditions for inmates of the city jail and providing Christmas for residents of a local rest home for the aged.

A course for instructors in home nursing is being planned with four of our members enrolled.

Members serving on various executive boards report important activities to our organization, and our time and efforts are employed in helping further their well being. We have representation on the following boards: Community Council, health and medical section of Community Council; Family Service, parent-teacher, heart, cancer, infantile paralysis, and tuberculosis associations; Tom Green County Baby Clinic; handicapped children's clinic; San Angelo Day Nurseries; council of churchwomen; Episcopal Guild; symphony association; county library; City Federation of Women's Clubs; and Y Service League.

We have attempted to continue to improve our public relations by working with others on the aforementioned activities as well as having two meetings for visitors, one specifically honoring members of the Federated Clubs.

We are sponsoring the AAPS essay contest for the first time.

A full scholarship has been given one student nurse as a gift; and a nurse recruitment campaign is to be carried out in the high schools this spring.

MRS. WILLIAM LACEY SMITH, San Angelo.

Travis County

The Woman's Auxiliary to the Travis County Medical Society shows an increase of 1 member over last year, making a membership of 159. Sixteen of this number, however, are new members.

With the growth of the auxiliary, the personnel file was renewed this year. Keeping in mind the objectives of the

auxiliary and drawing from the personnel file and material mailed us, the committees were set up and program planning started. Many program planning hours in early summer by the chairman brought great dividends and a fruitful year through much interest in programs and good attendance. Seven combination business and social meetings were held and one social.

Our guest speakers were ten in number and included Mr. C. G. Fairchild, assistant director, Vocational Rehabilitation Division, Texas Education Agency; Mrs. E. W. Coyle, State Auxiliary President; Miss Elizabeth King, nursing arts instructor at Brackenridge Hospital in Austin; and Miss Ruby Neubauer, authority on vocational nursing.

The most outstanding program was our public relations program. An interesting talk on vocational rehabilitation was given. Also, our members were interested to hear representatives from the hospital auxiliaries tell of their work and the membership. Mrs. Fred C. Norris of the YWCA was given speaking time on this program because last year a nursing scholarship was set up through this group, and, too, because it was celebrating its centennial year.

All members and guests enjoyed the program on "Talents and Hobbies." Painting and sculpturing were exhibited. One member told that she took up gardening on advice of her doctor.

Speakers on all programs were limited to twenty minutes including a question and answer period. Several were given only two to three minutes. We did this to maintain the interest of the membership and to keep the length of meetings within one and one and a half hours. Committee planning was done over cups of coffee, thereby allowing us to get better acquainted. Approximately ten coffees were held, including one for the district auxiliary women.

Outstanding is the work of our civil defense committee. All work offered has been completed. Ten members hold first aid cards and ten others took the course but chose not to complete notebook requirements. A second class is being held. A film "The Waking Point" was shown and cards showing the qualifications of members have been completed and placed on file at civil defense headquarters.

Our *Today's Health* chairman proudly reported an increase of 50 subscriptions. Twelve schools, libraries and organizations were given subscriptions. We will use these powerful words "the only authentic health magazine" and work toward placing this much improved *Today's Health* in the hands of the public, where it can play its part in health and public relations.

The committee on nurse recruitment reports six possible recruits through personal contacts. Some on this committee will continue to work through the summer since recruits enter training in July and September.

We again sponsored the AAPS essay contest with $80 in prizes. The auxiliary staffed the blood bank every Thursday throughout the year and cooperated with the diabetic detection tests. It was voted to sponsor the organization of the St. David's Hospital Auxiliary, and we participated in the mental health survey as requested by the State Mental Health Committee. Physical examinations totaled 248. Our members chose not to go into projects with prolonged work because a majority are active in civic affairs, often as leaders and many times over as committee members.

Publicity was excellent. News of meetings usually appeared twice before each meeting and once after. A full front page of photographs of busy doctors' wives was given the auxiliary in the Sunday Society Section.

The auxiliary has made substantial contributions to United Fund, Child and Family Service, Planned Parenthood, AMEF, Library Fund, and Student Loan Fund.

We continue giving $120 annually in monthly checks to a doctor's widow who is in a nursing home. One member stated she regularly visits the aged. This year baskets of fruit were presented to homes for the aged at Christmas. We are compiling information for a doctor's daughter, aged 80, who wishes later to enter a home for the aged. One member is attending meetings on establishing a loan closet. We have a member who is co-author of a textbook on safety entitled *Live and Help Live*. The book depicts healthy living and safety in homes.

The death of Mrs. Dalton (Margaret) Richardson on February 18, 1954, was a great loss to the auxiliary.

This auxiliary year has been fruitful in the objective of promoting friendship among doctors' families. We contribute its success to all presidents and committees who served before us and to the cooperation and enthusiasm as shown by all members. Also most appreciated are all the materials now available to us.

MRS. CHARLES B. DILDY, Austin.

Upshur County

The Woman's Auxiliary to the Upshur County Medical Society has 4 members, the same as last year. One meeting, social in nature, has been held. Two personal communications were sent to legislators. Members have participated in the civil defense program which is under way in the area.

All four members are active in church, school, and civic affairs. We promoted the County Health Unit. Contributions and services were given to Red Cross and polio, and three members assist in the crippled children's clinic. Members and their families have been urged to have yearly physical examinations. Members read the Auxiliary Section in the JOURNAL and the *News Letter*.

MRS. J. L. FENLAW, Gilmer.

Victoria-Calhoun-Goliad Counties

The year's work began with a luncheon for District 8 held in El Campo, with our State President, Mrs. E. W. Coyle, as guest speaker. This auxiliary was represented by two of its members from Port Lavaca, who brought a summary of Mrs. Coyle's message to our organization at its next meeting.

The suggestion brought from this meeting for methods of raising funds for the American Medical Education Foundation Fund was accepted by our members to be carried out on a volunteer basis.

The auxiliary has placed much emphasis on legislative matters this year and brought as our guest speaker our State Legislative Chairman, Mrs. John K. Glen of Houston. She imparted much worth-while information and left the members feeling much more capable of doing their part toward carrying information along to others.

One program was devoted entirely to mental health, at which time a most informative and interesting lecture was given by Dr. George A. Constant, local psychiatrist.

On March 30, Doctor's Day, a carnation will be sent to each doctor in our district. The day will be celebrated by a dinner at a local hotel with all doctors and their wives attending. Our entertainment committee will select a speaker for the evening.

MRS. HEATON SMITH, Victoria.

Walker-Madison-Trinity Counties

The Woman's Auxiliary to the Walker-Madison-Trinity Counties Medical Society has a membership of 8 and has no regular meeting time. However, we have met three times with an average of 3 attending. Most of the doctors'

wives in the communities work on the health committees in PTA, hospital auxiliaries, American Legion Auxiliaries, and study clubs. They have also assisted with drives for funds and with the blood drives. The hospital auxiliary makes bandages for the M. S. Anderson Foundation. The members work in the teen-age clubs and helped with signs for safety near the schools.

MRS. SAM R. BARNES, Trinity.

Washington-Burleson Counties

The members of the Washington-Burleson Counties Medical Auxiliary feel we have had a good year. We have had 13 members, and we are proud of the good attendance at our meetings.

Since we are a small group we have had combined social and business meetings. Three times we have met at luncheons with our business transacted afterward.

In October at one of our luncheon meetings we had as our guests Mrs. Joe B. Foster and Mrs. Mark Latimer, State Auxiliary President-Elect, of Houston. Their friendly advice and counsel encouraged us greatly in our plans for a complete reorganization of our auxiliary. Our membership now follows more closely the pattern of the state and national auxiliary constitutions.

In November six of our members worked at the chest x-ray unit in our county. Others of our members gave unselfishly of their time to the Red Cross drive.

Election of our 1954-1955 officers was held at our January meeting and the installation will be held in April.

One of the highlights of our auxiliary year was that of being privileged to be hostesses to the Ninth District Auxiliary at its meeting held in Brenham in March. At this meeting the ladies and their husbands were entertained at a chicken barbecue at the farm of Dr. and Mrs. W. A. Knolle. In the afternoon a tea was given for the ladies at the home of Dr. and Mrs. C. E. Southern.

Our auxiliary year closes in May when we plan to have a picnic for our husbands.

MRS. G. V. PAZDRAL, Sommerville.

Webb-Zapata-Jim Hogg Counties

In this first report of the Webb-Zapata-Jim Hogg Counties Medical Auxiliary, I will endeavor to set down briefly a few of our accomplishments for the past year, 1953-1954.

Many of our first meetings were devoted to organization; that is, discussions on the time and place of meetings, dues, local policies, setting up of committees, and projects for the year.

Our regular December meeting was enjoyable. Following a brief business session, Miss Diana Lafon, a home economics major, gave a demonstration of various table and holiday arrangements for the Christmas season.

We were most grateful when the doctors invited us to be their guests for dinner at the December meeting of the medical society when Mr. N. C. Forrester, Austin, Executive Secretary of the Texas Medical Association, addressed the group on "Your State Medical Association and Auxiliary." His topic was most interesting and informative to our newly organized auxiliary, particularly.

The January luncheon meeting honoring Mrs. E. W. Coyle, our State President, proved to be quite the highlight of the year inasmuch as auxiliary itself is concerned for, at this meeting, with her much-needed assistance, we were able to adopt our local constitution, to vote to sponsor the dressing program for the local chapter of the American Cancer Society, and to crystallize the final plans for the AAPS essay contest which we were sponsoring for the medical society. It was indeed an honor to have had the privilege of a visit from a gracious lady and a well-informed auxiliary member.

Another not-to-be overlooked highlight was the barbecue given by the auxiliary honoring the essay contestants and announcing the winners. This was a delightfully informal affair at which the doctors and their wives showed their appreciation to the students of the five schools who participated in the contest.

From the social angle, we have been quite successful. Several lovely buffet suppers by individual doctors and their wives, at which the local dentists and their wives, and the army medical personnel for the Laredo Air Force Base were included as guests, were given.

With all of the aforementioned activities, we feel that probably the most outstanding meeting of the year, from the actual service standpoint, was that of March 2, when our group (including the dentists' wives and widows, who are forthcoming associate members for 1954-1955) engaged in making our first dressings for the cancer society. Our dressing chairman, Mrs. M. L. Fuller, has done a splendid piece of work in organizing the program. She has contacted the hotel managers and tourist court owners who will cooperate by donating their old sheets. Our particular part in sponsoring the dressings program is to supply the old linens and to volunteer our time to make the dressings. We are proud of this project since it is the first opportunity we have had to function publicly as a medical auxiliary, and, it is also the first time this program has been done for the cancer society in Laredo.

All in all, our first year has been a little difficult with getting organized, but with such a good start and this much accomplished, there is no telling what our capacity is, nor what the future holds in store for our group.

MRS. M. E. MALAKOFF, Laredo.

Wharton-Jackson-Matagorda-Fort Bend Counties

The Wharton-Jackson-Matagorda-Fort Bend Counties Medical Auxiliary meets once a month at a combined dinner meeting with the medical society. After dinner, the auxiliary holds its business meeting and social hour while the medical society has its scientific meeting.

This auxiliary has a nursing scholarship of $50 a year to be paid back at the convenience of the nurse. At present, plans are being made to change this to a gift scholarship taking care of a nurse's tuition for three years.

The AAPS essay contest was represented by three schools with a total of fourteen entrants. The prize winning essays were entered in the state contest. A total of $95 was awarded in prizes.

The District 8 luncheon and business meeting was held in El Campo in October with this auxiliary acting as hostess. About 50 district members attended.

A yearbook was printed and distributed to the members. Individual subscriptions to *Today's Health* were sold and the auxiliary donated a subscription to all local high schools (twenty-five in number).

Many of the members of this auxiliary are active in church, civic, and political affairs.

MRS. R. E. LESLIE, El Campo.

Wichita County

The Wichita County Auxiliary has 79 active members and 17 honorary members, many of whom are still quite active in auxiliary work.

The District 13 meeting was held here in June, and it was our pleasure to have Mrs. E. W. Coyle, State President,

as our guest at the luncheon at the Wichita Falls Country Club.

During the North Texas-Southern Oklahoma Fall Clinical Conference in September, we joined our husbands and their guests for a banquet in the evening.

For our October business meeting, we toured the Wichita General Hospital (new City-County Hospital) under the direction of the administrator, Mr. P. W. Adhlstedt, who explained the great work of such an institution. Furnishing the doctors' lounge in this hospital has been our special project this year. Draperies, a sofa, chairs, and a table were bought to make it an attractive and comfortable room.

We entertained several hundred members and guests with a style show and tea in November. A February dinner-dance was enjoyed by about 200 doctors, wives, and guests, and in March we observed Doctor's Day with an informal barbecue.

Our auxiliary sponsored the Association of American Physicians and Surgeons essay contest. Prizes of $75, $35, and $15 were awarded for first, second, and third places. The winning essay will be read at the April meeting. May will find us in the country for a picnic to close our year's work.

A junior student in the Wichita Falls School of Nursing has been the recipient of much needed clothing and $70 in cash for her personal use.

Our members work with Gray Ladies and Women of Rotary at the Wichita Falls State Hospital (a mental institution), the Community Council at Sheppard Air Force Base, the Red Cross, blood bank, county-wide tuberculosis x-ray survey, polio and heart drives, the cancer clinic, and other civic organizations.

In fact, they are a group of friendly women who are ready to work at anything which benefits the community and humanity.

MRS. W. L. PARKER, Wichita Falls.

Wilbarger County

The Woman's Auxiliary to the Wilbarger County Medical Society has 17 members and has met three times this year. We have combined business and social meetings. All members contribute financially to civic drives and organizations and most work in the drives. Red Cross, polio, cancer and Community Chest have been supported in this way. The members have all read the State Auxiliary *News Letter*.

MRS. F. B. STEELE, Vernon.

Wood County

The Woman's Auxiliary to the Wood County Medical Society has had 3 members. Because of the small number of members it was voted to become members-at-large to the Smith County Auxiliary.

MRS. ROSCOE O. MOORE, Mineola.

STYLE SHOW LUNCHEON HONORING COUNTY PRESIDENTS

At 12:00 noon Monday, May 3, 1954, a style show and luncheon honoring county presidents was given in the Colonial Room of the Menger Hotel, San Antonio, with the President, Mrs. Edward W. Coyle, presiding. Mrs. S. Foster Moore, San Antonio, was chairman of the luncheon.

The invocation was given by Mrs. O. W. Robinson, Paris, a Past State President.

Following luncheon a lovely style show was presented by Joske's, San Antonio.

The President presented Mrs. A. O. Severance, San Antonio, Essay Contest Chairman, who presented Milton Copeland, Wichita Falls, AAPS essay contest state winner, who expressed his appreciation of the opportunity to enter the essay contest on the subject of "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care." He told of his belief in the private practice of medicine and urged the Auxiliary to continue its sponsorship of the contest. He mentioned that in his research he had realized anew that because of the high standards of medical education, the conscientious service by the individual doctor, and the freedom and right of the medical profession to organize this country is furnished with the finest medical care. He closed his remarks with the final paragraph of his theme: "Thus, since the private practice of medicine does furnish this country with the finest medical care, this system should be encouraged and maintained. Leadership and spokesmen should arise both from within and without the profession. All arguments for government control of medicine should be shattered by the living proof that our free way is the better way for the patients. By helping to keep the medical profession free, we will help to keep America free—and happy."

Mr. N. C. Forrester, Austin, Executive Secretary of the Texas Medical Association, brought greetings from the staff.

Dr. George Turner, El Paso, President of the Texas Medical Association, presented the first place award of $250 to Milton Copeland. In thanking Mr. Copeland, Dr. Turner said that the contest is just another expression of this generation's desire to fight for its freedom and that America won the prize—through the participants' expression of loyalty to the principles of freedom.

Following the luncheon the first business session was continued in the Minuet Room of the Menger Hotel. At 3:30 p. m. Mrs. Thomas H. Sharp, San Antonio, Chairman of Registration, announced that 478 women had registered.

Following the reports of the county presidents the meeting was recessed until 8:30 a. m. Tuesday, May 4.

SECOND BUSINESS SESSION

The second business session of the Woman's Auxiliary to the Texas Medical Association was held in the Minuet Room of the Menger Hotel, San Antonio, at 8:30 a. m. on Tuesday, May 4, 1954, with the President, Mrs. Edward W. Coyle, San Antonio, presiding.

The invocation was given by Mrs. W. R. Thompson, Fort Worth, a Past State President.

Mrs. Edward C. Ferguson, Beaumont, reporting for the Revisions Committee moved the adoption of the proposed revised Constitution and By-Laws. She stated that in accordance with the Constitution and By-Laws printed copies of the proposed revisions were sent at least sixty days prior to the Convention to members of the Executive Board and to all committee members. Amendments to the proposed revised Constitution and By-Laws which were sent in prior to the Convention were printed and handed out at the first session of the Convention, along with copies of the original proposed revisions. Action on each of these amendments was taken at this time. All amendments to the revisions were considered and voted upon individually and were adopted except the amendment under Article V of the Constitution, Section 1, which would have inserted the words "and county presidents." In accordance with this action, the words "and county presidents" were added to Article II, Section 6 (now Article IX, Section 6) of the By-Laws.

Mrs. John H. Wootters, Houston, moved the incidental motion that since copies of the proposed revised Constitu-

tion and By-Laws had been in the hands of the Executive Board and presented to county auxiliaries prior to the Convention and since copies had been handed out at the first business session of the Convention to be voted on at the second business session, and further since each amendment had been carefully considered and voted upon, that the proposed revised Constitution and By-Laws as amended be voted on without re-reading. The motion carried.

Upon motion of Mrs. Jacob F. Schultz, Houston, it was voted to follow the newer trend by combining our Constitution and By-Laws under one heading to be known as "By-Laws."

By general consent the Revisions Committee was given authority to delete the word "Constitution" throughout, to devise a method of amendment which would combine the stricter points of the two methods previously adopted for amending the Constitution and By-Laws, and to make such grammatical changes as deemed necessary so long as the original meaning remains the same.

The following revised Constitution and By-Laws was adopted:

By-Laws (Revised 1954)

Article I—Name

The name of this organization is the Woman's Auxiliary to the Texas Medical Association; it is a federacy of its component auxiliaries and a constituent member of the Woman's Auxiliary to the American Medical Association.

Article II—Objects

The objects of the Auxiliary are:

1. To assist the Texas Medical Association in its program for the advancement of medicine and public health.

2. To cultivate friendly relations and promote mutual understanding among physicians' families.

3. To coordinate and advise concerning the activities of component auxiliaries.

Article III—Membership

Section 1. Membership in the State Auxiliary shall be composed of (1) active members and (2) honorary members.

Section 2. Active members in this Auxiliary shall be:

(a) The wives of physicians who hold active membership in the Texas Medical Association and who are members in good standing in the component auxiliaries.

(b) Widows of physicians who were in good standing of the Texas Medical Association shall be active members and eligible for all offices except that of President.

(c) Members-at-large shall be active members from counties where there are no component auxiliaries, and who are wives of physicians who hold active membership in the Texas Medical Association.

Section 3. Honorary membership in this Auxiliary may be conferred by the Convention on the recommendation of the Executive Board on a member who has rendered long and signal service to this Auxiliary. Honorary members shall pay no state dues and shall have all the rights and privileges of active members.

Section 4. A member of the Texas Medical Association who is the wife of a physician shall be eligible for active membership in this Auxiliary.

Article IV—Officers

The officers of the Auxiliary shall be a President, President-Elect, five Vice-Presidents, a Recording Secretary, a Corresponding Secretary, a Publicity Secretary, a Treasurer, and a Parliamentarian.

Article V—Executive Board and Advisory and Executive Committees

Section 1. The officers, chairmen of standing and special committees, and district council women shall constitute an Executive Board.

Section 2. The Advisory Committee shall consist of the past Presidents.

Section 3. The Executive Committee shall consist of the officers and the five (5) living immediate past Presidents.

Section 4. The Executive Secretary of the Auxiliary to the Texas Medical Association may attend the meetings of the Executive Board and Executive Committee, without the privilege of membership. (The Executive Secretary shall be the member of the staff of the Texas Medical Association assigned to work with the Auxiliary.)

Article VI—The Convention

Section 1. The legislative powers of this Auxiliary shall reside in the Convention. The Convention shall transact all business of the Auxiliary not otherwise specifically provided for in the By-Laws.

Section 2. The Convention shall be constituted as follows: (1) all members of the Auxiliary and (2) voting delegates as provided for in Section 3 of this Article. All members of this Auxiliary shall be entitled to attend the sessions of the Convention and to report to or address the Convention or to discuss the business, or a portion thereof, pending before it; but only voting delegates may vote on the business of the Convention. The Executive Secretary may attend all sessions of the Convention without the privilege of membership.

Section 3. Each component auxiliary shall be represented in Convention by its president or her alternate, and one delegate or her alternate. These accredited delegates with the members of the Executive Board and the past Presidents shall constitute the personnel of voters at the Convention.

Section 4. The Convention shall meet annually at the same time and place as the annual sessions of the Texas Medical Association.

Article VII—Government

The Auxiliary shall be guided by the policies of the Texas Medical Association and shall seek the counsel of its Advisory Committee.

Article VIII—Nominations and Election of General Officers

Section 1. The Nominating Committee shall consist of seven members, one of whom shall be the immediate past President who shall serve as chairman. The other members of this committee, three of whom shall be members of the Executive Board, shall be elected by the Executive Board at its post-convention meeting. If there are more than six nominees, then the election shall proceed by ballot. A plurality vote shall elect. At the next annual Convention this committee shall present the nomination of a candidate for each elective office. Nominations from the floor shall be allowed.

Section 2. No person shall be elected to office who is not in attendance at the Convention at which the election is held, unless her presence is prevented by a legitimate excuse recognized by the Nominating Committee.

Section 3. The annual election of officers shall be held at the final business session of the Convention. A majority of votes shall constitute an election. The election shall be by ballot except where there is only one nominee for an

office, in which case the election shall be viva voce. The installation of officers shall take place at the close of the Convention.

Section 4. The term of office shall be for one year. The Recording Secretary, Treasurer, Publicity Secretary, and First Vice-President may serve two terms.

Section 5. The President-Elect shall automatically assume the office of the Presidency at the expiration of her term as President-Elect.

Section 6. Component county auxiliaries shall hold their elections by March 10.

Section 7. Council Women are to be elected by their own District members, the election to take place prior to the annual Convention, at which time each shall assume the office of Council Woman. The President-Elect of the State Auxiliary shall appoint Council Women in unorganized Districts.

Article IX—Duties of Officers

Section 1. Each officer shall present at the Convention a report concerning her activities during her term of office.

Section 2. The President shall preside at all meetings of the Convention and shall be chairman of the Executive Board and the Executive Committee. She shall be an ex-officio member of all committees except the Nominating Committee. She shall appoint, with the approval of the Executive Committee, the chairmen of standing and special committees except where these By-Laws provide to the contrary. She shall authenticate by her signature all orders on the treasury. She may call special meetings of the Auxiliary, the Executive Board and Executive Committee. On written request of seven members of the Executive Board a special meeting shall be called. She shall attend the annual Convention and the annual Conference of State Presidents and Presidents-Elect of the Woman's Auxiliary to the American Medical Association. As far as practicable, she shall make personal visits to the component county auxiliary groups. She shall appoint Convention committees to serve at the time of the Convention, whose term of office shall expire at the close of the Convention.

Section 3. The President-Elect shall be an active aid to the President. She may visit district auxiliary meetings as a duty of the office and other meetings upon request of the President. By membership on the Executive Board during her term of office she shall conduct herself so as to obtain the greatest possible acquaintanceship with the affairs of the Auxiliary, to enable her to fulfill efficiently the office of President when she succeeds thereto. She shall appoint, with the approval of the Executive Committee, the chairmen of the standing and special committees and the District Council Women in the unorganized Districts to serve during her term as President. Upon the organization of such District, the Council Woman shall then be elected by the district. She shall submit the names of a Corresponding Secretary and a Parliamentarian to the Nominating Committee. She shall attend the annual Convention and the annual Conference of State Presidents and Presidents-Elect of the Woman's Auxiliary to the American Medical Association.

Section 4. The First Vice-President shall be State Chairman of Organization and Membership. She shall, in the absence of the President, perform the duties of that office; and upon the death, resignation or removal of the President she shall fill that office for the unexpired term. The Organization and Membership Committee shall consist of the other Vice-Presidents and Council Women.

Section 5. The Second, Third, Fourth and Fifth Vice-Presidents shall be Regional Chairmen of Organization and Membership. Each shall develop and supervise the extension program of the Organization and Membership Committee of the Auxiliary in the region in which she resides, working in close cooperation with the First Vice-President, who is State Chairman of Organization and Membership. The Vice-Presidents in their order shall assume a vacancy that may occur in the office of President.

Section 6. The Recording Secretary shall keep in permanent form the minutes of all meetings of the Convention, the Executive Board, and the Executive Committee. She shall request and compile the annual reports of the members of Executive Board, including the Treasurer's report, and county presidents, for awards, filing, and for publication in the Texas State Journal of Medicine.

Section 7. (a) The Treasurer shall be the custodian of the General and Special Funds of the Auxiliary, except where these By-Laws provide to the contrary, and shall deposit them in a depository approved by the Executive Board. Disbursements may be made by the Treasurer only on written order of the President and the Chairman of the Finance Committee. She shall present a statement of account at all meetings of the Executive Board and shall make a full report to the Convention. The Treasurer's books shall be closed annually by two weeks following the Convention. The Treasurer shall be bonded in the amount of not less than ten thousand dollars ($10,000.00), the fee to be paid by the Auxiliary.

(b) The accounts of the Treasurer shall be audited by a certified public accountant approved by the Executive Board. The Accountant shall prepare from the records, without audit, a statement to be submitted by the Treasurer at the Convention, and, when the books are closed, shall make a complete, detailed audit, copies to be submitted to the President, Finance Chairman, and the Texas Medical Association for publication in the July issue of the Texas State Journal of Medicine.

Section 8. The Corresponding Secretary shall conduct the correspondence of the Auxiliary.

Section 9. The Parliamentarian shall advise on points of parliamentary law when requested and serve as ex-officio member of the Revisions Committee.

Section 10. The Publicity Secretary shall direct all monthly reports of meetings of component auxiliaries and press notices for the Texas State Journal of Medicine. She shall advise concerning publicity on the local level. She shall reside in the city where the Journal is published or in the same city as the President.

Article X—Duties of Council Women

Section 1. Each shall serve as Organization and Membership Chairman of the District she represents, working in cooperation with her regional chairman of Organization and Membership.

Section 2. Each shall coordinate the aims or objectives of the National, State, District, and County Auxiliaries as set forth in their respective Constitution and By-Laws.

Section 3. Each may create such committee or committees as may be necessary to carry out the duties of her office.

Section 4. Each shall preside at all regular and called meetings of the District Organization. If the District is not organized, the Council Woman shall be appointed by the President-Elect.

Section 5. Each Council Woman shall present at the Convention a report concerning her activities during her year in office.

Article XI—Duties of Executive Board and Executive Committee

Section 1. The Executive Board shall carry out the mandates and policies of the Auxiliary as determined by the Convention, subject to (1) the provisions of these By-Laws; (2) resolutions and enactments of the Convention; and (3) instructions from the Advisory Committee of the Texas Medical Association. The Executive Board shall have power and authority over the affairs of the Auxiliary during the interim between its Conventions, excepting that no debt or liability except for current and operating expenses approved by the Finance Committee shall be incurred.

Section 2. The Executive Committee shall transact such business as requires action before the next meeting of the Executive Board and shall fill any vacancies occurring in office not otherwise provided for in these By-Laws.

Section 3. The Executive Board and Executive Committee are authorized to transact business by mail when necessary.

Section 4. A regular meeting of the Executive Board shall be held immediately before and after each annual Convention and in the Fall, preferably in September, the date and place of the Fall meeting to be set by the Executive Committee. Special meetings may be called by the President or upon written request of seven members of the Executive Board.

Article XII—Standing Committees

Section 1. The standing committees of the Auxiliary shall be as follows: Advisory; American Medical Education Foundation; Bulletin; Civil Defense; Courtesy Resolutions; Editorial; Essay; Finance; Historical; Legislative; Library Fund; Memorial Fund; Memorial Services; Mental Health; Nominating; Nurse Recruitment; Organization and Membership; Program; Public Relations; Reference; Revisions; Student Loan Fund; Today's Health and Workshop.

Section 2. The chairman of each committee, or someone designated by her, shall present a report to the Convention on the activities of her committee during the year.

Section 3. The chairman of each standing and special committee, subject to the approval of the President, shall select the members of her committee except where the membership is otherwise designated in these By-Laws.

Section 4. The American Medical Education Foundation Fund Committee shall help in obtaining funds for the support of medical schools. Contributions to this committee shall be sent to the American Medical Association Committee for this Fund, a detailed report being made to the Treasurer of this Auxiliary.

Section 5. The Editorial Committee shall consist of the Editor of the *News Letter* as chairman, two other members, and the Executive Secretary of the Auxiliary as ex-officio members without the right to vote. It shall accumulate and edit material of interest to members of the Auxiliary.

Section 6. The Finance Committee shall consist of five members as follows: a chairman, the Treasurer, the immediate past Treasurer, the immediate past President, and a member from the general body. This committee shall, in cooperation with the incoming Finance Committee, prepare a budget based on dues received the current year, this budget to be read at the Convention for information and presented for action at the Post Convention Executive Board meeting. This committee shall work out a plan for all expenditures and shall receive all vouchers for payment of budget allocations. It shall be the duty of this committee to require detailed bills to accompany such vouchers before paying same. The chairman of this committee shall forward promptly all approved vouchers to the President for her approval and signature. Such vouchers shall then be forwarded to the Treasurer for payment. Bills shall be paid after expenditures are made. No bill may be paid unless itemized and approved by persons contracting them.

Section 7. The Historical Committee shall consist of a chairman and four members. This committee shall serve as the Awards Committee, working with the various committees in determining the annual awards in the Auxiliary fields of endeavor. This committee shall be responsible also for encouraging written histories of county groups, for keeping the historical chart up to date each year, and for the filing of all Auxiliary records in the Texas Medical Association Library Building.

Section 8. The Legislative Committee shall consist of a chairman and a member from each of the four regions of the State. This committee shall work closely with the Advisory and Judicial Committees of the Texas Medical Association and The American Medical Association and Auxiliary to keep the Auxiliary informed concerning existing laws and proposed legislation of interest to the medical profession.

Section 9. The Library Committee shall encourage gifts of funds, books and other materials, and cooperate with all requests to improve the Memorial Library of the Texas Medical Association.

Section 10. The Memorial Fund Committee shall encourage contributions to the Auxiliary Memorial Fund. The beneficiaries of the Memorial Fund shall be members of families of doctors in good standing of the Texas Medical Association at the time of their death or retirement.

Section 11. The Program Committee shall consist of a chairman, co-chairman, and the chairmen of the following standing committees: Civil Defense, Legislative, Mental Health, Public Relations, Nurse Recruitment, and Workshop. This committee shall encourage the preparation of yearbooks; physical examinations among members of physicians' households: and the sending copies of outstanding programs and other valuable program material to the Central Office. It shall be the duty of this committee to familiarize itself with the work of the State and National Auxiliaries, the American Medical Association, and the Texas Medical Association, and with authentic health literature, and to outline and suggest programs for component county auxiliaries.

Section 12. The Public Relations Committee shall consist of a chairman and one member from each of the four regions of the State. It shall be the duty of this committee to foster interest in matters of public importance relative to health education and, through the component auxiliaries and with the approval of the Advisory Committee of the Texas Medical Association, to correlate the work of the Auxiliary with that of other organizations.

Section 13. The Reference Committee shall consist of a chairman and two members appointed by the President. This committee shall receive and pass on Convention business before it is presented to the body.

Section 14. The Revisions Committee shall consist of three members, each with a term of office of three years, one term expiring each year and one appointment made by the President each year. The member serving her third year shall automatically become the chairman. The Parliamentarian shall be an ex-officio member of this committee.

Section 15. The Student Loan Fund Committee shall consist of five members appointed by the President. It shall have a chairman aad a co-chairman. The co-chairman shall act as the chairman of the George Plunkett Red Division of

the Student Loan Fund. Each city wherein an accredited Medical School is located shall have a representative on the committee. The beneficiaries of the Student Loan Funds shall be: (1) Students of junior and senior years of medical colleges in Texas recognized by the American Medical Association; (2) Students of junior and senior years who reside in Texas but attend medical colleges in another state may be eligible for loans at the discretion of the committee; and (3) residents of Texas serving internships and residencies in hospitals approved by the American Medical Association. The funds in these accounts shall be handled by the Texas National Bank of Houston, Trustee, loans being made at the discretion of the committee and the Trust Department of the bank.

Section 16. The duties of all other committees shall be as their names imply.

ARTICLE XIII—DUES

Each component auxiliary shall pay annual dues to the State Auxiliary at the rate of two dollars ($2.00) per capita; this to include the dues of one dollar ($1.00) per capita to the Woman's Auxiliary to the American Medical Association. The dues shall be sent to the State Treasurer by March First.

ARTICLE XIV—QUORUM

Twenty voting members, ten of whom shall be members of the Executive Board, shall constitute a quorum at any meeting of the Convention. Fifteen members shall constitute a quorum of the Executive Board.

ARTICLE XV—PARLIAMENTARY AUTHORITY

The rules contained in "Robert's Rules of Order Revised" shall govern the Auxiliary in all cases to which they are applicable and in which they are not inconsistent with these By-Laws.

ARTICLE XVI—AMENDMENTS

The By-Laws may be amended at any regular business session of the annual Convention of the Auxiliary by a two-thirds vote, provided notice of the proposed amendments has been submitted in writing to the component auxiliaries not less than sixty days prior to said meeting.

STANDING RULES

1. The Convention Committee shall consist of members of the hostess auxiliary and shall have charge of the registration and entertainment of members and visitors at the annual Convention, working in cooperation with the President and/or the Executive Committee.

2. A registration fee of one dollar ($1.00) shall be paid by those attending the Convention.

3. (a) Council Women shall maintain a membership roster of their district, said roster shall be checked for accuracy with the Treasurer of the Auxiliary.

(b) Wherever possible, Council Women shall effect merger or consecutive meetings of component auxiliaries for the purpose of a visit from the State Auxiliary President or her representative, thereby saving time and expense in carrying out this important objective of the offices.

4. The Auxiliary shall pay, from the Auxiliary Special Fund, the State and National dues of members whose husbands are serving temporarily in the armed forces.

5. There shall be a uniform method of preserving annual reports. The Recording Secretary of the Auxiliary shall give detailed instructions to those making reports. All records except current ones shall be kept in the Auxiliary files at the headquarters of the Texas Medical Association.

6. There shall be held annually, at the same time and place as the Fall Executive Board meeting, a Workshop specifically planned to aid county presidents and presidents-elect, the program to be arranged for by the President. It is suggested that this Board meeting and Workshop be held in Austin, the location of the headquarters of the Texas Medical Association.

7. In the interest of organization and membership, the State shall be divided into four geographical regions as follows:

1. Northern.—Districts 2, 3, and 13.
2. Eastern.—Districts 9, 10, 11, 12, 14, and 15.
3. Western.—Districts 1 and 4.
4. Southern.—Districts 5, 6, 7, and 8.

8. Districts shall be the same of the fifteen councilor districts as set up by the Texas Medical Association.

9. The State Auxiliary Handbook shall be kept up to date and passed on by members of the Executive Board and county presidents to those succeeding them.

10. No expenditure shall be voted upon at the Convention unless previously approved by the Finance Committee.

11. These Standing Rules may be amended or suspended at the annual Convention without previous notice, by a majority vote.

Dr. F. J. L. Blasingame, Wharton, President-Elect of the Texas Medical Association, extended greetings to the Auxiliary.

The highlights of the reports of the council women, committee chairmen and officers were given.

In lieu of the report of the American Medical Education Foundation Committee, which had been filed, Mrs. J. L. Jinkins, Galveston, Chairman, presented Mr. Hiram Jones, Chicago, Executive Secretary of the AMEF, and Dr. D. B. Calvin, Dean of the University of Texas Medical School, who spoke briefly on the need of the AMEF and urged our continued support.

These reports were interrupted to go into luncheon and were continued after luncheon.

The following are the reports filed:

REPORT OF FIRST DISTRICT COUNCIL WOMAN

The First District, composed of 12 counties, has 3 medical societies and 3 auxiliaries. There are 185 members, including 1 honorary member, in the district auxiliary.

In September I attended the Executive Board meeting in Austin. The first project of the year, following as our theme, "Knowledge, Judgment, and Action in Health Leadership," was for us to make a special effort to lead in health education.

From our largest auxiliary—El Paso—to our smallest—Big Bend Auxiliary, a new emphasis was placed on friendliness within. With good relations within we had that "extra something" we feel we need to go outside ourselves in community activities. In serving our various communities we have had a definite part in preserving our American way of life.

I made my official visit to El Paso County Auxiliary in February, 1954, at which meeting Mrs. E. W. Coyle, San Antonio, State President, was guest speaker. The chairmen's reports were outstanding in nurse recruitment, television programs, and mental health.

Pecos-Jeff Davis-Presidio-Brewster Counties Auxiliary has met each month, the members having supper with the doc-

tors and then going to their own meeting. There are 13 members. Distance is their big problem. Nurse recruitment was their important project. My official visit to this auxiliary was in November. The Reeves-Ward-Winkler-Loving-Culberson-Hudspeth Counties Auxiliary has a membership of 22 and 1 honorary member. The medical auxiliary women won in the Community Chest drive. Friendship within was stressed in this group. This auxiliary was hostess to the District 1 meeting. On February 12, 1954, I presided over the annual District 1 Auxiliary meeting at Pecos. The Auxiliary met with the doctors at the Pecos Valley Country Club for luncheon.

At the meeting Mrs. Coyle was guest speaker. She gave us an inspiring message.

Mrs. George Turner of El Paso, President-Elect of the National Auxiliary, was an honored guest. "Let's put more U in your commUnity" was her emphasis. Mrs. Robert Thompson, past State President from El Paso, commended the ladies for their good work.

Community public relations was shown when one of our druggists' wives, Mrs. D. W. Bozeman, had a pink tea for our guests that afternoon.

Dr. George Turner of El Paso, President of the Texas Medical Association, was guest speaker for the evening meeting. Dr. Leighton Green, councilor for District 1, showed slides.

The new president and council woman is Mrs. Andrew Eck of El Paso, Vice-President, Mrs. Hugh Martin of Pecos; and secretary, Mrs. Charles Oswalt of Fort Stockton.

More than a hundred doctors and wives attended the District meeting. I was presented an engraved sterling silver cup for my three years work as council woman. The doctors and wives voted this the best meeting we had ever had. They will meet in Pecos again next year.

MRS. HAROLD LINDLEY, Pecos.

REPORT OF SECOND DISTRICT COUNCIL WOMAN

The District 2 meeting was held in Sweetwater April 15. There were 22 women present. Mrs. E. W. Coyle, San Antonio, State President, spoke on the importance of community service by doctors' wives individually and collectively. Following the business session, the women of Sweetwater arranged a tea at the home of Mrs. T. D. Young. A cocktail party and banquet were held in the evening.

MRS. THOMAS MARINIS, Midland.

REPORT OF THIRD DISTRICT COUNCIL WOMAN

The Third District is composed of 36 counties, having 9 medical societies and 5 active auxiliaries. In all the 4 inactive auxiliaries, there are doctors' wives who have paid their state and national dues and are members of those organizations or are members-at-large of other auxiliaries.

I began my year as council woman by attending the state meeting in Houston and the post-convention Executive Board meeting and School of Instruction.

It was my privilege and pleasure to attend one of the first meetings of the Dallam-Hartley-Sherman-Moore Counties Auxiliary, a luncheon with Mrs. William V. Coventry of Dumas presiding. This is a new auxiliary in the district and they are doing a wonderful job.

I attended the fall Executive Board meeting in Austin and soon after this meeting wrote personal letters to each county president in District 3, outlining the state program for the year and offering to visit their auxiliary or help them in any way possible.

Because of the distance involved and frequent bad weather, it has been difficult to travel, so a great deal of my work has been done by correspondence and long distance telephone calls. I have had personal interviews with the presidents or vice-presidents of those auxiliaries which I have not visited as a group. In January, I visited the Hattie Hunt Auxiliary in Childress and spoke to them on the American Medical Education Foundation and Bricker Amendment.

On April 13, the annual meeting of the Panhandle District Medical Society (District 3) was held in Amarillo. A District Executive Board was formed, composed of the county presidents, the council woman, and the district secretary. This board met in the morning with Mrs. E. W. Coyle, San Antonio, State President, to discuss county reports and auxiliary problems.

A luncheon was held at the Amarillo Country Club honoring Mrs. Coyle. Potter County Auxiliary, with Mrs. W. E. Scott of Amarillo as president, was the hostess auxiliary.

The council woman presided at the business meeting at which time a constitution and by-laws were presented for the district. Mrs. Coyle was the guest speaker.

Communications directed to me have been answered and a record kept of all correspondence in hopes that it might be of some help to my successor.

MRS. E. K. JONES, Wellington.

REPORT OF FOURTH DISTRICT COUNCIL WOMAN

The emphasis for 1953-1954 in District 4 has been placed on encouraging and helping in every possible way with letters, phone calls, and visits the newly organized auxiliaries.

In District 4 there are 20 counties with 6 societies and 5 active auxiliaries. The auxiliary members total 90, with a possibility of having several members-at-large before the close of the year.

Geriatrics, nurse recruitment, nursing scholarships, the Association of American Physicians and Surgeons essay contest, health films, and cooperation with various health projects in each auxiliary's community have helped further public relations in our district.

Invitations were mailed to all district doctors' wives inviting them to attend the district convention in Brownwood on October 8, 1953. The auxiliary met with their husbands for lunch at Hotel Brownwood where they heard an inspiring talk given by Dr. F. J. L. Blasingame, President-Elect to the Texas Medical Association.

After lunch, auxiliary members met at the home of Mrs. Paul Wheelis for tea and a meeting and discussion period. Officers elected for 1954-1955 are Mrs. Oscar N. Mayo, council woman, Brownwood; Mrs. John L. Wright, vice-president, Big Lake; Mrs. W. Lacey Smith, secretary-treasurer, San Angelo.

Our next District 4 convention will be held in San Angelo in October, 1954.

MRS. PERRY J. C. BYARS, San Angelo.

REPORT OF FIFTH DISTRICT COUNCIL WOMAN

During this past year I have written thirty-five letters to the Auxiliaries in District 5, keeping these groups in touch with the various projects that were being done. I wrote letters to members in the district, inviting all to our Bexar County Auxiliary April meeting, our guest day.

In October, it was my pleasure to visit the Kerr-Kendall-Gillespie-Bandera Counties Auxiliary meeting, at which time our State President was present and gave an inspirational

and informative talk about the year's work. This meeting was held in Mrs. Sam Thompson's beautiful home.

Later in the year a visit was made in Atascosa County. I also attended a meeting in Karnes-Wilson Auxiliary.

In Guadalupe County an interesting meeting was held followed by luncheon. Comal County Auxiliary is cooperating in a splendid way.

As individuals these members are active in most civic and philanthropic projects in their communities.

MRS. JOHN L. PRIDGEN, San Antonio.

REPORT OF SIXTH DISTRICT COUNCIL WOMAN

District 6 is composed of 18 counties, 8 medical societies and 8 auxiliaries. The auxiliaries which have carried on an active program have stressed civil defense, nurse recruitment, subscription to *Today's Health,* the Association of American Physicians and Surgeons essay contest, public relations, and a legislative program.

The Fifth and Sixth District meeting was held in Corpus Christi, July 10, 1953. The auxiliary luncheon and style show at the Corpus Christi Country Club was well attended. Mrs. E. W. Coyle, San Antonio, State President, was the speaker and gave us an interesting report on her activities. A business meeting followed at which I presided. Mrs. Stanley Bohmfalk of Weslaco was nominated and elected our next council woman and will take office at the July meeting.

September 10 I attended the Board meeting in Austin. Mrs. Sam Powell, the Nueces County Auxiliary president, accompanied me, and we were especially impressed with the new Library Building and the luncheon provided by the Austin members. We were unable to attend the night meeting.

In Alice at the home of Dr. and Mrs. P. S. Joseph, the Auxiliary to the Brooks-Duval-Jim Wells Counties Medical Society was organized on October 29, 1953. It was my pleasure to install Mrs. G. G. Wyche, Sr. as the first president. This is the only invitation I have received from an auxiliary in this district and it was a pleasure, indeed.

State dues have been paid by all auxiliaries in this district.

The State Meeting in San Antonio will be attended by this council woman, and we will be looking forward to the District meeting in July, 1954, in Corpus Christi.

MRS. JUNE YATES, Corpus Christi.

REPORT OF SEVENTH DISTRICT COUNCIL WOMAN

Because of inactivity in District 7 last year, the year 1953-1954 was spent in stressing friendship and trying to set up a program of activity suited to the interests of all auxiliaries involved.

Nurse recruitment is the major project of the Woman's Auxiliary to the Bastrop-Lee Counties Medical Society where Mrs. Robert B. Burns of Giddings is president. Their program is excellent and should be fruitful. Mrs. Kermit Fox of Austin helped this group during the past summer. Hats off to the splendid progress this newly organized auxiliary is making!

Mrs. Albert LaLonde was personally responsible for the recruitment of three nurses from her home town of Buda.

In Caldwell County, Mrs. A. A. Ross, president, the Cancer Crusade has been the main project, with emphasis on educating the lay people. This is an excellent program for a small auxiliary—where every member counts.

We are proud to say that Caroline Covington, a junior in Burnet High School, is first prize winner for the AAPS essay contest in District 7. Mrs. Joe A. Shepperd of Burnet has been our District 7 contest chairman, and we are proud of her interest, effort, and achievement in this field.

Mrs. Eugene Schock, chairman for civil defense in the Woman's Auxiliary to the Travis County Medical Society as well as for District 7, has worked diligently all year and has presented a concise, workable program for emergency and disaster relief—educating the doctors' wives in first aid courses and registering them as civil defense volunteers.

When the Travis County Auxiliary held its luncheon style-show in February honoring Mrs. E. W. Coyle, President, Woman's Auxiliary to the Texas Medical Association, all presidents of auxiliaries comprising District 7 were invited to attend as my guests. The style-show was excellent, and Mrs. Coyle's address was a fine example for all doctors' wives to follow.

On February 18, 1954, the Seventh District Medical Society held its mid-winter session. A tea for the wives of members was held in the home of Mrs. Charles B. Dildy, Austin. It is hoped this can be made an annual affair in the future, for it certainly affords us a good opportunity to know each other better.

The Travis County Auxiliary, under the able leadership of its president, Mrs. Dildy, has presented an excellent and varied program this year. With the large membership divided into committees many activities such as civil defense, *Today's Health,* community service, health education, and nurse recruitment were carried forward and the community definitely has been made to feel that the doctors' wives in this community are active, interested citizens who are working to preserve our American Way of Life!

Each auxiliary in the district was requested to have a definite representative and alternate to serve for two years on a District Council in order to assure the district council woman a true picture of activity in her district.

During the year 200 postcards were sent out, 30 letters were written, and 5 long distance calls were made.

MRS. THOMAS J. ARCHER, Austin.

REPORT OF EIGHTH DISTRICT COUNCIL WOMAN

The potentialities of District 8 are great. At present 4 of the 6 county auxiliaries in the district have carried on fairly rounded programs. Outstanding work has been done by two of the groups. The average number of meetings for the groups is 8 a year, most of them being held at night with dinner with husbands before programs. All 6 groups took part in contributing to the AMEF. Four auxiliaries cooperated with the essay contest, with 131 essays being written. One county reports 100 per cent subscription to *Today's Health,* and all auxiliaries celebrated Doctor's Day.

Four nurses are in training on loans or scholarship funds totalling $950. One small group has two nurses in training, one of whom is a Negro, at an expense of $600.

The district meeting was held on October 23, 1953, at El Campo, and a detailed report has been filed with the State President, with copies of letters sent to groups attached.

MRS. WILLIAM D. NICHOLSON, Freeport.

REPORT OF NINTH DISTRICT COUNCIL WOMAN

District 9 has 7 organized auxiliaries and 1 chapter. One finds varying degrees of interest and activity in these auxiliaries.

We held our annual meeting this year on March 25 in Brenham with the Washington-Burleson Auxiliary serving as hostesses. The highlight of this meeting was an informative talk by the President-Elect of the State Auxiliary, Mrs. Mark H. Latimer of Houston.

There was an interest shown in increasing knowledge and methods of auxiliary work in several of the counties and an effort will be made to furnish these details at an early date.

MRS. H. O. SAPPINGTON, Baytown.

REPORT OF TENTH DISTRICT COUNCIL WOMAN

There were two meetings held during the year. In the fall a tea was given in the home of Mrs. L. C. Heare, Port Arthur. We were privileged to have our President-Elect, Mrs. Mark Latimer, Houston, with us. She gave an inspiring talk covering all aspects of auxiliary work. The spring meeting was in Nacogdoches, where we were entertained with a trip to all the historical places and later returned to Mrs. J. Frank Beall's home for refreshments.

MRS. R. C. BELLAMY, Liberty.

REPORT OF TWELFTH DISTRICT COUNCIL WOMAN

The Woman's Auxiliary to the Twelfth District Medical Society, comprising the 13 auxiliaries of Bell, Bosque, Brazos-Robertson, Coryell, Erath-Hood-Somervell, Falls, Hamilton, Hill, Johnson, Limestone, McLennan, Milam and Navarro Counties met for its first meeting July 14, 1953, at the Alcoa plant in Rockdale with Milam County as hostess auxiliary. Thirty members, representing 9 counties, were present. Each county presented and discussed plans for the coming year. Mrs. F. F. Kirby of Waco introduced Mrs. E. W. Coyle, San Antonio, President of the Auxiliary to the Texas Medical Association. Mrs. Coyle held a discussion period on the various functions of the departments of the state and national auxiliaries. Mrs. Charles L. McGehee of San Antonio, State Corresponding Secretary, was also a guest.

In the fall, as council woman, I visited the Navarro, Milam, Bell, and McLennan County Auxiliaries to gather and distribute helpful suggestions. Each auxiliary of the district was contacted by phone and by many letters throughout the year.

The McLennan County Auxiliary was hostess for the winter meeting which was held at the Roosevelt Hotel in Waco, January 12. Twenty-eight members of 7 auxiliaries registered. County reports were read and a nominating committee composed of Mrs. S. H. Burnett, Corsicana; Mrs. F. F. Kirby, Waco; Mrs. J. H. Johnson, Temple, was appointed. Officers elected for 1954-1955 were president, Mrs. G. V. Brindley, Jr., Temple; vice-president, Mrs. E. B. Fine, Waco; secretary, Mrs. S. J. Barron, Corsicana; and press-reporter, Mrs. S. R. Miller, Marlin.

Donations totaling approximately $25 were sent, in memory of deceased members, to the State Auxiliary's Memorial Fund.

Response from the older, larger auxiliaries was excellent throughout the year. However, this council woman was discouraged by the lack of response from many of the newer, smaller auxiliaries in the district.

A tentative total of 293 credits for *Today's Health* subscriptions have been obtained in District 12.

On the whole I feel the Twelfth District Auxiliary is an active unit which, by helping to distribute ideas and information, contributes much to the individual county auxiliaries.

MRS. MILTON SPARK, Waco.

REPORT OF THIRTEENTH DISTRICT COUNCIL WOMAN

The Thirteenth District Medical Auxiliary met as guests of the Tarrant County Woman's Auxiliary on March 24 in Fort Worth for a luncheon. Mrs. Jack A. Crow, district council woman, presided. The invocation was given by State Civil Defense Chairman, Mrs. Mal Rumph of Fort Worth.

County auxiliary presidents gave a brief summary of the past year's work. Talks were given by Mrs. John D. Gleckler, Denison, First Vice-President and Chairman of Organization for the State Auxiliary, a guest; Mrs. Rumph; Mrs. A. B. Pumphrey, Fort Worth, State Mental Health Chairman; and Mrs. J. A. Hallmark, Fort Worth.

The following slate of new officers was presented by Mrs. Pumphrey, chairman of the nominating committee, and duly elected: Mesdames Frank Armstrong, Fort Worth, council woman; Mrs. Blaine Divine, Graham, vice-president; and Mrs. D. O. D. Ware, Fort Worth, secretary-treasurer.

MRS. JACK A. CROW, Abilene.

REPORT OF FIFTEENTH DISTRICT COUNCIL WOMAN

District 15 consists of 10 counties, all of which have an organized auxiliary, although Upshur and Red River Counties Auxiliaries, with 4 members each, are inactive.

The annual Fifteenth District meeting was held in Longview. At a short business session held in the morning, Mrs. Charles J. Wise of Naples was elected to serve as council woman for the coming year. Luncheon and a tea and style show were held in the afternoon, with members of the Gregg County Auxiliary serving as models for the style show.

MRS. CHARLES J. WISE, Naples
(Incoming Council Woman).

REPORT OF ADVISORY COMMITTEE

The duties of this committee are defined to act in an advisory capacity to the President, other officers, and committee chairmen.

As chairman of the Advisory Committee it has been my privilege to work closely with our capable President, Mrs. E. W. Coyle. Upon request, I have expressed opinion and advised with other officers and committee chairmen.

The accomplishments of the year are gratifying. Of particular interest is the progress and usefulness of our outstanding *News Letter*. The new Handbook is a work of art, a source book of necessary auxiliary information, and something of which we should be proud to own. To meet the needs of the growth of the Auxiliary in recent years, necessary revisions of the Constitution and By-Laws have been worked out and proposed for your approval.

In the interest of the Auxiliary I have attended the post-convention Board meeting, the September Board meeting, the meeting of the Texas Medical Association Executive Council in January, and the American Medical Association Rural Health Conference in March.

To be included in making plans for the Woman's Auxiliary to the Texas Medical Association and watching these plans materialize has been a pleasure. In the name of the other six members of this committee I thank you for the opportunity for further service.

MRS. GEORGE TURNER, El Paso, Chairman.

REPORT OF AMERICAN MEDICAL EDUCATION FOUNDATION COMMITTEE

As chairman of such a new committee as the American Medical Education Foundation Committee, there has been much to do to plan and organize this work.

On July 5 cards were mailed to all auxiliary presidents, asking them to appoint a chairman for AMEF and by all means to include this project in the year's work.

In September, one week after the fall Board meeting, each auxiliary president and each council woman was sent a letter explaining, in detail, the functions, aims, and goal of AMEF. Many suggestions were made about methods of raising money or getting contributions. Pamphlets on the subject, prepared by national headquarters, were mailed to the president or chairman, where an appointment had been made.

Only 9 counties answered the first card and appointed local chairmen.

In February notices were sent to the presidents reminding them of report time and urging them to send their contributions, if they had not already done so.

During the year 37 auxiliaries sent contributions. One sent its gift directly to the national AMEF office; 8 others gave only as a part of their district; 4 auxiliaries wrote they were inactive; 7 others answered that they could not give this year; and 58 auxiliaries did not acknowledge any of the cards and letters in any way. Districts 2 and 11 sent gifts from their districts. District 8 was the only district in which each auxiliary in the district gave a contribution.

As your chairman, I have written and sent out approximately 600 cards and letters during the year.

As of May 28, 41 counties had reported contributions to the AMEF and the total of county, district, and individual contributions stood at $2,795.85. Also, it was voted at the Convention that $300 be given in memory of Drs. E. H. Cary, H. R. Dudgeon, and M. L. Graves, and that in addition the State Auxiliary supplement the gift to AMEF so that the amount contributed by county auxiliaries and the $300 memorial gift would total at least $3,500. Accordingly, an additional $500 from the Auxiliary's Special Fund was appropriated, bringing total contributions to $3,595.85.

The following is a report of contributions made as of May 28, 1954:

County Auxiliary Contributions—		
Andrews-Ector-Midland	$ 40.00	
Armstrong-Donley-Childress-Collingsworth-Hall	5.00	
Bell	50.00	
Bexar	400.00	
Bowie-Miller	20.00	
Brazoria	20.05	
Caldwell	2.00	
Cameron-Willacy	8.00	
Camp-Morris-Titus	15.00	
Cass-Marion	2.00	
Cherokee	12.00	
Coleman	5.00	
Colorado-Fayette	4.00	
Crane-Upton-Reagan	8.00	
Dallas	200.00	
DeWitt-Lavaca	5.00	
Ellis	1.00	
El Paso	20.00	
Falls	50.00	
Galveston	289.40	
Grayson	25.00	
Gregg	5.00	
Hardin-Tyler	5.00	
Harris	700.00	
East Harris	15.00	
Harrison	10.00	
Hopkins-Franklin	10.00	
Howard-Martin-Glasscock-Borden-Scurry-Kent-Dickens-Garza-Stonewall	10.00	
Jefferson (Beaumont Chapter, $161.00, and Port Arthur Chapter, $56.00)	217.00	
Lamar	16.00	
LaSalle-Frio-Dimmit	6.00	
Liberty-Chambers	51.00	
Lubbock-Crosby	100.00	
Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala	5.00	
Navarro	5.00	
Nueces	20.00	
Tarrant	213.00	
Taylor-Jones	11.00	
Tom Green-Eight	25.00	
Travis	74.00	
Victoria-Calhoun-Goliad	38.40	
Wharton-Jackson-Matagorda-Fort Bend	33.00	$2,750.85
District Auxiliary Contributions—		
District 2	$ 9.00	
District 11	30.00	$ 39.00
State Auxiliary Contributions—		
From Three Members in Lieu of Orchid	$ 6.00	
Memorial Contribution in Honor of Drs. E. H. Cary, H. R. Dudgeon, and M. L. Graves	300.00	
From Special Fund	500.00	$ 806.00
Total Contributions		$3,595.85

MRS. J. L. JINKINS, Galveston, Chairman.

REPORT OF ARCHIVES COMMITTEE

Your Archives Committee has worked many hours culling out materials and has used a chronological classification to give some idea of the material on hand. A more accurate classification has been made by labeling folders for each year's work.

Your committee recommends that:

1. Before sending data to the Archives, you consult with Mrs. Draker at the central office in Austin concerning the size of material used, since it must be standard size to fit in the new filing cabinets.

2. The quantity of work for the officers grows each year as the organization grows. Therefore, we recommend your sending just the most pertinent material concerning your county auxiliary's accomplishments for the year.

We thank the Texas Medical Association for sharing Mrs. Draker with us, also for housing our Archives files in the headquarters building at Austin.

MRS. F. F. KIRBY, Waco, Chairman,
MRS. GEORGE TIPTON, Austin,
MRS. H. O. WYNEKEN, San Antonio.

REPORT OF BULLETIN COMMITTEE

The *Bulletin,* with its new look, has been welcomed as a bargain by Texas Auxiliary members this year. Subscriptions have been sought particularly by auxiliary officials on all levels—county, district, and state.

Renewal notices went to subscribers, and local presidents responded to your chairman's request for assistance. In May and October, subscriptions were most prevalent. The best method used was inclusion of *Bulletin* in yearly dues. Many auxiliaries strive for 100 per cent Executive Board subscription. To save time and to acquire pertinent information, all members should make a "Bee" line for the *Bulletin* Chairman.

Final count for Texas' fiscal year will be available following the June issue of the *Bulletin.*

MRS. EMIL H. MAREK, Yoakum, Chairman.

REPORT OF CIVIL DEFENSE COMMITTEE

There is nothing mysterious about the atomic threat to the United States. We all are conscious of the peril that exists to our homes because of the high speed global bomb-

ers and the arsenal of atomic weapons which includes the hydrogen bomb and the guided missile. Yet, the few reports received (only 32 out of a possible 115) indicate we are doing little to protect ourselves and our property in case of an attack. Civil defense is a local problem—an individual responsibility that should be started in the home.

In the communities where civil defense programs are getting started or are well-established some of the auxiliary members are working closely with civil defense planning in the blood donor program, by taking as well as instructing courses in Red Cross first aid and home nursing, and by participating through hospital auxiliaries and Parent-Teacher Associations. A few auxiliaries reported that programs were given with talks and films on civil defense shown. Several have completed a file of the nurse members in the group.

Two outstanding reports of auxiliary membership participation came from the Travis County Auxiliary and the El Paso County Auxiliary. Each of these groups has registered its entire membership and placed a card file at the local civil defense headquarters. This file contains information needed in time of disaster—whether civil or natural.

Ten members of the Travis County Auxiliary who completed the Red Cross first aid course taught for auxiliary members served as first aid workers at the Livestock Show in Austin. Other members also are being trained in first aid and this group had a program on civil defense showing the film "The Waking Point."

The El Paso Auxiliary sponsored a series of thirteen weekly television programs, "Nurse Please," on civil defense and home nursing. These were adapted to the local needs. One teacher used the programs for homework in her health class. Many viewers requested the leaflet "Six Survival Secrets" which was offered.

As interest grows and we realize more and more the importance of civil defense in our lives, let us keep in mind this verse: "For God hath not given us the spirit of fear; but of power, and of love, and of a sound mind."—*II Timothy 1:7.*

Your greatest power is you. Prepare now for a safer tomorrow.

MRS. MAL RUMPH, Fort Worth, Chairman.

REPORT OF ESSAY CONTEST COMMITTEE

For the 1954 essay contest of the Association of American Physicians and Surgeons, forty county auxiliaries reported they planned to sponsor the contest locally in their high schools. The subject of the essay was "Why the Private Practice of Medicine Provides This Country With the Finest Medical Care." The following results have been reported:

1. Reports received—35.
2. Reports not received—5.
3. Auxiliaries reporting success—22.
4. Auxiliaries reporting poor results—15.
5. Auxiliaries reporting no response—3.
6. Money given in county prizes—$2,865.
7. Approximate number of essays written in Texas—866.
8. Approximate number of schools participating—100.

The Texas Medical Association donated $1,000 in prize money. The winners and prizes were as follows:

First prize, $250—Milton Copeland, Wichita Falls.
Second, $150—David Curry, El Paso.
Third, $100—Kate Wood, El Campo.
Fourth, $50—Gerald Richmond, Henderson.
Fifth, $25—Tobye Fram, Baytown.
Sixth, $10—Carolyn Monaghan, Waco.
Seventh, $10—Bernadette Borchers, Laredo.
Eighth, $10—Sheridan Mott, El Paso.
Ninth, $10—Helen Meurer, Fredericksburg.
Tenth, $10—Jackey Lumpkin, Houston.

In addition, there were fifteen prizes of $25 each for the best essay in each of the Councilor Districts.

District winners were:

District
1—David Curry, El Paso.
2—Nancy Conway, Big Spring.
3—Norma Friedman, Amarillo.
4—Gladys Coldewey, Winchell.
5—Helen Meurer, Fredericksburg.
6—Bernadette Borchers, Laredo.
7—Caroline Covington, Burnet.
8—Kate Wood, El Campo.
9—Tobye Fram, Baytown.
10—Billy M. Willis, Nacogdoches.
11—Gerald Richmond, Henderson.
12—Carolyn Monaghan, Waco.
13—Milton Copeland, Wichita Falls.
14—Ernest Couch, Dallas.
15—Clara Schell, Longview.

The San Antonio gentlemen who so kindly consented to serve as state judges were: Dr. Royall M. Calder; Owen J. Reamer, Ph. D., Professor of English, Trinity University; and Robert D. O'Callaghan, LL. B., lawyer.

After studying results and reports, I recommend personal contact with the teachers early in the school year; posters or other visual announcements in the school; and a definite outstanding method of presenting prizes. Teachers who do an outstanding job of cooperating should be given recognition.

MRS. A. O. SEVERANCE, San Antonio, Chairman.

REPORT OF FINANCE COMMITTEE

The Finance Committee met in Houston during the Convention and prepared a budget which was presented and accepted at the post-convention Executive Board meeting. As nearly as possible this budget has been adhered to throughout the year.

Letters were sent to all officers, committee chairmen, and council women with enclosed vouchers, information as to use, and the amount allocated in the budget to their office.

I attended the Executive Board meeting in Austin, at which time we made the following recommendations:

1. That the Archives Committee be instructed to purchase a filing cabinet similar to the one already in use, the approximate cost to be $140.

2. That ring binders be purchased for officers, committee chairmen, council women, and county presidents, these binders to be the property of the Auxiliary, to be used to contain all materials pertinent to the office, and to be passed on to the successors in office.

3. That the films which have been approved at this meeting be purchased, these films to be kept in the headquarters building of the Texas Medical Association.

4. That the editor of *News Letter* be allowed $2,000 maximum expenses for the year.

These recommendations were approved by the Executive Board.

On March 1 another letter was sent to all officers, committee chairmen, and council women asking them to return all vouchers to me not later than April 1 in order that the Treasurer might be able to pay all bills and close her books in time for a preliminary audit before the Convention May 2 in San Antonio.

Upon request of the President and President-Elect, a joint meeting of the Finance Committees for 1953-1954 and 1954-1955 was called in April in Dallas. All members except one were present. A budget for 1954-1955 was prepared, to be presented at the Convention.

All bills have been paid promptly. You know from the report of the Treasurer that our finances are in splendid order. It has been a real pleasure to have a part in this

year's work with our President, Anita Coyle, and our efficient Treasurer, Mary Marchman.

MRS. H. LESLIE MOORE, Dallas, Chairman.

REPORT OF HISTORIAN

Your Historian began her year's work by attending the Board meeting in Austin last September. At this meeting it was voted to award blue ribbons in twenty fields of endeavor. The auxiliaries were to be grouped into four groups according to membership to compete for the ribbons.

During the year there have been five official letters mailed out to county auxiliaries, council women, and state committee chairmen concerning the awards. A list of the twenty fields of endeavor was mailed to each county president in October so that she would know about the awards and could work for one. The Historian also mailed letters asking for yearbooks and histories. There has been good response to her requests.

Awards were made by the Historian's Committee with the help of the chairmen of standing state committees who submitted recommendations for awards. These recommendations were checked by the Historian's Committee in an effort to place the awards as fairly as possible. Final decisions were made at a joint meeting of the chairmen held during the Convention.

The Historian this year was able to function only through the splendid interest, cooperation, and help of her committee and the various chairmen.

The following is a history of the year's activities.

History of Year's Work

The year 1953-1954 has been a full and satisfying one for the Woman's Auxiliary to the Texas Medical Association because of the interest, cooperation, and efforts of auxiliaries and individuals.

With "Knowledge, Judgment and Action in Health Leadership" as our theme, special emphasis was placed on friendliness within, that there might be that "extra something" we must feel to accept fully the privileges and responsibilities as individual citizens as well as doctors' wives. Reports show that there was unity in our objectives of fellowship, knowledge and action, and a realization of the true meaning of the national auxiliary theme: "Together We Progress."

We have 105 organized auxiliaries, which include one organized chapter (a part of our largest auxiliary), and nine counties having members-at-large, giving us a total membership of 4,749, an increase of 286 members. One group reported being responsible for the organization of a medical society so that they might have an auxiliary! To strengthen our Organization and Membership program, our Constitution and By-Laws was revised and a fifth vice-president was added. She will serve with the second, third, and fourth vice-presidents as regional chairmen of Organization and Membership, and the first vice-president will serve as state chairman. May we remember that in some parts of the State distances are such that members have to travel 150 miles to attend meetings.

A special effort was made by the President, in cooperation with the Organization Chairman, the Council Women, and the President-Elect, to keep in touch with county groups and to offer encouragement and auxiliary information. Fifty official visits were made to auxiliaries, eleven to district meetings, and, personally and by telephone, approximately twenty-five other contacts with small groups were made while "Touring Texas."

Reports from all size auxiliaries are magnificent, enthusiastic, and stimulating. One auxiliary of three members wrote: "We are necessarily circumscribed in our activities. We feel, however, that we form a nucleus of informed members who can work on an individual basis for better community health and public relations. Through organization we can keep in touch with other communities over the state and be ready to grow when the opportunity presents itself. Although we do not meet regularly, we did present one film on cancer and more films are planned. We would be happy to hear what other small auxiliaries over the state are doing." When such heartening notes as this come in, then we may feel we truly are serving as an Auxiliary to the Medical Profession.

Complete program material, secured from state and national sources and including suggestions from the President of the Texas Medical Association, Dr. George Turner, was prepared and given to county presidents at the annual convention last year. A School of Instruction was conducted at the post-convention Executive Board meeting. Additional material was sent later in the summer by the various chairmen and through the *News Letter*. A one-day Board meeting and conference with a preview of available films was held in September at the headquarters building of the Texas Medical Association in Austin.

Social meetings varied from the strictly social to those combined with other phases of our program. Large and small groups alike adopted projects to increase interest and attendance at medical society meetings, among which was the serving of dinners in homes and medical society library buildings.

Programs for self-education were stressed by speakers, panel discussions, demonstrations by children from such schools as that for the deaf, visits to welfare agencies and special education classrooms, book reviews, and answers to roll call on assigned subjects. "Know Your AMA," "Know Your Auxiliary," "Know Your Community," "Our State Medical Association and Library," civil defense, mental health, safety, juvenile delinquency, geriatrics, legislation, vocational rehabilitation, public relations, health departments, American Medical Education Foundation, nurse recruitment, constitution and by-laws, hobbies, cancer, polio, and many other subjects were presented. Thirty-seven yearbooks of programs were received from county auxiliaries.

"Public Relations in '53 Means Community Service for You and Me," suggested by our chairman at the beginning of the year, truly has been our guide. Health education programs were presented in many different ways on practically every known health subject. Community leaders were taken on tours of hospitals and free clinics. There was an essay contest. Radio and television programs—live and recorded, single and in series—were given on such subjects as "Healthy Living," "Help Yourself to Health" and "Focus on Health." Surveys of health facilities, resources, needs, and the like were made. Exhibits and booths at fairs, stock shows, and rodeos were sponsored, and posters and much health literature was distributed.

In community service we held to the thought that as citizens we play a very definite part in preservation of our "American Way of Life." Auxiliary members, individually and collectively, have cooperated generously with practically all known community agencies, both in special drives and by year-round service on various advisory committees and boards. Other activities included work at "Well-Baby" and other clinics; service on the anti-rabies committee of a Chamber of Commerce; physical examinations among members, their families, servants, and friends; and participation in a "Go to Church" campaign. We sponsored a school immunization program; sent 4,000 medical journals and 500 textbooks to Korea; maintained a coke machine at a county

hospital which netted sufficient for two oxygen tents and other equipment; sponsored the collection of dolls from all clubs in a city for a Christmas Clearing Bureau; and assumed the responsibility for financial, personnel, and special care for children temporarily in a "children's shelter." Books were collected for libraries; parentcraft classes with special TV programs for expectant parents conducted; films donated for weekly showing at juvenile homes; the sale of blind-made products sponsored; and so on. Incomplete reports credit us with 25,390 hours and as having contributed more than $2,500 in cash.

Our Handbook was a special project of the Public Relations Committee. It includes objectives, projects, duties, and lists of auxiliary officers and legislators on state and national levels. The property of the Auxiliary, it was given to every officer, committee chairman, council woman, and county president, to be passed on by her, along with records and suggestions, to her successor.

Eight hundred and sixty essays were written on the subject of "Why the Private Practice of Medicine Furnishes This Country with the Finest Medical Care." County awards, amounting to $2,800, were given by county medical societies. The Texas Medical Association gave a total of $1,000 to state winners. The first place winner was our luncheon guest at our convention, when the President of the Association presented to him the award. Texas had two national winners, again, this year—the third and sixth place winners!

Nurse recruitment was adopted as a project for all size groups. The films "Keepers of the Lamp" and "When You Choose Nursing" have been added by the Auxiliary to those available at the Texas Medical Association's Memorial Library. Fourteen loans totaling $2,475 and eighteen gift scholarships amounting to $3,653 were reported. Four vocational nurses were reported in training and one scholarship given. Approximately 2,233 nurse prospects were reached, with 210 actual recruits. We have forty Future Nurses Clubs, including one male club. The President and the Nurse Recruitment Chairman served on the Coordinating Council of the State Committee for the Improvement of Nursing Service. The President-Elect attended their fall meeting. At a recent meeting of the Coordinating Council, which is composed of the Board of Directors of the Texas Graduate Nurses Association and the Texas League for Nursing, our Auxiliary was commended for the brochure previously mentioned and for the work done throughout Texas in nurse recruitment.

As a mental health project we sponsored, in cooperation with the Texas Society for Mental Health, a "spot survey" of the facilities, resources, and needs of the handicapped child under eighteen years of age. This was done by auxiliaries in all population groups. "Angry Boy" was purchased for use throughout the state, along with other mental health films in our Texas medical library. There were many different kinds of programs, including those on recreation (particularly hobbies) and vocational rehabilitation. "Scattered Showers" was presented on numerous programs. Members worked on financial drives and served on various executive and advisory boards. One auxiliary originated a new slant—an annual visit to a state mental institution, to which community leaders were invited. The patients furnished the program, and reports have it that the patients eagerly look forward to these affairs and plan for them months in advance.

Working in cooperation with the coordinator of women's activities in the State's Defense and Disaster Relief program, a well-planned civil defense program was presented to each auxiliary. This was printed in the monthly bulletin prepared by the Division of Defense and Disaster Relief, with copies of the bulletin being made available to auxiliaries. Our state civil defense chairman served on the Advisory Board of this group. Information and reports show auxiliaries cooperated with local organizations as members on planning committees and working with blood mobiles and other blood donor programs. Surveys were made of qualifications of members and encouragement was given other groups to do the same. This information was placed on file in civil defense headquarters. Suggestions were made on "What To Do" in case of emergencies, and many took part in and taught first aid and home nursing. One thirteen-week TV series was entitled "Nurse, Please."

Our Legislative Committee worked under the direction of the Council on Medical Jurisprudence of the Texas Medical Association. Information received from the national auxiliary was passed on through our chairman and through our *News Letter* to individuals and county groups. There were study groups, speakers, open meetings, "pay your poll tax and vote" campaigns, and communications sent to local, state, and national legislators. Most groups received the AMA's *Washington News Letter,* and attention was called to the *Bulletin* and to the legislative article in the state and AMA journals. The President attended AMA's Regional Legislative Conference in Dallas, Texas, in January.

Auxiliaries and individual members have contributed, often as memorials in lieu of flowers, to our three benevolent funds and the American Medical Education Foundation fund. The amounts contributed this year were:

1. Memorial Fund.—Gifts and interest to this fund amounted to $1,852.26, with $455.10 being given as "love gifts."

2. Student Loan Fund.—Gifts, interest, and loans repaid added $1,700 to this fund, and loans totaling $1,400 were made.

3. Library Fund.—From gifts, $1,000 was given to the Library Building Fund and $340 for rare books, old transactions, and other needed materials.

4. American Medical Education Foundation Fund.—Forty-one counties and two districts reported gifts amounting to $2,795. From our Treasury additional amounts given increased the total to $3,595.

Receipt of an award of merit was announced at the Convention by Mr. Hiram Jones, the national executive secretary of AMEF.

Today's Health was stressed through doctors and members of the Auxiliary. Copies have been placed in libraries and waiting rooms, and have been given out at fairs and health booths. The magazine is used as an official textbook in the schools in one of our larger towns. One group reported giving it to local newspaper editors. Our chairman reported 2,559 credits, with fifteen counties having reached 100 per cent or more of their quotas. *Bulletin* subscriptions have been urged. Five counties report 100 per cent subscription. Ten counties report 100 per cent Executive Board subscription—with our two largest auxiliaries included in this number. County reports showed 536 subscriptions. Our chairman designed a clever little tag to be worn at meetings—which was used by the *Bulletin* committee at the November Conference in Chicago.

Our *News Letter,* a bi-monthly publication sent to every member and to national officers and other state editors, has improved dissemination of information and facilitated better public relations.

Other publicity channels are the "Auxiliary Section" of the TEXAS STATE JOURNAL OF MEDICINE, which has special articles written by Association and Auxiliary officers and chairmen and information concerning county auxiliaries

and individuals. Local newspapers and radio and television stations have been most generous.

We are delighted and honored with the guidance and assistance given by the Texas Medical Association. We have worked closely with the President, Dr. George Turner, and the public relations and legislative councils and more recently met with the Rural Health Committee. In September, 1953, the State Association assigned one of its staff journalists to serve as our executive secretary, whose services have resulted in better planning and greater achievements for the auxiliaries. Office space and a place for our permanent files also were given. Our Archives Committee this year sorted and filed chronologically all records since our organization in 1918. Communications from state officers and committee chairmen were sent out from the central office. Our fall Executive Board meeting was held in the headquarters building for the first time. There was a marked increase in efficiency and interest in the proceedings because of the assistance of the entire staff.

Among projects on the state level, we add that of the revision of our constitution and by-laws. This had not been done, except for minor revisions, since 1942. One important change, in addition to those in organization, is the arrangement of a Program Committee with an appointed chairman instead of an elected vice-president and members to include the chairmen of public relations, civil defense, legislation, mental health, and nurse recruitment. Another is the plan whereby the current and incoming Finance Committee cooperate in preparing the budget.

At our annual state convention in San Antonio, May 1-5, Mrs. George Feldner, President of the Auxiliary to Southern Medical Association, was our guest and speaker for our preconvention luncheon and Executive Board meeting. We had long looked forward to the special pleasure and privilege of having our National President, Mrs. Leo J. Schaefer of Salina, Kan., with us and sincerely regret that because of illness in her family she could not be present. We were honored and pleased, however, to have as our guest speaker the National President-Elect, Mrs. George Turner, El Paso. The Texas Auxiliary is honored to give, for the fourth time, a President to the Auxiliary to the American Medical Association. It is with genuine pride and joy that we give "our Nina," Mrs. George Turner, to serve as President for 1954-1955.

MRS. TRAVIS SMITH, Abilene.

REPORT OF LEGISLATION COMMITTEE

Freedom remains the most valuable possession of Americans. Our prosperity is naught beside it. Of recent years our freedom has been assailed in the interest of distributing our prosperity, and unquestionably the tides of battle have gone more in favor of distribution than of freedom. Apathy remains freedom's greatest enemy.

Your chairman last year in her report stated a credo of the highest type. She placed some confidence in the new national administration but was cognizant that the New Fair Deal stood a good chance of turning the administration away from the ideals expressed in the credo unless apathy were dispelled and individuals—all individuals—got busy and worked to support the beliefs they held.

It has been the endeavor of your committee this year to stimulate auxiliary members throughout the state to assume more interest and effort in legislative affairs at all levels. This being an off-year for the state legislature, we were under no necessity to do anything pertaining to specific legislation at the state level. Local auxiliary presidents and legislative chairmen were urged to assist actively the legislative committees of their respective medical societies in local legislative affairs. The legislative committee of the state auxiliary has exerted its principal effort in informing local presidents and chairmen of the national legislative situations as they arose.

Let us advise all auxiliary members again through this report to remain keenly aware of the continuing rapid advance toward socialism to which much of the health legislation now pending exposes us. If we remain apathetic, uninformed, and silent we progressively will surely lose more of our freedom by default.

As of March, 1954, the bills or issues to watch are:

1. The Bricker Amendment, which lost by one vote and will probably come up in one form or another again soon.
2. Federal reinsurance corporation for voluntary health plans.
3. Medical benefits for veterans with non-service connected disabilities.
4. Federal aid to medical education.
5. Reed-Keogh type bills, allowing tax deferment funds for the self-employed.
6. Free hospitalization benefits for beneficiaries under old age and survivors insurance act.
7. Extension of the Social Security Act to include physicians and other self-employed persons.

I wish to express my thanks for the splendid efforts of my committee members.

It is my pleasure to introduce your legislation chairman for 1954-1955, Mrs. F. Paul Burow of Killeen.

MRS. JOHN KING GLEN, Houston, Chairman.

REPORT OF LIBRARY FUND COMMITTEE

When we think of the reasons we have for feeling proud of being doctors' wives in Texas, one of the first things that comes to mind, I believe, is our contribution to the Association's Memorial Library. The Woman's Auxiliary has been happy to have a part in the realization of the dream of Dr. and Mrs. Sam E. Thompson of Kerrville.

The Auxiliary has given six $1,000 donations, and Mrs. Thompson includes two more—the Thompson Memorial Fund and the Hattie Preston Hunt Memorial Fund, making a total of $8,000. This year we are adding another $1,000 endowment through our county auxiliary donations and Library Memorial Cards.

We are grateful to the Past Presidents for their project this year of supplying rare books and journals for the Library shelves.

A valuable set of volumes 1 to 100 of "The Practitioners" was selected as the gift from eight of our Past Presidents of the Auxiliary.

Our sincere thanks go to Dr. and Mrs. P. I. Nixon of San Antonio and the Bexar County Medical Society and Auxiliary for a wonderful contribution to the Library, several volumes of the "Transactions" of the Texas Medical Association.

Also, from the library shelves of Dr. and Mrs. Sam Thompson a complete library on tuberculosis has been given by them. We will ever be grateful for the vision, work, and love of our Dr. and Mrs. Sam Thompson.

In 1953-1954, 36 auxiliaries donated to the Library Fund. A total of $408.50 was contributed through 70 Library Memorial Cards, which, with the Auxiliary donations of $302.50 and the 1953 balance makes our total $1,126.50. The Past Presidents have contributed $340 to their project of books for the Library.

May we quote again from Dr. Thompson: "Our Library will in time come into its fullest service. It is doing a wonderful work now, but I want to see its purposes and

services broadened and expanded until every doctor in Texas is making use of it."

MRS. S. F. HARRINGTON, Dallas, Chairman,
MRS. SAM E. THOMPSON, Kerrville, Co-Chairman.

REPORT OF MEMORIAL FUND COMMITTEE

It has been said that "an effort made for the happiness of others lifts us above ourselves."

The Memorial Fund Committee has made every effort through the years to scatter a little happiness and comfort to our friends, our doctors' wives or members of a doctor's family who have been left in unfortunate circumstances.

We are grateful to the auxiliaries which made contributions large or small to the Memorial Fund this year. I am sure you have been rewarded with real pleasure and satisfaction. We sincerely hope your interest will continue. To those of you who did not contribute to the Fund, we trust you will become interested in this worthy cause and stress the importance of the work to your auxiliary.

We might say that the Memorial Fund Committee has a three-fold purpose. It is a convenient privilege to contribute to the Fund in lieu of flowers in memory of deceased friends. The relatives who receive the lovely engraved memorial cards deeply appreciate the living memorial honoring their loved ones. Literally the most gratifying aspect of this Fund is our knowledge that it enables us to take an active interest in the often secret but trying hours of a doctor's wife or a member of a doctor's family, hours we could never share individually.

The total amount of contributions to the Memorial Fund this year is $1,170.17, with 34 counties contributing. Our beneficiaries were given $455.

There are two auxiliaries which the committee feels deserve special recognition through their interest and generous contributions to the Fund. Navarro County with a membership of 25 gave $289.40 and according to membership exceeded all other auxiliaries in the state.

Then, Reeves-Ward-Winkler-Loving-Culbertson-Hudspeth Auxiliary with a membership of 21 gave $50. In order to make this gift the auxiliary made a thoughtful gesture in foregoing their annual exchange of Christmas gifts.

"They that do much themselves deny
Receive more blessings from the sky."—*Creech.*

As active, busy women, privileged in life's circumstance because of our husband's high profession, we should recognize the transcience of providence which sometimes apportions us lean years after plenty. Those of us still blessed with health and security must never close our hearts to the needs of others.

MRS. J. GUY JONES, Dallas, Chairman,
MRS. O. M. MARCHMAN, Dallas, Co-Chairman.

REPORT OF MEMORIAL SERVICE COMMITTEE

Letters have been written to each county president asking for names of deceased members, and letters of condolence have been written to the nearest of kin.

Invitations to attend the Memorial Service were sent to the families of deceased members. A memorial tribute was given at the state meeting.

MRS. G. V. BRINDLEY, Temple, Chairman.

REPORT OF MENTAL HEALTH COMMITTEE

The new Committee on Mental Health has undertaken the awakening of state auxiliary members as to the needs each community has in regard to this type of illness. To carry out this plan, an educational campaign was begun early in September. A complete set of suggestions with valuable information was sent each local president. This material was designed not only to inform our own members, but to encourage them to inform the public on this major health problem—a problem growing in intensity each day.

The memorandum presented a variety of activities that could be carried on by any voluntary organization in the health welfare or educational fields. We suggested that our organization do as much as possible in each particular community.

In addition to this, the committee instigated a spot check survey in cooperation with the Texas Mental Health Society. This survey was made by 30 auxiliaries on the problem of handicapped children in each of these localities. The survey listed size of population, number of handicapped, ages, medical treatment, private or public schools, facilities available, number not in school, and what counseling was available to parents. The auxiliaries cooperated well. A statistical report will be published at a later date.

It is felt that the results were well worth the effort, as the survey was done in a scientific manner and was accurate. It informed local auxiliary members as to the conditions of mental problems in their own communities. We hope after being informed that each auxiliary will feel the desire to help alleviate conditions for the mental cases in all fields.

Many counties did valiant work in programs and in individual endeavors in addition to the survey. Perhaps it would be well to commend the following auxiliaries: Armstrong-Donley-Childress-Collingsworth-Hall; Cherokee; Dallas; El Paso; Harris; Harrison; Jefferson; Potter; and Tarrant. Many others carried out suggestions made, as the county reports show.

A bell is the symbol of the mental health movement. The Mental Health Bell was cast in April, 1953, from bits of metal taken from restraints formerly used to bind the mentally ill. It will be rung each year at the launching of Mental Health Week.

Hardly a family in the United States has not in some way been brought close to the problem of mental illness. At any one time probably more than one of every 200 of the population need hospitalization for mental illness, and over a lifetime 1 out of 12 may be expected to need such hospitalization at some time.

The job of helping people become or remain mentally healthy is ours with which to help.

MRS. A. B. PUMPHREY, Fort Worth, Chairman,
MRS. CLEMENT C. BOEHLER, El Paso,
MRS. JOE THORNE GILBERT, Austin,
MRS. RIDINGS LEE, Dallas,
MRS. D. O. D. WARE, Fort Worth.

REPORT OF NEWS LETTER EDITOR

Volume II of the *News Letter* consisted of six issues, published bi-monthly by the printing department of the central office in Austin. Production and mailing are done by the staff there. The editor has planned the material and edited it in accordance with the state auxiliary program for the year.

The total costs have been approximately $1,750. Of this amount, $540 has been for postage; $300, paper; $600 (approximately), mechanics of production; and $300, miscellaneous (including photographs, art, editor's supplies, telephone calls to Austin, and postage).

Besides going to state members, the *News Letter* is sent to editors of other states and national auxiliary and AMA

officers. Often special requests for extra copies are filled as in the case of the picture and story of Mrs. Edward McCormick, wife of the president of the American Medical Association; Mr. Eugene Smith; the National Safety Council; and so forth.

Files are kept by the central office and the editor.

Following the Executive Board meeting in September, 1953, the editor conducted a conference on auxiliary publications assisted by Miss Harriet Cunningham, Mr. Dan Lehman, and Mrs. A. H. Neighbors, Jr.

The editor acknowledges her indebtedness to the many who have assisted in the work of the *News Letter:* the staff in Austin, Mrs. Edward Coyle, Dr. and Mrs. George Turner, Dr. Troy Shafer, state chairmen, and numerous county presidents and secretaries.

MRS. HASKELL D. HATFIELD, El Paso, Editor.

REPORT OF NURSE RECRUITMENT COMMITTEE

In studying reports submitted by county auxiliaries, one fact stands out: Future Nurses Clubs are definitely the means of interesting more girls and boys in the field of nursing and other careers pertaining to the medical world. More enthusiasm was shown in those counties where the auxiliary members themselves were responsible for the sponsoring of these clubs. We should be pleased with the cooperation received from everyone concerned because the response to the clubs has been gratifying.

It has long been recognized that selling girls on the idea of choosing nursing as their careers takes much publicity. Two auxiliaries, Dallas and El Paso, stand out in this endeavor.

Dallas County, under the guidance of Mrs. Joseph L. Knapp as chairman, did an excellent job of publicizing nurse recruitment. It cooperated with representatives of other groups similarly interested, namely, the Committee on Careers in Nursing, the Red Cross director, the Home Nursing instructor, and the deans of nursing from the four schools of nursing in the city. This group sponsored a contest to select "Miss Dallas Student Nurse" at the request of Twentieth-Century Fox Studio and the Interstate Theaters, this being part of the publicity in the first showing of the picture, "The White Witch Doctor." The group then layed the groundwork for Nurse Recruitment Week. Mayors of Dallas and near-by towns proclaimed a week in September as Nurse Recruitment Week. Fifty-two store windows displayed student nurses' uniforms and literature of nursing. In all 3,600 posters and brochures were used for display and distribution. Fifty-eight drug stores joined in with displays of first aid kits and posters in their windows. The radio and television stations gave free time for talks and spot announcements and the newspapers gave free space for special features and pictures. It was the opinion of all individuals who helped in this project that it stimulated the interest of many potential students in making nursing their career, as well as educating the general public concerning the opportunities in nursing as a profession.

El Paso, with Mrs. Louis Breck as chairman, set up a decorated trailer at a local fair for the purpose of acquainting the public with the benefits of nursing as a profession. Both student nurses and members of the auxiliary were present to answer questions and to give literature. El Paso had an excellent idea in the development of a paper cap with the name "Future Nurse" printed across the front; this cap is worn by club members during meetings. This auxiliary compiled brochures on all schools of nursing in the state and gave two copies to each high school in El Paso. It submitted two resolutions for consideration by the Convention. These are that: (1) a brochure of all schools of nursing in Texas be prepared by the State Auxiliary and copies placed in each high school in Texas, and (2) that literature aimed at convincing parents that nursing is a desirable career, showing the salaries, the possibilities for advancement, the hours of work, and the respect in which a career of nursing is held by the community be distributed through the county medical auxiliaries.

The Houston Auxiliary was responsible for having the picture of a student nurse on the front page of the rotogravure section of the *Houston Chronicle,* thus commemorating anniversaries of both the Texas Medical Association and Harris County Medical Society.

Cameron-Willacy Auxiliary reports an excellent job of organizing Future Nurses Clubs. Galveston Auxiliary also has maintained much interest in this portion of its year's work.

Many auxiliaries participated in "Career Days" in local high schools, some actively taking part and others furnishing transportation to various colleges for the same programs.

MRS. J. C. TERRELL, Stephenville, Chairman.

REPORT OF PUBLIC RELATIONS COMMITTEE

"Public Relations in '53 Is Community Service for You and Me." This motto has been carried out well from the state and county levels. The state set the pace by the completion and distribution of the Auxiliary Handbook, the purpose of which is to provide information useful to county and state auxiliary leaders.

The county reports show excellent results in all phases of volunteer work, and a good proportion of the county budgets was spent on public relations projects. These auxiliaries provided speakers, skits, films, and educational material for lay groups and state fairs. Rural group education was stressed, and more people from rural areas took part in medical education projects.

There was evidence also of closer cooperation between the county medical society and the county auxiliary, particularly in the fields of radio and television education, essay contests, and raising funds for the American Medical Education Foundation.

Nurse recruitment and *Today's Health* projects received major attention, with an increasing number of smaller auxiliaries showing impressive results there and in community health workshops.

There was not a community project for better mental and physical health; better social relations; better schools, roads, fire protection; better citizenship; or better community cooperation in which numbers of the auxiliary did not serve as workers or leaders.

Surely this fine display of citizenship demonstrates the execution of the Auxiliary public relations motto and that of our President: "Knowledge, Judgment, and Action in Health Leadership." With large and small auxiliaries showing such outstanding health and sociological leadership, Texans will find a healthy climate for the continuance of the American way of good medicine.

MRS. V. J. SIMMON, Temple, Chairman,
MRS. A. A. ROSS, Lockhart,
MRS. E. A. ROWLEY, Amarillo,
MRS. TRUMAN C. TERRELL, Fort Worth,
MRS. ANDREW S. TOMB, Victoria,
MRS. L. L. D. TUTTLE, Houston,
MRS. H. B. WILLIFORD, Beaumont.

REPORT OF RESEARCH COMMITTEE

A letter was sent in November to all state officers, council women, committee chairmen, and county presidents requesting material for our state files on the following subjects: outstanding and different programs; unique skits; informative and interesting talks by guest speakers; biographies of outstanding physicians; historical reprints; and information on what part medical personnel has played in obtaining and improving health laws and conditions in the various counties. Approximately thirty articles have been received to date.

MRS. J. PEYTON BARNES. Houston, Chairman.

REPORT OF REVISIONS COMMITTEE

The Revisions Committee has undertaken the rewriting of the Constitution and By-Laws. Copies of the proposed revisions were mailed to officers, committee chairmen and members, council women, and county presidents with an enclosed postcard to be returned with comments on the same.

The work has been done under the able direction of the President, Mrs. E. W. Coyle; the President-Elect, Mrs. Mark H. Latimer; the Parliamentarian, Mrs. H. S. Renshaw; and the Executive Secretary, Mrs. Arleen Draker.

MRS. EDWARD C. FERGUSON, Beaumont, Chairman,
MRS. SCOTT C. APPLEWHITE, San Antonio,
MRS. T. H. THOMASON, Fort Worth.

REPORT OF SCHOOL OF INSTRUCTION COMMITTEE

A School of Instruction was held at the post-convention Board meeting in Houston on April 29.

Two hundred and twenty-five invitations were mailed to Board members including the officers, past presidents, council women, county presidents, and committee chairmen. The theme for the School of Instruction was "The Auxiliary Tree of Facts," which brought out facts concerning auxiliary work. The School was planned in order to present information needed for the year's work.

MRS. RAMSAY H. MOORE, Dallas, Chairman.

REPORT OF STUDENT LOAN FUND COMMITTEE

This has been an active year for the Student Loan Fund. Every area of the state has shown interest in this important work. Thirteen of the fifteen districts participated. Many checks from auxiliaries were more generous than before.

A greater number of requests for loans have come to the committee than at any time since your chairman has been associated with the Fund. Six loans have been made for a total of $1,400. There is at this time on my desk a request for a greatly needed loan from a senior medical student. Apparently, the need is growing. A recent letter from Dr. Carl A. Nau, chairman of the committee for loans to students at the Medical Branch of the University of Texas at Galveston, says, "The demands here are heavy and we have reached the point where we are at the 'bottom of the barrel.' We are badly in need of funds and anything that you and your group might do will be greatly appreciated."

Mrs. E. H. Cary, Dallas, made a generous gift in memory of Dr. Cary. Through this gift additional loans can be made. Dr. Cary meant much to the young men in medicine of Texas over the years. His influence will continue for many years because they respected and loved him, and now this memorial will continue to benefit worthy students in a practical way.

The following is a report on growth of the Fund from May 1, 1953, to May 1, 1954:

Gifts from Auxiliaries as Additions to Fund	$ 499.50
Interest on Loans	44.61
Income Earned on Invested Principal	334.18
Gifts Made as Memorials	550.00
Total Increase	$1,428.29

A payment of $50 was made on a long overdue loan. Also, one loan of $250 was repaid and another loan was extended for one year.

It has been a privilege to serve as your Student Loan Chairman for three years. The splendid increase this year is a tribute to your interest and generosity. Since no effort is made by the committee to solicit funds, your support merits even greater commendation.

Mrs. J. Charles Dickson, Houston, who has served so ably during these three years as co-chairman will be chairman next year. She has long been actively interested in this work. She understands the working of the Fund and is most sympathetic with the needs of the students. She will make an excellent chairman.

I shall always retain my interest in the Student Loan Fund and remember with much joy the many contacts it gave me.

MRS. JOHN H. WOOTTERS, Houston, Chairman.

REPORT OF YEARBOOK COMMITTEE

In August letters were written to every county auxiliary president urging them to make their yearbooks and distribute them, sending copies to the President, Historian, Recording Secretary, and Yearbook Chairman.

The Recording Secretary advised this year that her copy of the yearbooks be sent to the central office for filing.

Thirty-seven yearbooks have been received and are on display at this meeting. These yearbooks will be judged according to the four membership groups and blue ribbons will be awarded the winner in each group.

MRS. R. T. TRAVIS, Jacksonville, Chairman,
MRS. DUDLEY JACKSON, JR., San Antonio.

REPORT OF PRESIDENT-ELECT

One of the chief duties of a president-elect is to prepare herself fully that she may meet the challenging responsibilities ahead with intelligence and confidence. This President-Elect has had ample opportunity to learn, to broaden her scope, and to make invaluable contacts through the thoughtfulness of the President, who invited this officer to represent her at several meetings, who made trips with her, and who helped her all along the way.

The President-Elect represented the President at two allied meetings during the year—the first annual convention of the Texas League of Nursing in Austin and the National Rural Health Conference in Dallas.

On a national level the President-Elect attended the annual convention of the Woman's Auxiliary to the American Medical Association in New York, June 1-5, 1953. The highlight of the meeting was the election of Texas' own Nina (Mrs. George) Turner of El Paso as President-Elect of the National Auxiliary. Later, the Annual Conference of State Presidents and Presidents-Elect in Chicago, November 18-20, proved to be a real school.

On a state level this officer attended the post-convention Executive Board meeting in Houston, was presented, and offered herself as an interested apprentice to the President. During the year she attended the fall Executive Board meeting; the Conference on Auxiliary Publications; the Conference of County Presidents and Secretaries of the Texas

Medical Association; and the Association's January Executive Council meeting. These meetings all convened in Austin.

On a district level she represented the President and spoke at the District 14 meeting in Gainesville; the District 10 meeting in Port Arthur; and the District 9 meeting in Brenham.

On a county level she assisted the council woman of District 9 in the reorganization of Washington-Burleson Counties Auxiliary and spoke to Bowie-Miller Counties Auxiliary. Other county auxiliary presidents contacted along the route include those from Polk-San Jacinto, Nacogdoches, Cass-Marion, Anderson-Houston-Leon, Montgomery, and Walker-Madison-Trinity. This officer also accompanied the President when she spoke to the Harris and Liberty-Chambers Counties Auxiliaries.

She was invited to work with the President and the Revisions Chairman in rewriting the state Constitution and By-Laws. This was, indeed, a thoughtful courtesy.

This officer has contacted every county president, council woman, and past State President by personal letter seeking advice and suggestions for appointments and talents. Only with an up-to-date file of such information can all of Texas be represented adequately. This file has been started.

The President-Elect wishes to thank the Texas Medical Association, especially Dr. George Turner, President, and Dr. F. J. L. Blasingame, President-Elect; the central office staff, particularly Mrs. Arleen Draker, Executive Secretary of the Woman's Auxiliary to Texas Medical Association, and Mr. Dan Lehman; and auxiliary members for their patience, understanding, and cooperation during this year of preparation.

MRS. MARK H. LATIMER, Houston.

REPORT OF FIRST VICE-PRESIDENT—CHAIRMAN OF ORGANIZATION

As Chairman of Organization, your First Vice-President wishes to thank the splendid group of council women who have worked so faithfully and conscientiously throughout the year 1953-1954 to promote the aims of the Woman's Auxiliary to the Texas Medical Association. Every effort has been made to sustain and maintain each medical auxiliary in Texas.

At the fall Board meeting last September, the council women who were present met with your chairman to discuss the most practical and far-reaching plan to hold the newly organized auxiliaries and at the same time maintain interest in the established auxiliaries. At that time each council woman received a map of her district, which she accepted with enthusiasm, welcoming the challenge it suggested. Pamphlets and kits of organization material from national headquarters were distributed at this meeting.

As the year progressed, your chairman met with, telephoned, and wrote many letters to each of the council women regarding her individual district and problems. We sincerely feel, on reviewing the past months' accomplishments, that the work done by all the committee with the untiring help of Mrs. Coyle and Mrs. Latimer was tremendous and outstanding.

During the months following the September Board meeting, the picture of state organization became clearer. Where auxiliary strength was found, it was encouraged, and where there was weakness, every effort through personal contact, letters, and telephone calls was made to renew interest and friendship. Not one organization was "left to die" if it felt it could not maintain itself.

At the beginning of the year your chairman asked the older well-established auxiliaries to adopt a smaller newer auxiliary for the purpose of instructing and befriending that auxiliary. Many auxiliaries invited their young neighbor groups to share their programs with them now and then, and we sincerely hope that this will become a custom, as it will give mutual pleasure and support.

As of May 2 we have 105 organized auxiliaries, with members at large from nine counties where there are medical societies. Our total membership has increased to 4,749, of which we are very proud.

MRS. JOHN D. GLECKLER, Denison.

REPORT OF SECOND VICE-PRESIDENT—CHAIRMAN OF PHYSICAL EXAMINATIONS

As Chairman of Physical Examinations, I wrote a personal letter to each county auxiliary president asking her to urge that all members and servants in every doctor's family have physical examinations.

The report as of April 1 is as follows:

District	No. Examinations	District	No. Examinations
1	349	9	1,986
2	1	10	729
3	341	11	76
4	131	12	436
5	488	13	1,044
6	831	14	2,240
7	277	15	139
8	359		
		Total	9,427

MRS. CECIL O. PATTERSON, Dallas.

REPORT OF THIRD VICE-PRESIDENT—CHAIRMAN OF TODAY'S HEALTH

As Third Vice-President and Chairman of *Today's Health*, I have sent out letters and material from the *Today's Health* circulation department to all auxiliaries. Also, sample letters from our National *Today's Health* Chairman, Mrs. Richard F. Stover of Florida, were sent out to provide suggestions for promoting the sale of *Today's Health*. In December a mimeographed "Texas Tips 'N Topics" on *Today's Health* was sent to each auxiliary.

Our contest closes April 14, 1954, so my report is incomplete; however, I am hopeful our final report will show Texas in the forefront.

A report from *Today's Health* circulation department lists the following auxiliaries having 100 per cent or more subscription: Angelina (176%), Armstrong-Donley-Childress-Collingsworth-Hall (353%), Bell (100%), Brazos-Robertson (114%), Cameron-Willacy (171%), Camp-Morris-Titus (240%), Cherokee (178%), Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson (100%), Hardin-Tyler (117%), Kerr-Kendall-Gillespie-Bandera (203%), McLennan (297%), Navarro (275%), Orange (106%), Potter (101%), and Wharton-Jackson-Matagorda-Fort Bend (162%).

A special mention should go to Harris, Dallas, and Bexar Counties for their splendid *Today's Health* and public relations joint effort.

Many thanks for a wonderful year for Texas.

MRS. RALPH B. PAYNE, Amarillo.

REPORT OF FOURTH VICE-PRESIDENT—CHAIRMAN OF PROGRAM

The program for the Woman's Auxiliary to the Texas Medical Association has been built around the President's

slogan for the year: "Knowledge, Judgment, and Action in Health Leadership." Materials have been sent to county presidents concerning the various projects the Auxiliary is promoting, as well as material on health topics which could be used as a basis for programs during the year.

The program material from the Woman's Auxiliary to the American Medical Association was received in August, and this material was distributed to the county presidents in the fall of 1953. The theme of this material "Know Your Community" met with response in many groups this year and, perhaps, will be enlarged upon in future programs. Safety, juvenile delinquency, and mental health were three subjects used most often in programming.

It is becoming evident in program materials that the emphasis of auxiliary members is turning more from just "Good fellowship among doctors' wives" to "Good relationships in our communities as doctors' wives."

MRS. GUY E. KNOLLE, Houston.

REPORT OF RECORDING SECRETARY

It was a pleasure to serve as Recording Secretary for the post-convention and fall Executive Board meetings. However, due to illness in my family I was unable to carry on my duties after Christmas. Full credit should go to Mrs. Charles McGehee, San Antonio, Corresponding Secretary, and Mrs. Newton F. Walker, El Paso, Recording Secretary pro tem, who have substituted for me most capably and graciously. My lasting appreciation goes to Mrs. E. W. Coyle for her understanding and assistance.

MRS. PAUL BRINDLEY, Galveston.

REPORT OF TREASURER

State and national dues have been credited to 4,726 members as of April 20, 1954. Included in this number are seventy-three wives of doctors in service whose dues were paid from the Special Fund, two state honorary members who are exempt from state dues and one national honorary member who pays no dues.

Your Treasurer has four funds in her custody: the General Fund, which is the administrative account; the Special Fund, in which the receipts from Texas Medical Association are kept and disbursed for specified purposes; the Memorial Fund Account, which is the depository for memorial donations and the interest received from the trust and disbursed to indigent widows; and the Library Fund, which holds the donations to this fund until they are given to the Texas Medical Association Memorial Library.

A thorough check of these accounts was made April 20, 1954, by the auditor and his letter of verification has been submitted. The complete audit extends to the final closing of the books and the detailed account of transactions will be found in the report of the auditor. The balance on hand in these accounts April 20, 1954, follows:

General Fund	$12,806.45
Special Fund	6,673.06
Memorial Fund:	
Checking account	$359.83
Emergency account	452.77
	812.60
Library Fund	126.50
Total Funds under custody of Treasurer	$20,418.61

The Memorial Trust Fund is held by the Republic National Bank of Dallas. On March 31, 1954, the following report of assets was issued:

Cash	$ 1,031.52
Bonds	8,953.00
Common Trust A	5,480.00
Accrued Interest on Bonds	292.00
Total Memorial Trust Fund	$15,756.58

The Student Loan Fund Trusts are held by the South Texas National Bank of Houston. On March 1, 1954, the following report of assets was issued:

George Plunket Red—Trust 33	
Bond	$ 3,000.00
Savings	2,537.15
Cash	85.07
Notes Receivable	660.00
Total	$ 6,282.22
Student Loan Fund Trust—Trust 147	
Bonds	$ 3,000.00
Stock	3,748.50
Cash	5,370.58
Notes Receivable	3,969.83
Total	$16,088.91
Total Student Loan Fund Trust Funds	$22,371.13

(Since there is a difference in the date of report on the various funds and trusts, the total assets figure is necessarily an approximate one.)

Approximate total assets of the Woman's Auxiliary to the Texas Medical Association, May 1, 1954, $58,496.32.

I wish to add that since this report was filed, the membership has increased to 4,749.

MRS. OSCAR MARCHMAN, JR., Dallas.

REPORT OF AUDITOR—SUBMITTED BY TREASURER

Woman's Auxiliary to the Texas Medical Association
Dallas, Texas
Ladies:

In accordance with your request, we have examined the records of receipts and disbursements of the following fund accounts of the Woman's Auxiliary to the Texas Medical Association for the period April 22, 1953, to May 18, 1954: General Fund, Special Fund, Regular Memorial Fund, Emergency Memorial Fund, and Library Fund.

Our examination was made in accordance with generally accepted auditing standards and included such tests of the records of receipts and disbursements as we considered necessary.

In our opinion, the accompanying Summary of Fund Transactions and the Statement of Receipts and Disbursements for each fund present fairly the results of operations of such funds for the period April 22, 1953, to May 18, 1954.

May 25, 1954.

E. R. BOYD & COMPANY.

SUMMARY OF FUND TRANSACTIONS
April 22, 1953, Through May 18, 1954

	General Fund	Special Fund	Regular Memorial Fund	Emergency Memorial Fund	Library Fund	Total
Balance on Hand April 22, 1953	$11,706.43	$ 5,256.99	$ 362.67	$ 443.86	$ 408.36	$18,178.31
Add: Receipts	9,696.00	5,569.52	2,105.03	8.91	1,058.14	18,437.60
Total To Be Accounted For	$21,402.43	$10,826.51	$ 2,467.70	$ 452.77	$ 1,466.50	$36,615.91
Less: Disbursements	9,319.28	4,984.51	1,902.17	452.77		
					1,340.00	17,998.73
Balance on Hand May 18, 1954	$12,083.15	$ 5,842.00	$ 565.53	$ —0—	$ 126.50	$18,617.18

STATEMENT OF GENERAL FUND RECEIPTS

April 22, 1953, Through May 18, 1954

Counties:	
Aoderson-Houston-Leon	$ 30.00
Andrews-Ector-Midland	114.00
Angelina	34.00
Armstrong-Donley-Childress-Collingsworth-Hall	32.00
Atascosa	12.00
Austin-Waller	16.00
Bastrop-Lee	22.00
Baylor-Knox-Haskell	18.00
Bee-Live Oak-McMullen	16.00
Bell	156.00
Bexar	748.00
Bosque	18 00
Bowie-Miller	55.00
Brazoria	52.00
Brazos-Robertson	36.00
Brooks-Duval-Jim Wells	30.00
Brown-Comanche-Mills-San Saba	48.00
Caldwell	12.00
Cameron-Willacy	110.00
Camp-Morris-Titus	32.00
Cass-Marion	30.00
Cherokee	42.00
Clay-Montague-Wise	22.00
Coleman	18.00
Collin	4.00
Colorado-Fayette	31 00
Comal	18.00
Cooke	24.00
Coryell	10.00
Crane-Upton-Reagan	8.00
Dallam-Hartley-Sherman-Moore	22.00
Dallas	1,214.00
Dawson-Lynn-Terry-Gaines-Yoakum	30.00
Denton	48.00
DeWitt-Lavaca	52.00
Eastland-Callahan-Stephens-Shackelford-Throckmorton	34.00
Ellis	46.00
El Paso	286.00
Erath-Hood-Somervell	20.00
Falls	48.00
Fanoin	6.00
Freestone	6.00
Galveston	245.00
Gonzales	10.00
Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson	76.00
Grayson	84.00
Gregg	98.00
Grimes	14.00
Guadalupe	6.00
Hale-Floyd-Briscoe-Swisher	12.00
Hamilton	4.00
Hardeman-Cottle-Foard-Motley	12.00
Hardin-Tyler	16.00
Harris and East Harris	1,311.00
Harrison	32.00
Hays-Blanco	22.00
Henderson	18.00
Hidalgo-Starr	88.00
Hill	10.00
Hopkins-Franklin	28.00
Howard-Martin-Glasscock	40.00
Hunt-Rockwall-Rains	56.00
Jasper-Newton	24.00
Jefferson	350.00
Johnson	38.00
Karnes-Wilson	16.00
Kaufman	4.00
Kerr-Kendall-Gillespie-Bandera	70.00
Kimble-Mason-Menard-McCulloch	2.00
Kleberg-Kennedy	20.00
Lamar	46.00
Lamb-Bailey-Hockley-Cochran	6.00
Lampasas-Burnet-Llano	24.00
LaSalle-Frio-Dimmit	8.00
Liberty-Chambers	28.00
Limestone	2.00
Lubbock-Crosby	158.00
Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala	54.00
McLennan	140.00
Milam	28.00
Montgomery	2.00
Nacogdoches	30.00
Navarro	50.00
Nolan-Fisher-Mitchell	14.00
Nueces	258.00
Orange	40.00
Palo Pinto-Parker-Young-Jack-Archer	46.00
Pecos-Jeff Davis-Presidio-Brewster	26.00
Polk-San Jacinto	14.00
Potter	190.00
Red River	8.00
Reeves-Ward-Winkler-Loving-Culberson-Hudspeth	46.00
Runnels	12.00
Rusk-Panola	34.00
San Patricio-Aransas-Refugio	38.00
Shelby-San Augustine	12.00
Smith	120.00
Tarrant	662.00
Taylor-Jones	150.00
Tom Green-Eight	96.00
Travis	320.00
Upshur	10.00
Van Zandt	2.00
Victoria-Calhoun-Goliad	62.00
Walker-Madison-Trinity	16.00
Washington	20.00
Webb-Zapata-Jim Hogg	40.00
Wharton-Jackson-Matagorda-Fort Bend	70.00
Wichita	168.00
Wilbarger	34.00
Williamsoo	14.00
Wood	2.00
Total County Receipts	$9,416.00
Dues paid from Special Fund for wives of doctors io service	74.00
Total Receipts from Current Dues	$9,490.00
Other Receipts:	
Late dues	$169.00
Gift from Burroughs Welcome	25 00
Prior year check cancelled	12.00
Funds transferred from Library Fund for convenience of transmittal	$1,340.00
Less, disbursements for Library Fund	1,340.00 −0−
Total Other Receipts	206.00
Total Receipts—General Fund	$9,696.00

STATEMENT OF GENERAL FUND DISBURSEMENTS

April 22, 1953, Through May 18, 1954

Officers' Expenses:		
President, Discretionary	$1,000.00	
Clerical, Supplies, Telephone and Telegraph	425.00	$1,425.00
President-Elect		257.34
Recordiog Secretary		27.78
Corresponding Secretary		44.29
Publicity Secretary		26.22
Treasurer		250.00
Historian		51.99
Total Officers' Expenses		$2,082.62
Committee Chairmen's Expenses:		
Archives	$ 12.81	
Organization	40.44	
Program	26.59	
Physical Examinations	5.40	
Today's Health	9.96	
Finance	12.50	
Student Loan	17.42	
Memorial Fund	23.00	
Memorial Service	5.00	
Mental Health	15.91	
Library	15.00	
Yearbook	9.00	
Research	5.25	
Bulletio	16.00	
School of Instruction	26.00	
Nurse Recruitment	31.86	
Revisions	50.46	
Civil Defense	18.55	
American Medical Education Foundation	35.50	
Total Committee Chairmeh's Expenses		376.65

Council Women's Expenses:		
District 1	$ 25.00	
District 3	39.31	
District 6	24.00	
District 7	8.38	
District 8	14.36	
District 10	23.49	
District 12	25.00	
District 15	25.00	
Total Council Women's Expenses		184.54
General Expenses:		
National Dues	$4,744.00	
Printing	155.81	
Refund of Overpayment of Dues	4.00	
Miscellaneous	39.05	
Memorial Trust Fund of Woman's Auxiliary to the Texas Medical Association in Memory of Deceased Presidents of Auxiliary	200.00	
American Medical Education Foundation in Memory of Dr. E. H. Cary, Dr. H. R. Dudgeon, and Dr. M. L. Graves	300.00	
Total General Expenses		5,442.86
Total Disbursements—Current Year		$8,086.67
Disbursements for Prior Year:		
American Medical Education Foundation	$1,000.00	
National Dues	84.00	
Treasurer	21.95	
Convention Message	11.79	
Council Women	69.11	
Present to Texas Medical Building	41.65	
Historian	4.11	
Total Disbursements for Prior Year		1,232.61
Total Disbursements—General Fund		$9,319.28

STATEMENT OF SPECIAL FUND RECEIPTS AND DISBURSEMENTS

April 22, 1953, Through May 18, 1954

Receipts:		
Refund from Houston Convention Committee		$ 102.52
Texas Medical Association—		
July 2, 1953	$ 691.00	
November 7, 1953	135.00	
January 6, 1954	440.50	
April 4, 1954	4,200.50	5,467.00
Total Receipts—Special Fund		$5,569.52
Disbursements:		
Current Year		
Travel Expense of President and President-Elect to AMA Convention and Conference	$ 771.12	
Essay Committee	51.75	
Convention Expense	572.50	
Handbooks	394.83	
Health Films	186.58	
Public Relations	17.61	
Legislation Committee	13.45	
Filing Cabinet	137.27	
Executive Secretary	26.50	
Dues for Wives of Doctors in Service	74.00	
News Letter	1,903.47	
American Medical Educational Foundation	500.00	
Total Current Disbursements		4,649.08
Disbursements for Prior Year:		
Convention	$ 54.00	
News Letter	281.43	
Total Disbursements for Prior Year		335.43
Total Disbursements—Special Fund		$4,984.51

STATEMENT OF REGULAR MEMORIAL FUND RECEIPTS

April 22, 1953, Through May 18, 1954

Receipts from Contributions:		
Counties:		
Andrews-Ector-Midland	$ 10.00	
Angelina	5.00	
Armstrong-Donley-Childress-Collingsworth-Hall	2.00	
Bell	10.00	
Bexar	92.50	
Cameron-Willacy	5.00	
Cass-Marion	2.00	
Cherokee	1.00	
Cooke	5.00	
Dallas	390.50	
DeWitt-Lavaca	5.00	
El Paso	10.00	
Galveston	20.00	
Grayson	10.00	
Harris and East Harris	93.00	
Harrison	10.00	
Howard-Martin-Glasscock	10.00	
Hunt-Rockwall-Rains	4.00	
Jefferson	30.00	
Lamar	5.00	
Liberty-Chambers	2.00	
Lubbock-Crosby	25.00	
Nacogdoches	2.50	
Navarro	289.40	
Nueces	5.00	
Pecos-Jeff Davis-Presidio-Brewster	11.00	
Potter	15.00	
Reeves-Ward-Winkler-Loving-Culberson-Hudspeth	50.00	
Taylor-Jones	5.00	
Tom Green-Eight	15.00	
Victoria-Calhoun-Goliad	5.00	
Washington-Burleson	5.00	
Wharton-Jackson-Matagorda-Fort Bend	5.00	
District 12	15.27	
Total Contributions		$1,170.17
Other Receipts:		
Transfer from Emergency Memorial Fund	$452.77	
Interest Received from Memorial Trust Fund	482.09	
Total Other Receipts		934.86
Total Receipts—Regular Memorial Fund		$2,105.03
Disbursements:		
Gifts to Doctors' Widows:		
Case A	$ 50.00	
Case B	400.00	
Case D	5.10	$ 455.10
Transfer of Contributions to Memorial Fund Trust Account at the Republic National Bank of Dallas		1,447.07
Total Disbursements—Regular Memorial Fund		$1,902.17

STATEMENT OF EMERGENCY MEMORIAL FUND RECEIPTS AND DISBURSEMENTS

April 22, 1953, Through May 18, 1954

Receipts:	
Interest Earned	$ 8.91
Total Receipts—Emergency Memorial Fund	$ 8.91
Disbursements:	
Transfer Funds to Regular Memorial Fund on May 17, 1954	$452.77
Total Disbursements—Emergency Memorial Fund	$452.77

STATEMENT OF LIBRARY FUND RECEIPTS AND DISBURSEMENTS

April 22, 1953, Through May 18, 1954

Receipts:	
Individual Contributions:	
Dr. and Mrs. Orville Egbert	$ 25.00
Dr. and Mrs. V. R. Hurst	25.00
Dr. and Mrs. Charles Dildy	20.00
Dr. and Mrs. C. L. Gray, Jr.	6.00
M. Miller	5.00
Dr. and Mrs. J. T. Carlisle	2.50
Mrs. J. T. Carlisle	25.00
Dr. and Mrs. Joseph McCracken	8.00
Dr. and Mrs. S. M. Hill	17.00
Dr. and Mrs. Ray Harrington	35.00

Dr. and Mrs. S. F. Harrington	50.00	
Mr. and Mrs. Mitch Gray Gilbert	35.00	
Mrs. G. A. Ray	50.00	
Brig. Gen. and Mrs. Millard Lewis	100.00	
Dr. and Mrs. Mark Latimer	5.00	
Total Individual Contributions		$ 408.50
Past President's Project for Purchasing of "The Practitioner" for the Library:		
Mrs. Sam Thompson	$ 50.00	
Mrs. S. F. Harrington	50.00	
Mrs. E. C. Ferguson	50.00	
Mrs. S. M. Hill	50.00	
Mrs. J. B. Foster	50.00	
Mrs. Robert F. Thompson	20.00	
In Memory of Mrs. C. B. Alexander	20.00	
Mrs. O. W. Robinson	50.00	
Total		340.00
County Contributions:		
Andrews-Ector-Midland	$ 12.00	
Bell	5.00	
Bexar	5.00	
Bowie	5.00	
Brazoria	5.00	
Brazos-Robertson	5.00	
Cameron-Willacy	10.00	
Cass-Marion	2.00	
Cherokee	5.00	
Coleman	1.00	
Cooke	10.00	
Crane-Upton-Reagan	20.00	
Dallas	25.00	
Denton	1.00	
DeWitt-Lavaca	5.00	
El Paso	5.00	
Galveston	5.00	
Grayson	5.00	
Gregg	5.00	
Harris	15.00	
East Harris	5.00	
Harrison	5.00	
Hidalgo-Starr	10.00	
Jefferson	25.00	
Kerr-Kendall-Gillespie-Bandera	15.00	
Lamar	6.00	
Lubbock-Crosby	25.00	
Nacogdoches	2.50	
Navarro	5.00	
Nueces	5.00	
Potter	3.00	
Taylor-Jones	5.00	
Tom Green-Eight	10.00	
Travis	15.00	
Victoria-Calhoun-Goliad	10.00	
Wharton-Jackson-Matagorda-Fort Bend	5.00	
Total County Contributions		302.50
Other Receipts:		
Interest Earned		7.14
Total Receipts—Library Fund		$1,058.14
Disbursements:		
Texas Medical Association Library		$1,000.00
Library of Texas Medical Association for the Purchase of "The Practitioner"		340.00
Total Disbursements—Library Fund		$1,340.00

E. R. BOYD & COMPANY, CPA, Dallas.
MRS. O. M. MARCHMAN, JR., Dallas.

REPORT OF CORRESPONDING SECRETARY

As Corresponding Secretary it was my pleasure to attend the state meeting in Houston and San Antonio, and the fall Board meeting in Austin.

Cards were mailed to the delegates representing Texas at the national convention. Letters and cards were written to obtain the names of incoming county presidents.

Cards were sent to all officers and chairmen asking for names of committee members and for amounts of stationery needed. Lists were compiled of the names and addresses of officers, committee chairmen, committee members, council women and county presidents.

Letters were written when possible for the President, and several county and district meetings were attended with her. Notices were sent of the fall Board meeting.

Because of unforeseen circumstances, this office handled the annual reports which are usually processed by the Recording Secretary.

It has been a distinct privilege to work in such close contact with our State President who has done so much to alert us to our responsibilities as auxiliary members and as active citizens.

MRS. CHARLES L. MCGEHEE, San Antonio.

REPORT OF PUBLICITY SECRETARY

The Publicity Secretary attended the Board meeting in Houston and the Board meeting held in Austin in the fall.

Since this year brought a new policy for our TEXAS STATE JOURNAL OF MEDICINE publicity, I tried to help the program by attending the Conference on Auxiliary Publications which was held in September. This conference was called to discuss the various medias of communication used by the Auxiliary. The media available are primarily the county bulletins, local newspapers, state auxiliary *News Letter*, TEXAS STATE JOURNAL OF MEDICINE, and the national *Bulletin*. The program for each of these channels was planned.

With the assistance of two staff members, an outline in detail for the material used in the JOURNAL was approved. The articles used in the JOURNAL were of interest in recording items which were reflective of the objectives and major attainments of the Auxiliary. Our goal also was to interest physicians in the work of the Auxiliary and encourage their cooperation with the Auxiliary. Over the period of this past year we have tried to use articles which would touch on all major phases of our Auxiliary work. This procedure gave the various state chairmen an opportunity to reach their audience, not only auxiliary members (their co-workers), but also their doctor-husbands.

The general articles described have not taken all the allotted space in the JOURNAL each month. We have used the remaining space to give reports of activities done in counties over the state. These reports have in no way covered all we would have wished to report but were the items reported to me.

For the first time a scrapbook of auxiliary publicity has been compiled in order to give an account of the year's publicity and to act as a guide for incoming county presidents and publicity secretaries in showing how, where, and what makes for good auxiliary publicity.

In September each county president and publicity secretary was given a directive, "Publicity for Woman's Auxiliary," this to be used as an aide for writing and obtaining material for JOURNAL news, ideas for newspaper publicity, and for radio and television spots. Postcards were sent later in the year requesting news for the national *Bulletin*.

Detailed information giving suggestions for publicity was sent out to several counties upon request. For example, Grayson County Auxiliary asked for ideas on how to publicize its first Doctor's Day observance.

MRS. A. H. NEIGHBORS, JR., Austin.

REPORT OF PARLIAMENTARIAN

As Parliamentarian it has been my privilege to consult with our President, Mrs. E. W. Coyle, whenever called upon concerning parliamentary procedure. I have worked with the Revisions Committee and Mrs. Coyle upon the revisions

of the state Constitution and By-Laws. I have attended the post-convention Executive Board meeting in Houston in May, 1953, the Executive Board meeting in Austin in September, 1953, and the Executive Board meeting in San Antonio in May, 1954.

MRS. H. S. RENSHAW, Fort Worth.

REPORT OF PRESIDENT

The year 1953-1954 has been a most enjoyable, stimulating and an enriching one for your President, and *you* have made it so. Your friendliness, your interest, and your enthusiastic cooperation in the aims and ideals of our Auxiliary have produced the excellent results shown in your reports.

This officer is proud of your wonderful achievements and realizes the only claim she can make to any part of your success is in the hope that as she visited you, or in correspondence with you, she conveyed information and inspiration, plus the feeling she has concerning the privileges and responsibilities that we have as doctors' wives and citizens. She did try to pass on to you information and suggestions from the Texas Medical Association, and the American Medical Association and its Auxiliary, as well as thoughts from messages of outstanding lay speakers heard at state and national meetings and the Conference of State Presidents and Presidents-Elect and information on legislation and other subjects in our state and national medical journals.

Since her activities have been covered in detail elsewhere, your President mentions only that she presided at three Executive Board meetings—the post-convention breakfast-meeting in Houston, the fall meeting in Austin, and the pre-convention luncheon-meeting in San Antonio—and the Annual State Convention in San Antonio, May 1-5, 1954.

She has served on the Advisory Boards of the State March of Dimes, the Texas Division of the American Cancer Society, and the Coordinating Council of the Texas Graduate Nurses and the Texas League for Nursing. Though she was invited to attend meetings of the state mental health and civil defense organizations, the Auxiliary was represented officially by our chairmen of these two committees. She attended the American Medical Association's Regional Legislative Conference in Dallas, and regretted that she was unable to attend its Rural Health Conference.

Though greatly disappointed that she could not personally visit all auxiliaries, she did meet with approximately fifty county and eleven district groups. At these meetings she contacted representatives of approximately twenty-five smaller groups not otherwise visited. While "touring Texas" she visited with presidents and other members of the newer small auxiliaries and reached numerous others by telephone. She stressed the importance of their united efforts and working as individuals in their communities and was delighted to find that many groups feel as does a group of three who wrote: "We are necessarily circumscribed in our efforts. However, we feel that we form a nucleus of informed members who can work on an individual basis for better community health and public relations. In organization we can keep in touch with other communities throughout the state and be ready to grow when the opportunity presents itself. We did show one film on cancer and other films are planned. We shall be interested in hearing what other small communities are doing." You may be interested to know that approximately 23,000 miles were traveled by plane, train, and car in the year's "touring."

Though there is no record of outgoing mail, approximately $75 in stamps was used. An effort was made to answer all mail promptly. When your President was out of the city, mail was taken care of by her husband and the Corresponding Secretary. When she was home, answers were made by personal postals, letters, telegrams, and telephone. She must confess that there are many "thank you" notes still unwritten. She is constantly remembering and is grateful for your many thoughtful courtesies extended when visiting you, and for all that you, through individual and collective effort, did during the year in your community.

The record of your achievements has been sent to the National Auxiliary and is included in the History compiled by your Historian and President and appearing as a part of these Transactions. May I urge you to read it so that you may realize anew the value of your service even though we know that no one can realize how far reaching a continuing influence such as yours can be.

Your President wishes to express to the following her sincere gratitude and appreciation for all that has been done to make this year such a happy and fruitful one:

I. The Texas Medical Association, through:

A. The Board of Trustees for:

1. Their interest in and appreciation of the efforts of the Auxiliary in its purpose to serve as an Auxiliary to the Medical Profession;
2. The financial assistance which has enabled the Auxiliary to serve more intelligently and efficiently and with greater and more far reaching results, through publication and mailing of the *News Letter,* expanded this year to a bi-monthly publication; attendance by the President and President-Elect at the meeting of the Auxiliary to the American Medical Association and the annual Conference of State Presidents and Presidents-Elect; publication and distribution of a Handbook for officers, committee chairmen, council women and county presidents; purchase of a mental health and two nurse recruitment films; payment of State and National dues of members whose husbands are temporarily serving in the armed forces; giving of a substantial gift to the American Medical Educational Foundation Fund; and payment of the major portion of Convention expenses, certain essay committee expense, and the like;
3. Furnishing an Executive Secretary whose guidance and assistance during the year and with the Convention is incalculable and whose services will continue to grow in value. The work and effectiveness of the Auxiliary program have greatly increased.

B. Mr. N. C. Forrester, Executive Secretary of the Texas Medical Association, Miss Harriet Cunningham, Managing Editor of the TEXAS STATE JOURNAL OF MEDICINE, Mr. Dan Lehman, Association staff member in charge of services, and other members of the staff for their complete cooperation and help in many ways.

C. Mrs. Arleen Draker, Auxiliary Executive Secretary, who has been most gracious and efficient in the planning and the execution of plans for the year and for the Convention, and whose services definitely enhanced the effectiveness of the work of the President.

D. Dr. George Turner, President of the Texas Medical Association, for his valuable suggestions, guidance, understanding, and even his spontaneous "chuckle" which furnished encouragement all along the year's

way. The President is grateful for the information and inspiration received by her and other members of the Auxiliary through attendance at the Association's Executive Council Meetings;

E. The Public Relations and Judicial Committees for information and guidance in the fields of public relations and legislation, and for the privilege of meetings with these committees; also, the Committee on Rural Health for its information and encouragement for Auxiliary programs in this field.

F. The firm of Syers, Pickle and Winn, public relations counsel of the Texas Medical Association, for their direction and particular help with the Handbook, as well as all other phases of our work plus the special mailings sent to each member of the Auxiliary prior to the Convention.

II. Mrs. John Parsons, the General Chairman for the Convention, and her committees for the planning and smooth operation of all arrangements which made the Convention our most successful and enjoyable one.

III. You, "My Official Family," who so willingly cooperated in carrying out the duties and privileges of your various offices; you, each member, whose interest, work, and importance is deeply appreciated.

IV. Mr. H. B. Zachry, who furnished plane transportation to various county and district meetings, making it possible to visit more groups, and, because of the ease with which the President "toured" on these trips, to serve more efficiently and with greater enthusiasm.

V. My spouse, Edward, whose unselfishness, thoughtfulness, and helpfulness during the year exemplified the fact that without the complete cooperation and understanding of our husbands, auxiliary members, particularly the President, cannot execute well their various official duties.

And so, for the honor, privilege, and responsibilities which I have enjoyed to the fullest, may I, again, say "Thank you."

MRS. E. W. COYLE, San Antonio.

LUNCHEON HONORING MRS. E. H. CARY AND CHARTER MEMBERS

At 12:00 noon Tuesday, May 4, 1954, a luncheon honoring Mrs. E. H. Cary, Dallas, first President of the Woman's Auxiliary to the Texas Medical Association, and charter members was given in the Colonial Room of the Menger Hotel, San Antonio, with the President, Mrs. Edward W. Coyle, San Antonio, presiding. Mrs. S. Foster Moore, San Antonio, was chairman.

The invocation was given by Mrs. P. R. Denman, Houston, a Past State President.

The President read the names of the 1918 officers and council women, then known as district organizers. Two of these, Mrs. M. L. Graves, Houston, Fourth Vice-President and Chairman of Organization in her district, and Mrs. E. V. DePew, San Antonio, Publicity Secretary, were introduced. Messages from the following 1918 officers and district organizers were acknowledged: Mrs. A. P. Howard, Houston; Mrs. H. G. Walcott, Dallas; Mrs. O. M. Marchman, Dallas; Mrs. Frank Boyd, Fort Worth; Mrs. William Simminger (formerly Mrs. J. M. Daly), Abilene; Mrs. Charles R. Hartsook, Wichita Falls; Mrs. J. E. Dildy, Brownwood; Mrs. T. J. Bennett, Arlington, formerly of Austin; and Mrs. J. W. Burns, Cuero.

Eight charter members present then were introduced by the President: Mrs. H. Leslie Moore, Dallas; Mrs. Scott C. Applewhite, San Antonio; Mrs. P. I. Nixon, San Antonio; Mrs. J. P. Oldham, San Antonio; Mrs. John L. Pridgen, San Antonio; Mrs. Frank W. Sorrell, San Antonio; Mrs. Jack Watts, San Antonio; and Mrs. Frank N. Haggard, San Antonio.

In the absence of Mrs. E. H. Cary, the President gave the following early information of the Auxiliary and read portions of a letter from Mrs. Cary:

Our meeting today is incomplete because our first State President, Mrs. Edward H. Cary, could not be with us. We had hoped until the last moment that she might feel that she could attend. Before I read portions of a letter from her, may I bring a bit of information of our organization.

Before 1918, the wives were just "visiting ladies." There were all-day shopping tours, teas, little dinner parties, and grand receptions—all for their pleasure. In 1918, there were drives, breakfasts, musical teas, swimming parties, Mexican eats and knitting parties for the boys "over there." The *San Antonio Express,* May 16, 1918, said that: "The entertainment committee of the Auxiliary to the Bexar County Medical Association gave a luncheon at the Country Club . . . honoring the wives and daughters of members of the State Medical Association, the affair being marked by the organization of a state auxiliary. . . . Covers were laid for 350. The auxiliary will lend its aid in all patriotic, philanthropic and social activities. . . .

". . . more than 200 women enjoyed an early morning swim and . . . breakfast . . . cooked in the open. . . ."

Dr. E. H. Cary of Dallas had enthusiastically championed the cause of the new organization and was greatly responsible for its being born. I want to read to you portions of a letter received from Mrs. Cary: "Easter has come again, leaving me with a renewed sense of gratitude to our Creator that among other gifts to mankind, He provided for those who are in sorrow His compassion and the sympathy of friends. . . . The extra copies of the *News Letter* with its tribute to him (Dr. Cary) are treasured by us all. . . . May I repeat the lines which are so beautiful?

DR. CARY

'Silently . . .
in greeting,
in kindness shown,
in humble and in noble tasks well done,
in faithfulness to that for which he lived
this man had grown
his own magnificat,
quick'ning in the lives of all whom he had known
more lastingly than words of pen
or lines in stone may tell,
an epitaph eternal.'

In an unequalled way this expresses the fineness of him and other doctors who have gone. I want to thank its author.

"When you suggested having the luncheon in honor of your first President and her co-workers and charter members of the first State Auxiliary, I was deeply touched and pleased . . . into my inexperienced hands, so long ago, was placed the first two years of the Presidency. Our work, of course, was principally that of organization. I wrote to every president of every county medical society in Texas. Some opposition was shown, but our objective of social, philanthropic and patriotic work won enough support to carry on and we did quite a lot of war work. . . . There was no pattern to guide us during those first years . . . but the newly formed county auxiliaries found and did much good work. . . . For the second meeting I wrote a paper entitled, I think, 'Since

we have the vote, what shall we do with it?' It was most comprehensive, starting with woman's influence since the dawn of civilization to the then present day. . . . I suggested that we doctors' wives use our votes to further health legislation and for the protection of the Medical Profession. . . . I do want you and the Auxiliary, through you, to know of the deep appreciation I have of the honor, the sympathy, and help given me through the years—individually and as an organization. In my last greatest sorrow, their help has been incalculable.

"I am sorry not to be at the Luncheon and the meeting. To the workers in the formative stage of the State Auxiliary, I send anew my thanks for their support and interest; to the impressive line of brilliant and efficient Presidents who followed me, my greetings; and to the members of the State Auxiliary as a whole, my affectionate appreciation.

"I am enclosing a check for the Student Loan Fund in memory of my husband, Edward Henry Cary. He appreciated the work of the Auxiliary and would be pleased that through it a young man could be helped to enter the Medical Profession which he loved and considered the greatest career of all—that of being a *good* doctor.

"With gratitude and affectionate good wishes, I am,

Most sincerely,

GEORGIA F. S. CARY."

The President presented the Convention Chairmen and thanked them, again, for all the planning and efforts that had made the Convention so successful. Messages were read from Mrs. Paul Brindley, Galveston; Mrs. S. A. Collom, Texarkana; and Mrs. O. M. Marchman, Dallas.

Report of Resolutions Committee

Mrs. Joseph H. McCracken, Jr., Dallas, Chairman of the Resolutions Committee, presented the following report:

As we come to the close of our thirty-sixth annual meeting of the Woman's Auxiliary to the Texas Medical Association, held in the beautiful and historical city of San Antonio, May 1 through 5, 1954, the Resolutions Committee wishes to express for the entire Auxiliary our deepest appreciation for the wonderful meeting we have had and the achievements which have been accomplished in each county and district through the work of each county president, council woman, and committee chairman.

We wish to express to our charming State President our love and appreciation for the work she has so competently accomplished for our State.

To Dr. George Turner of El Paso and the doctors of Texas, we wish to express our appreciation for our having the privilege of being a part of the great organization, and for the wonderful work they do for the health and happiness of the people of Texas.

At this time we should also like to express our appreciation to the committee of three men which judged the AAPS essays.

To the Menger Hotel, which is ninety-six years of age and has played such an important part in the life of San Antonio and Texas, we wish to say "Thank you" for all the courtesies extended the Auxiliary during our meeting.

To Mrs. John Parsons and the Bexar County Auxiliary, we wish to express our thanks for the delightful meeting and entertainments we have enjoyed and the spirit with which they have carried out the plans and wishes of this meeting.

We wish to thank also the press for the wonderful publicity they have given to this most successful Convention.

BE IT RESOLVED, that in appreciation for the above stated courtesies, a copy of these Resolutions be entered into the minutes of this meeting.

MRS. JOSEPH H. MCCRACKEN, Dallas,
Chairman;
MRS. CARLOS HAMILTON, Houston;
MRS. SAMUEL M. HILL, Dallas;
MRS. NEWTON F. WALKER, El Paso.

Mrs. S. F. Harrington, Dallas, suggested that thanks be sent to Dr. and Mrs. P. I. Nixon, San Antonio, and Bexar County Medical Society for early transactions of the Texas Medical Association given to the Memorial Library.

The President expressed her appreciation and gratitude for the generous contributions made by Mr. H. B. Zachry during the year to the Auxiliary and, thus, to the Medical Profession. Through his kindness and generosity, she had been able to visit by plane, more auxiliaries than originally planned, thereby allowing her to give more time and efficient service to the Auxiliary.

The President expressed regret that Mrs. Leo J. Shaefer, Salina, Kan., President of the Woman's Auxiliary to the American Medical Association, was unable to attend the Convention due to the serious illness of Dr. Shaefer. Mrs. Frank N. Haggard, San Antonio, moved that a telegram be sent to Mrs. Shaefer expressing our regret. Motion carried.

The President then introduced Mrs. George Turner, El Paso, one of our Past Presidents and now President-Elect of the Woman's Auxiliary to the American Medical Association and the official representative of the national organization at the Convention. Mrs. Turner gave the following address:

Address of Mrs. George Turner

We never fully merit the honors bestowed upon us, for there are so many others with whom any accomplishment must be shared. To each of you of my own El Paso County Auxiliary and State Auxiliary who have given me the opportunity to serve, I share the honors you have made possible for me. As I speak to you, I am filled with mixed emotions. The responsibility of the office I am about to assume and the confidence you have manifested in me on many occasions make me feel very humble. The opportunity of another year to serve the Auxiliary in the promotion of health education and community health service makes me most happy.

In any endeavor, we are guided by the light of the lamp of past experience. There is no safer way of projecting plans for the future than by the past. I accept with pride the years of experience which is our heritage. I pledge to you that I will use it as a pattern and guide to advance progressively the program and sphere of the Auxiliary, as outlined for us by the American Medical Association and the varying needs of the communities in which we live. I pray for guidance and that I may be deserving of the confidence placed in me and ask your cooperation and help. I wish to speak to you on *Leadership in Community Health.*

Aim.—In any undertaking a definite aim must be established and a program planned to support it. Leadership in Community Health will be our aim. Our program will be blueprinted for self education within the Auxiliary and health education and health service in the respective communities. The mantle of health leadership falls upon the shoulders of the doctor's wife the day she marries her doctor; the people in her community naturally look to her for guidance and help in health problems. Outside the realm of home, family, and church, the obligation of the doctor's wife is an active interest in her husband's profession which can be met if she fulfills her duties as an auxiliary member.

The diverse program of the Auxiliary makes it possible for the member to choose the field for her contribution to her community. It may be something in which she is already trained or that in which she has a vital interest.

The problem today seems to be how to live "in the thick of thin things," to borrow a phrase from Edith Wharton. It can be done by bolstering our convictions, seeing things as they are, and where possible changing them for the better. This is not always the easy or popular thing but it does put us in a position to do a better job.

It can be done by recognizing that vast areas of life are wholesome. This realization is a source of confidence to us and adds strength to our efforts to make life, as we see it, more effective.

It can be done by casting our lot with ideas and institutions in which we believe. The Auxiliary has done this—we do believe in the ideas and ideals of American medicine and our lot is cast with the American Medical Association, State Medical Association, and the various county medical societies.

It can be done by work, words, and deeds worthy of record. The 64,000 women who make up the membership of the Auxiliary are working for health, speaking out for health, and striving to establish acceptable health standards through Leadership in Community Health.

Organization.—The structural frame of our organization is complete. However, the recent announcement of 146,723 members of the American Medical Association sets a new and all time high goal for our membership. A matching auxiliary membership would establish the idea of complete unity and be an effective means of placing the Auxiliary in the role of Leadership in Community Health.

Community Facilities.—It is recommended that county and state auxiliaries make a survey of the existing health facilities and make their findings available to the community, as a public service and directive to better community health. A prepared leaflet with this information should receive wide distribution, especially among newcomers in the community and the lower income bracket groups. The medical society, the health department, the hospitals and health clinics, the American Cancer Society, the National Foundation for Infantile Paralysis, the Cerebral Palsy clinics, the Light House for the Blind, the Commission on Chronic Illnesses, the Red Cross, school health services, the nursing associations, and the like are maintained in the communities for the betterment of community health. Individual participation in the work of these organizations by the auxiliary member places her in a natural role for Leadership in Community Health.

Program.—Nothing new is added to the program this year. Re-evaluation, special emphasis where needed, and an all-out effort will be placed behind the projects already under development to increase their effectiveness. Health legislation, civil defense, the American Medical Education Foundation, nurse recruitment, and rural health are vital factors for consideration in the health pattern of the community.

The fact that more proposed bills with medico-economic implications are introduced to Congress than any other type of legislation is positive proof of public interest in health. The county auxiliary must be informed currently on this type of proposed legislation by a monthly report from its legislative chairman. Individually, members are asked to participate in the "get out the vote campaign" for the November, 1954, elections.

Voluntary health insurance plans are in a state of reorganization since the introduction of the proposed federal "reinsurance" of voluntary health insurance. Industry and the insurance companies are discussing a new type plan, which would cover catastrophic illnesses and contain a deductible clause whereby the beneficiary would underwrite the first one to two hundred dollars medical expense, as he would pay for minor auto damage under a deductible policy.

Recruiting, training, and registration of volunteers for civil defense must continue at a stepped-up speed. The recent hydrogen bomb tests reveal the increased power of explosion such as to render bomb shelters totally inadequate. Obviously, the problem becomes one of mass evacuation, transportation, housing, and nutrition in temporary surroundings, in addition to all the other aspects of such disaster. Likewise, recruiting and training of nurses remains a specific and acute problem.

A steady supply of well trained physicians is essential to meet the demands of the armed forces and the civilian population. This year the deficit in maintenance of our seventy-nine medical schools totaled ten million dollars. The American Medical Association and the Auxiliary believe that private contributions, rather than government aid, should solve this problem. Individual, county, and state auxiliary donations added together will help materially to reach the goal of the American Medical Education Foundation.

Rural people have become very health conscious and adept in solving their own health problems and improving their general living conditions. Auxiliaries can render a real community service by assisting this group with their health problems by sponsoring health forums featuring speakers on timely subjects of local interest and general health education.

Special Emphasis.—In cooperation with your county medical society, encourage the revival or the establishment and the availability of a *speakers bureau* composed of medical society and auxiliary members for community health programs.

The *medical forum* idea is snowballing throughout the country as medical societies, auxiliaries, and the newspapers join forces to bring their communities up to date health information. Medical societies will capitalize on the public relations potential of the Woman's Auxiliary in carrying through on this project. You are urged to climb aboard the medical forum bandwagon for 1954-1955 by being instrumental in putting on, at least, one health forum in your community.

Mental health is a burning question on all sides. You are asked to study and actively work with your county and state mental health societies, as individuals. As a stimulus, advise your county medical society, your state mental health commissioner, and the local and state psychiatric societies that you are interested in working with them. The mental health committee of the American Medical Association requests the names of state and county medical societies and auxiliaries having mental health chairmen with a resumé of aims and accomplishments in mental health.

Put *safety* high on your activity list. Medical science will never produce a vaccine to prevent accidents. The recent White House Conference on Highway Safety emphasized the importance of participation of women's groups in initiating safety programs; developing a conscious responsibility for traffic safety; and a positive, active support of the efforts of the professional highway safety people. Everyone knows the three "E's" of traffic safety: Engineering, Enforcement, and Education. If we, through conscious responsibility, are willing to set an example of carefulness and consideration and influence others to do the same, we can add other "E's" to safety: Example and Experience. Mobilization of public opinion is the solution and here lies another opportunity

for Leadership in Community Health. Saving healthy lives is more important than saving diseased lives.

Juvenile delinqency problems blazon the headlines of all newspapers and magazines. Again, the problem is only indirectly related to health. Drug addiction, alcoholism, sex perversion, and petty thievery seem to be the main offenses of these youths who sooner or later become both physical and mental cases. Leadership in Community Health through the juvenile courts, youth agencies, and Parent-Teacher Associations is the auxiliary member's entree into the solution of this community problem.

Auxiliary members, as individuals, were asked this year to support and cooperate in the local areas in the vaccine validity study of the National Foundation for Infantile Paralysis and the Crusade for Freedom which is the project of the American Heritage Foundation. No doubt, this or a similar opportunity for community service will again be ours in 1955.

Self Education.—To be a qualified health leader, auxiliary members must keep informed by reading the *Bulletin; Today's Health;* the editorials and organization sections and the President's monthly message in the *Journal of the American Medical Association* and the state journals of medicine; and the letters and literature sent to you by the Auxiliary committee chairmen and officers. Our central offices in Chicago and Austin are maintained to serve you and through our efficient staffs and the resources available to them, you may obtain any help you need.

Universal interest in the American Medical Association is significant because it is the voice of American medicine. The world is small. This realization led to the organization of the World Medical Association which is the voice of 700,000 practicing physicians, representing forty-three national medical associations. The World Health Organization is in no way connected with these two organizations. It is a branch of the United Nations and represents governments of the world in the health field. As individuals, I implore you to study the history, aims, and the resources of these three organizations as a part of your education for Leadership in Community Health.

The achievements of American medicine are unparalleled and our pride in them justifiable. However, we must realize that the appreciation of the public is not based on excellent medical care alone but in ratio to our devotion to the welfare of the community through health education and community health service. It is in this unobtrusive daily relationship between the doctors and his patients and the doctor's wife and her contacts that confidence in our sincerity and ability as leaders in community health is established.

"A leader is best
When people barely know he exists,
Not so good when people obey and acclaim him,
Worse when they despise him.
Fail to honor people, they fail to honor you
But a good leader, who talks little,
When his work is done, his aim fulfilled,
They will all say, 'We did this ourselves.' "

—Laotze, 500 B. C.

The annual Auxiliary awards were presented by the Historian, Mrs. Travis Smith, Abilene, as follows:

AWARDS

Bosque County Auxiliary, District 12, and Webb-Zapata-Jim Hogg Counties Auxiliary, District 6, both with a 233.3 per cent increase in membership, were awarded a tie for the silver membership loving cup.

Other awards include the following:

(Group 1 includes auxiliaries having a membership from 1 through 25; Group 2 from 26 through 50; Group 3 from 51 through 100; and Group 4 all over 100.)

MEMBERSHIP

Group 1—Bosque.
Webb-Zapata-Jim Hogg.
Group 2—Wharton-Jackson-Matagorda-Fort Bend.
Group 3—Cameron-Willacy.
Group 4—Harris and East Harris Chapter.
Galveston.

MEMBERSHIP, 100%

Group 1—Caldwell.
Group 2—None.
Group 3—Potter.
Group 4—None.

LEGISLATION

Group 1—Cherokee.
Group 2—Victoria-Calhoun-Goliad.
Ellis, tie ribbon.
Group 3—Bell.
Group 4—Tarrant.
Harris, tie ribbon.

TODAY'S HEALTH

Group 1—Cooke, 83%.
Group 2—Victoria-Calhoun-Goliad, 75%.
Group 3—Taylor-Jones, 35%.
Group 4—Jefferson, 84%.

TODAY'S HEALTH, 100%

Angelina.
Armstrong-Donley-Childress-Collingsworth-Hall.
Atascosa.
Brazoria.
Brazos-Robertson.
Cameron-Willacy.
Camp-Morris-Titus.
Cherokee.
Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson.
Hardin-Tyler.
Harris.
McLennan.
Navarro.
Potter.

BULLETIN

Group 1—Dewitt-Lavaca.
Group 2—Grayson.
Group 3—McLennan.
Group 4—Jefferson.

BULLETIN, 100%

Liberty-Chambers.
Freestone.
Hopkins-Franklin.
East Harris Chapter, Special Mention.

NURSE RECRUITMENT

Group 1—San Patricio-Aransas-Refugio.
Pecos-Jeff Davis-Presidio-Brewster, tie ribbon.
Group 2—Brazoria.
Kerr-Kendall-Gillespie-Bandera, tie ribbon.
Group 3—Cameron-Willacy.
Group 4—Galveston.
Dallas, tie ribbon.

MENTAL HEALTH

Group 1—Harrison.
Cherokee, tie ribbon.
Group 2—None.
Group 3—Potter.
Group 4—El Paso.

PHYSICAL EXAMINATIONS

Group 1—Caldwell.
Hamilton, Special Mention.
Group 2—Gray-Wheeler-Hansford-Hemphill-Lipscomb-Roberts-Ochiltree-Hutchinson-Carson.
Tom Green-Eight, tie ribbon.
Group 3—Cameron-Willacy.
Group 4—Dallas.

PHYSICAL EXAMINATIONS, 100%

Caldwell.
Hardin-Tyler.

CIVIL DEFENSE

Group 1—Navarro.
Caldwell, tie ribbon.
Group 2—Tom Green-Eight.
Group 3—Cameron-Willacy.
Group 4—El Paso.
Travis, tie ribbon.

LIBRARY FUND

Group 1—Crane-Upton-Reagan.
Group 2—Gregg.
Group 3—Lubbock-Crosby.
Group 4—Dallas.

STUDENT LOAN FUND

Group 1—Reeves-Ward-Winkler-Loving-Culberson-Hudspeth.
Group 2—Bowie-Miller.
Group 3—Lubbock-Crosby.
Group 4—Harris.
Galveston, tie ribbon.

MEMORIAL FUND

Group 1—Reeves-Ward-Winkler-Loving-Culberson-Hudspeth.
Navarro, tie ribbon.
Group 2—Tom Green-Eight.
Group 3—Lubbock-Crosby.
Group 4—Dallas.

AMERICAN MEDICAL EDUCATION FOUNDATION
(Greatest Per Capita Contribution)

Group 1—Liberty-Chambers.
Group 2—Victoria-Calhoun-Goliad.
Group 3—Lubbock-Crosby.
Group 4—Galveston.

AMERICAN MEDICAL EDUCATION FOUNDATION
(100% Membership Contribution First Reported)

Group 1—Coleman.
Group 2—Wharton-Jackson-Matagorda-Fort Bend.
Tom Green-Eight, tie ribbon.
Group 3—Taylor-Jones.
Group 4—Bexar.

YEARBOOKS

Group 1—Denton.
Brown-Comanche-Mills-San Saba, tie ribbon.
Group 2—Navarro.
Grayson, tie ribbon.
Group 3—Bell.
Taylor-Jones, tie ribbon.
Group 4—El Paso.
Tarrant, tie ribbon.

PUBLIC RELATIONS

Group 1—Caldwell.
Group 2—Grayson.
Group 3—Wichita.
Group 4—El Paso.
Dallas, tie ribbon.

SCRAPBOOK

Group 1—Navarro.
Group 2—None.
Group 3—Taylor-Jones.
Group 4—Tarrant.
El Paso, tie ribbon.

COUNTY HISTORIES

Group 1—Navarro.
Group 2—None.
Group 3—Lubbock-Crosby.
Group 4—Bexar.

COMPLETE COUNTY HISTORIES

Group 1—Brown-Comanche-Mills-San Saba.
Group 2—None.
Group 3—Taylor-Jones.
Group 4—Harris.

ESSAY

Group 1—Rusk-Panola.
Webb-Zapata-Jim Hogg, tie ribbon.
Group 2—Brazoria.
Group 3—Taylor-Jones.
Potter, tie ribbon.
Group 4—El Paso.
Harris, tie ribbon.

Election and Installation of Officers

In the absence of the Parliamentarian, the Recording Secretary read from the By-Laws concerning the officers and their election.

In the absence of Mrs. Robert F. Thompson, El Paso, Chairman, the report of the Nominating Committee was read by Mrs. F. F. Kirby, Waco. There being no nominations from the floor, upon the motion of Mrs. E. H. Marek, Yoakum, the following officers were elected by voice vote:

President—Mrs. Mark H. Latimer, Houston.
President-Elect—Mrs. Joseph H. McCracken, Jr., Dallas.
First Vice-President—Mrs. Mal Rumph, Fort Worth.
Second Vice-President—Mrs. Harold Lindley, Pecos.
Third Vice-President—Mrs. Howard Dudgeon, Jr., Waco.
Fourth Vice-President—Mrs. Troy Shafer, Harlingen.
Fifth Vice-President—Mrs. August J. Streit, Amarillo.
Treasurer—Mrs. J. C. Terrell, Stephenville.
Recording Secretary—Mrs. P. M. Kuykendall, Ranger.
Corresponding Secretary—Mrs. William Palm, Houston.
Publicity Secretary—Mrs. A. H. Neighbors, Jr., Austin.
Parliamentarian—Mrs. John E. Hill, Marshall.

(Mrs. Hill could not be present for reasons explained and accepted by the Nominating Committee.)

These officers were installed by Mrs. George Turner, El Paso, as follows:

The installation of new officers is a momentous occasion. It is the end of a year and the beginning of a year. The accomplishments of the officers who are retiring from office are projected into the year which you are entering. To be elected to these offices is an honor, but, the final and lasting honor depends upon how well you carry your responsibilities and discharge your duties.

Leadership is the guiding of the activities of an organization; and the accomplishments of the year depend upon the quality of the leadership.

Leaders must assume responsibility.
Leaders must be hard workers.
Leaders must make decisions.
Leaders must have confidence in themselves.
Leaders must have knowledge.
Leaders must be open-minded.
Leaders must be unselfish, unbiased, and understanding.
Leaders must delegate details.
Leaders must spend their time organizing, deputizing, and supervising.

Mrs. Latimer, as President you are the chief executive officer. Your duties are to promote the objectives and advance the work of the Auxiliary; plan the work with the Executive Board and officers; consult with the Advisory Committee; select the chairmen of standing committees with the approval of the Executive Committee; assist the committees with their work; assist the county auxiliaries by visits, communications and literature; plan and preside at all meetings; and finally, at the end of the year, submit your reports.

The honor of being elected President has come to you in recognition of your years of loyal service to the Auxiliary. Your sincerity, enthusiasm, ability, and belief in the Auxiliary will bring credit and honor to us. Yours is a great responsibility.

Mrs. McCracken, as President-Elect the office of President automatically falls upon you after the next annual Convention. You were chosen for your ability and your devotion to the work of the Auxiliary in the other offices which you have held. The coming year will give you the opportunity to study and familiarize yourself with the routine of the

President's office. You may do this by working with the President, carrying out your assigned tasks, and attending district, state and national meetings. May you have a profitable year.

Mrs. Rumph, as First Vice-President you are the Chairman of Organization and Membership. You shall perform the duties of the President, in her absence, and if for any reason the office of President becomes vacant, you shall succeed to that office with all the prerogatives and duties pertaining thereto.

The Second, Third, Fourth and Fifth Vice-Presidents, Mrs. Lindley, Mrs. Dudgeon, Mrs. Shafer, and Mrs. Streit, you shall be Regional Chairmen of Organization and Membership in the region where you reside, working under the First Vice-President. In order, you shall assume vacancies in offices as they occur.

The Recording, Corresponding, and Publicity Secretaries, Mrs. Kuykendall, Mrs. Palm, and Mrs. Neighbors, you are charged with keeping an accurate record of the Auxiliary transactions and reports; answering and keeping a file of the Auxiliary correspondence; and giving publicity, as deemed advisable, to Auxiliary affairs. The history of the Auxiliary is based upon your records.

Mrs. Terrell, as Treasurer you are the custodian of the funds. Your specific duties are to instruct the county treasurers in their work; collect the dues; keep the membership records up to date; keep accurate record of all receipts and disbursements and present a financial report upon the request of the President; and give an annual audited report at Convention.

These officers, by their presence here, have signified their willingness to serve. May we, as members, pledge them our loyalty and support? Our responsibility to them is as great as theirs is to us. Will you please rise and thereby give assurance of your wholehearted cooperation?

As installing officer, I now declare these officers duly elected and installed. Under their leadership, the Auxiliary should enjoy another successful year. The Nominating Committee is to be congratulated for selecting such a fine group of officers.

The gavel and the President's Pin were presented to Mrs. Latimer by Mrs. Coyle:

Presentation and Acceptance of Gavel and President's Pin

We are glad, Charlotte, that Auxiliary matters are to be in the hands of one so capable and so fine and who realizes the ever increasing responsibilities we have to the medical profession and to the world we live in. We look forward to a year of interest and progress under your leadership. At the end of the year, I know you will find as I have that you have reaped far more than you could sow. The combined love, goodwill, and enthusiastic cooperation given you everywhere will give you a feeling that your own efforts were feeble by contrast. It has been a genuine joy to work with you this year. I look forward to our continued service together, however, I trust that I shall not forget that I am a *Past President* even though my love for the Auxiliary and my belief in our purpose and objectives shall never wane. It is with mixed emotions that I present to you our gavel and our President's pin. A bit of sadness creeps in when I realize that I shall be missing the touring and the visits this year, but I am happy because it is to you that I am passing those privileges and joys. May the coming year be our most successful one!

As Mrs. Latimer accepted the gavel and President's Pin she was presented a bouquet of red roses from the Woman's Auxiliary to the Harris County Medical Society. Her message was as follows:

This pin I shall wear over my heart as evidence that my heart is in the work of this organization. I shall wear it with pride and joy. How fortunate I am to be privileged to represent such a great body of women.

It is appropriate yet trite to say I accept this gavel, the symbol of great responsibility, with qualms—wondering how I can measure up to my predecessors, especially Mrs. Coyle, whose outstanding work and accomplishments are so fresh in our minds.

Yet I chose to say it is because of these fine women and the specific contributions each has made that I accept the responsibility as a challenge. They shall be my pattern. But in the end we must be ourselves, not in a personal, petty way but by working diligently and constructively in the way we know to work.

There is no set formula for success, yet that is what we ever strive for in all walks of life. I like the definition of the late Henry Ford who said:

> "Getting together is a Beginning.
> Staying together is Progress.
> Working together is Success."

With the Grace of God and the help and trust of each of you we can have a healthy, happy year of work together. Yes, we can have success.

Mrs. Frank N. Haggard, San Antonio, then presented the Past President's Pin and a lovely silver tray from the Bexar County Auxiliary to Mrs. Edward W. Coyle:

Presentation and Acceptance of Past President's Pin

Anita, I am indeed happy to present to you for your very own a facsimile of this beautiful gold pin you have cherished for the past year. May it be a reminder of the love and esteem this Auxiliary has held for your constructive work during your administration, and now that you will no longer be touring Texas officially I would like to welcome you home to the ranks of the retired presidents.

Our gracious Bexar County president, Mrs. John C. Parsons, was to have had the honor of presenting this gift to you from the Bexar County Medical Auxiliary, but she was called away to preside at our tea which follows.

We feel that few members have given so much to her auxiliary, community, church and home, as has Anita. This token symbolizes the love and appreciation of our entire membership.

Mrs. Coyle graciously accepted the Past President's Pin and the silver tray:

Thank you, Josephine. I shall cherish this pin, always. It shall remind me constantly of the vision and the accomplishments of you who have contributed so much. I shall ever be conscious of the love, interest, and the work of you who led us in building the foundation and adding each year to the growth of the organization which we are so proud of today. I am conscious of the high honor and the rare privilege of serving this year and of joining, now, that wonderful group of auxiliary members—the Past Presidents!

And, thank you again, Josephine. The tray is beautiful and I shall enjoy using it. It shall remind me of the joys and privileges I have enjoyed through the years as a member of the Bexar County Auxiliary; of the training received while serving here that has enabled me to continue doing my bit for the medical profession through our State Auxiliary; of the Auxiliary's fine work in fellowship and community service this year; and of the wonderfully successful Convention, with you, the Auxiliary to the Bexar County

Medical Society, as hostess. With all my heart, I thank you.

The final registration number of 537 was announced by the Registration Chairman, Mrs. Thomas H. Sharp, San Antonio.

There being no further business, the President, Mrs. Latimer, declared the thirty-sixth annual convention of the Woman's Auxiliary to the Texas Medical Association adjourned, sine die.

MRS. NEWTON F. WALKER, El Paso,
Recording Secretary Pro Tem.

TEA AND TOUR

Following the adjournment of the 1953-1954 convention, a tea and tour of the King William Street Homes in San Antonio was given honoring the State President, Mrs. Edward W. Coyle, San Antonio, and the President-Elect, Mrs. Mark H. Latimer, Houston, and the National President-Elect, Mrs. George Turner, El Paso. Other honored guests were Mrs. F. J. L. Blasingame, Wharton, wife of the President-Elect of the Texas Medical Association; Mrs. Merton M. Minter, San Antonio, wife of the President of the Bexar County Medical Society; and Mrs. John C. Parsons, San Antonio, President of the Woman's Auxiliary to the Bexar County Medical Society.

POST-CONVENTION EXECUTIVE BOARD MEETING

The Executive Board of the Woman's Auxiliary to the Texas Medical Association met in post-convention session at 9:30 a. m., Wednesday, May 5, 1954, in the Minuet Room of the Menger Hotel, San Antonio, with the President, Mrs. Mark H. Latimer, Houston, presiding. Approximately 100 Board members and guests, including eighteen county presidents, were present.

The invocation was given by Mrs. P. R. Denman, Houston.

The President introduced Mrs. S. M. Hill of Dallas, who presented the President-Elect, Mrs. Joseph H. McCracken, Jr., Dallas. Mrs. McCracken brought greetings and expressed appreciation for the confidence placed in her.

With the consent of the Board, Mrs. Latimer appointed the following committee to approve the minutes of the post-convention Executive Board meeting: Mrs. O. W. Robinson, Chairman, Paris; Mrs. Joseph H. McCracken, Jr., Dallas; and Mrs. Thomas J. Vanzant, Houston.

Mrs. E. W. Coyle, San Antonio, immediate Past President, was introduced. Mrs. Latimer also presented her mother, Mrs. Walter Knowd of Houston.

The President then introduced Mrs. George Turner, El Paso, President-Elect of the Woman's Auxiliary to the American Medical Association, who spoke briefly.

Following the introduction of the twelve Past Presidents attending the meeting, Mrs. Latimer greeted members and guests and thanked Bexar County Auxiliary members; the General Convention Chairman, Mrs. John C. Parsons, San Antonio; and all Convention chairmen, particularly Mrs. John L. Pridgen, San Antonio, chairman for the post-convention meeting of the Board. The President expressed appreciation for the arrangements and many courtesies.

Mrs. Latimer announced the theme for 1954-1955, "Better Health in a Free America." She emphasized the idea that we must develop a positive attitude of leadership in community health. We must keep ourselves informed and alert concerning matters of medicine, with special stress placed upon safety, juvenile delinquency, and mental health. No organization is better than its members, she said. We are proud of our position as doctors' wives and we must accept the responsibility such a position entails. Mrs. Latimer expressed her desire to know each county auxiliary, its strength and its weakness, and she asked that county presidents keep her informed of their local problems. Her informal talk closed with the hope for much accomplishment in 1954-1955.

The President appointed Mrs. O. W. Robinson of Paris to serve as Parliamentarian pro tem for the meeting in the absence of the Parliamentarian, Mrs. John E. Hill of Marshall, and announced the following special appointments for the year: Chaplain, Mrs. P. R. Denman, Houston, and President's Book, Mrs. W. Frank Renfrow, Houston.

Officers and Committees

Mrs. P. M. Kuykendall, Ranger, Recording Secretary, then read the names of the officers and standing committee chairmen. The complete listing of officers, committees, and council women for 1954-1955 is as follows:

OFFICERS

President—Mrs. Mark H. Latimer, Houston.
President-Elect—Mrs. Joseph H. McCracken, Jr., Dallas.
First Vice-President—Mrs. Mal Rumph, Fort Worth.
Second Vice-President—Mrs. Harold Lindley, Pecos.
Third Vice-President—Mrs. Howard R. Dudgeon, Jr., Waco.
Fourth Vice-President—Mrs. Troy A. Shafer, Harlingen.
Fifth Vice-President—Mrs. August J. Streit, Amarillo.
Treasurer—Mrs. J. C. Terrell, Stephenville.
Recording Secretary—Mrs. P. M. Kuykendall, Ranger.
Corresponding Secretary—Mrs. William M. Palm, Houston.
Publicity Secretary—Mrs. A. H. Neighbors, Jr., Austin.
Parliamentarian—Mrs. John E. Hill, Marshall.
Executive Secretary—Mrs. Arleen Draker, Austin.

STANDING COMMITTEES

Advisory—Mrs. Joseph B. Foster, Chairman, Houston; All Past Presidents members.

Civil Defense—Mrs. J. V. Blair, Chairman, Corpus Christi; Mrs. James W. Atchison, Co-Chairman, Gainesville; Mrs. George D. Bruce, Baytown; Mrs. Charles L. McGehee, San Antonio; Mrs. Milton W. Talbot, Jr., Big Spring.

Convention (all of Fort Worth)—Mrs. Ivan H. Readinger, Chairman; Mrs. John B. Patterson, Co-Chairman; Mrs. H. S. Renshaw, Co-Chairman; Mrs. C. Keith Barnes, Finance; Mrs. Robert D. Bickel, Hospitality Rooms; Mrs. R. V. Brasher, Decorations; Mrs. Walter West, Post Executive Board Meeting; Mrs. J. R. Cochran, Registration; Mrs. E. M. Cyrus, Jr., Arrangements; Mrs. J. A. Hallmark, Luncheons; Mrs. W. N. Jenkins, Information; Mrs. Cuvier P. Lipscomb, Favors; Mrs. A. B. Pumphrey, Courtesy; Mrs. Mal Rumph, Transportation; Mrs. D. O. D. Ware, Publicity.

Courtesy Resolutions—Mrs. Cecil O. Patterson, Chairman, Dallas; Mrs. Robert F. Thompson, Co-Chairman, El Paso; Mrs. Marvin Duckworth, Cuero; Mrs. E. H. Marek, Yoakum; Mrs. Howard E. Puckett, Amarillo.

Essay—Mrs. Perry J. C. Byars, Chairman, San Angelo; Mrs. John T. Porter, Co-Chairman, Baytown; Mrs. Elmo L. Clark, Cleburne; Mrs. C. L. Gary, Jr., Corsicana; Mrs. W. Lacey Smith, San Angelo.

Finance—Mrs. V. M. Longmire, Chairman, Temple; Mrs. O. W. Robinson, Co-Chairman, Paris; Mrs. E. W. Coyle, San Antonio; Mrs. O. M. Marchman, Jr., Dallas; Mrs. J. C. Terrell, Stephenville.

Historical—Mrs. John H. Wootters, Chairman, Houston; Mrs. Rabun T. Wilson, Co-Chairman in charge of Archives,

Austin; Mrs. Paul Brindley, Galveston; Mrs. Truman C. Terrell, Fort Worth; Mrs. George S. Woodfin, Paris.

Legislation—Mrs. F. Paul Burow, Chairman, Killeen; Mrs. William C. Barksdale, Co-Chairman, Borger; Mrs. Ernest E. Anthony, Jr., Fort Worth; Mrs. F. J. L. Blasingame, Wharton; Mrs. Everett T. Duncan, San Antonio.

Memorial Service—Mrs. Marion R. Lawler, Chairman, Mercedes; Mrs. Tom B. Bond, Local Chairman, Fort Worth.

Mental Health—Mrs. Jacob F. Schultz, Chairman, Houston; Mrs. A. B. Pumphrey, Co-Chairman, Fort Worth; Mrs. Clement C. Boehler, El Paso; Mrs. W. E. Cline, Corpus Christi; Mrs. Joe Thorne Gilbert, Austin; Mrs. Scott H. Martin, San Angelo.

Nominating—Mrs. E. W. Coyle, Chairman, San Antonio; Mrs. J. V. Blair, Corpus Christi; Mrs. Jacob F. Schultz, Houston; Mrs. August J. Streit, Amarillo; Mrs. L. S. Thompson, Dallas; Mrs. Andrew S. Tomb, Victoria; Mrs. Newton F. Walker, El Paso.

Nurse Recruitment—Mrs. William D. Nicholson, Chairman, Freeport; Mrs. Claunch G. Brindley, Co-Chairman, Borger; Mrs. Joseph L. Knapp, Dallas; Mrs. S. Braswell Locker, Brownwood; Mrs. Andrew J. Magliolo, Dickinson.

Organization and Membership—Mrs. Mal Rumph, First Vice-President, Chairman, Fort Worth; Mrs. Harold Lindley, Second Vice-President, Pecos; Mrs. Howard R. Dudgeon, Jr., Third Vice-President, Waco; Mrs. Troy A. Shafer, Fourth Vice-President, Harlingen; Mrs. August J. Streit, Fifth Vice-President, Amarillo; All Council Women.

Philanthropic Funds:

American Medical Education Foundation—Mrs. J. L. Jinkins, Chairman, Galveston; Mrs. Newton F. Walker, Co-Chairman, El Paso; Mrs. W. Frank Armstrong, Fort Worth; Mrs. H. J. Ehlers, Houston; Mrs. L. S. Thompson, Dallas.

Library—Mrs. Allan Shields, Chairman, Victoria; Mrs. Sam E. Thompson, Co-Chairman, Kerrville; Mrs. S. F. Harrington, Dallas; Mrs. V. R. Hurst, Longview; Mrs. P. I. Nixon, San Antonio; Mrs. August J. Streit, Amarillo.

Memorial—Mrs. J. Guy Jones, Chairman, Dallas; Mrs. O. M. Marchman, Co-Chairman, Dallas; Mrs. Paul H. Mitchell, Corsicana; Mrs. Frank Steed, San Antonio; Mrs. Seward H. Wills, Houston.

Student Loan Fund—Mrs. J. Charles Dickson, Chairman, Houston; Mrs. M. L. Graves, Chairman Emeritus, Houston; Mrs. John B. Bourland, Dallas; Mrs. John W. Middleton, Galveston; Mrs. Edward T. Smith, Houston.

Program—Mrs. Guy E. Knolle, Chairman, Houston; Mrs. Charles B. Dildy, Co-Chairman, Austin; Mrs. R. C. Bellamy, Workshop Chairman, Liberty; Mrs. J. V. Blair, Civil Defense Chairman, Corpus Christi; Mrs. F. Paul Burow, Legislation Chairman, Killeen; Mrs. Ridings E. Lee, Public Relations Chairman, Dallas; Mrs. William D. Nicholson, Nurse Recruitment Chairman, Freeport; Mrs. Jacob F. Schultz, Mental Health Chairman, Houston.

Publications:

Bulletin—Mrs. Charles V. Bintliff, Chairman, Texarkana; Mrs. Sol B. Estes, Co-Chairman, Abilene; Mrs. Carlos R. Hamilton, Houston; Mrs. Jack M. Partain, San Antonio; Mrs. R. T. Travis, Jacksonville.

News Letter—Mrs. Haskell D. Hatfield, Editor, El Paso; Mrs. Jacob Rodge, El Paso; Mrs. George Turner, El Paso.

Texas State Journal of Medicine—Mrs. A. H. Neighbors, Jr., Publicity Secretary, Austin.

Today's Health—Mrs. Milton Spark, Chairman, Waco; Mrs. S. V. Granata, Co-Chairman, Beaumont; Mrs. C. E. Oswalt, Jr., Fort Stockton; Mrs. G. V. Pazdral, Somerville; Mrs. R. L. Rode, Abilene.

Public Relations—Mrs. Ridings E. Lee, Chairman, Dallas; Mrs. Speight Jenkins, Co-Chairman, Dallas; Mrs. W. N. Jenkins, Fort Worth; Mrs. Delphin Von Briesen, El Paso; Mrs. H. B. Willeford, Beaumont.

Reference—Mrs. Lynn Hilbun, Chairman, Henderson; Mrs. F. F. Kirby, Co-Chairman, Waco; Mrs. Joe Nichols, Atlanta.

Revisions—Mrs. T. H. Thomason, Chairman, Fort Worth; Mrs. Scott C. Applewhite, San Antonio; Mrs. Ramsay H. Moore, Dallas.

Workshop—Mrs. R. C. Bellamy, Chairman, Liberty.

SPECIAL APPOINTMENTS

Chaplain—Mrs. P. R. Denman, Houston.

President's Book—Mrs. W. Frank Renfrow, Houston.

COUNCIL WOMEN

District 1—Mrs. A. J. Eck, El Paso.
District 2—Mrs. Thomas P. Marinis, Midland.
District 3—Mrs. William C. Barksdale, Borger.
District 4—Mrs. Oscar N. Mayo, Brownwood.
District 5—Mrs. John C. Parsons, San Antonio.
District 6—Mrs. S. W. Bohmfalk, Weslaco.
District 7—Mrs. Abner A. Ross, Lockhart.
District 8—Mrs. Andrew J. Magliolo, Dickinson.
District 9—Mrs. Carl M. Hansen, Navasota.
District 10—Mrs. L. C. Heare, Port Arthur.
District 11—Mrs. C. H. Stripling, Jacksonville.
District 12—Mrs. G. V. Brindley, Jr., Temple.
District 13—Mrs. W. Frank Armstrong, Fort Worth.
District 14—Mrs. Emmett Essin, Sherman.
District 15—Mrs. Charles J. Wise, Naples.

Mrs. Latimer pointed out that Mrs. Charles B. Dildy, Austin, as Co-Chairman of the Program Committee will have charge of supplying county presidents with program materials from the central office, while Mrs. Rabun T. Wilson, Austin, will serve on the Historical Committee as Co-Chairman in charge of the Archives.

The President asked that all proposed letters to county presidents and other auxiliary officials be directed for preparation and mailing to Mrs. Arleen Draker, the Auxiliary's Executive Secretary at the central office in Austin. Mrs. Draker was introduced and spoke briefly.

Mrs. Latimer stressed the importance of county auxiliary presidents consulting with their local county medical society concerning planned activities and urged presidents to read carefully all communications received.

Reports of Officers and Committee Chairmen

The President next called for reports from officers and committee chairmen. Mrs. Mal Rumph, Fort Worth, First Vice-President and Chairman of the Organization and Membership Committee, presented the four other vice-presidents and the fifteen district council women, all of whom are members of this committee. Mrs. Rumph explained that the State is divided into four regional districts, with the vice-presidents serving as regional chairmen of organization and membership as follows:

Western Region.—Districts 1 and 4. Mrs. Harold Lindley, Pecos, Second Vice-President, Chairman.

Eastern Region.—Districts 9, 10, 11, 12, 14, and 15. Mrs. Howard R. Dudgeon, Jr., Waco, Third Vice-President, Chairman.

Southern Region.—Districts 5, 6, 7, and 8. Mrs. Troy A. Shafer, Harlingen, Fourth Vice-President, Chairman.

Northern Region.—Districts 2, 3, and 13. Mrs. August J. Streit, Amarillo, Fifth Vice-President, Chairman.

The Treasurer, Mrs. J. C. Terrell, Stephenville, submitted

for approval by the Board the names of the Fidelity and Casualty Company of New York through Ellis Insurance Agency of Stephenville, Texas, to care for the bonding; the Stephenville State Bank of Stephenville, Texas, to handle the Auxiliary accounts kept by the Treasurer; and Mr. Carl E. Crimmins, Stephenville, Texas, certified public accountant whose license number is 4272, to audit the accounts.

Upon a motion made by Mrs. S. H. Watson, Waxahachie, and seconded by Mrs. F. F. Kirby, Waco, it was voted to accept the Treasurer's report.

Printed outlines on suggested programs were given to county presidents by Mrs. Guy E. Knolle, Houston, Program Chairman, who said that the outlines were aimed to meet the needs of the smaller auxiliaries particularly. Mrs. Knolle stated the material would be mailed to those presidents who were not present and asked that each president insert the information in her copy of the State Auxiliary Handbook.

The regular order of business was interrupted in order to discuss possible ways in which to honor Mrs. George Turner upon her installation as President of the Woman's Auxiliary to American Medical Association at the national convention in San Francisco in June. Upon a motion made by Mrs. Jacob F. Schultz, Houston, which was seconded by Mrs. J. L. Jinkins, Galveston, it was voted to take up a voluntary contribution from the Board for the American Medical Education Foundation in honor of Mrs. Turner. The collection was taken at this time and it was agreed to present the contribution in the form of a money corsage at the national installation ceremonies.

Mrs. Ramsay H. Moore, Dallas, moved that $25 be taken from the Auxiliary's Special Fund and added to the contribution from the Board so that the gift might come from the entire auxiliary membership. The motion was seconded and carried.

Mrs. Perry J. C. Byars, San Angelo, Essay Contest Chairman, announced the subject for the 1954-1955 Association of American Physicians and Surgeons essay contest would be "The Advantages of Private Medical Care." She emphasized the importance of contacting the schools well in advance of the fall term. Literature on the contest may be obtained by writing Mrs. Byars.

The Legislation Chairman, Mrs. F. Paul Burow, Killeen, reiterated the need for keeping informed on legislative matters throughout the summer.

Mrs. Haskell D. Hatfield, El Paso, Editor of the *News Letter,* requested that items for publication be sent to her ten days before the announced deadlines.

Mrs. A. H. Neighbors, Jr., Austin, Publicity Secretary, asked that all county auxiliaries send copies of publicity received in local newspapers to the Auxiliary office in Austin.

Mrs. Milton Spark, Waco, *Today's Health* Chairman, urged county auxiliaries to push the sale of *Today's Health* and suggested that copies be placed in all schools.

Mrs. R. C. Bellamy, Liberty, Workshop Chairman, reminded council women to inform county presidents of the Workshop for County Presidents and other interested auxiliary members to be held during the Executive Board meeting in September at Austin. She urged members to attend this meeting.

Adoption of Budget

The budget for 1954-1955 was presented as the next order of business by Mrs. V. M. Longmire, Temple, Finance Chairman, who moved its adoption. The motion was seconded by Mrs. J. L. Jinkins, Galveston, and approved as follows:

BUDGET FOR 1954-1955

General Fund

Balance on Hand April 20, 1954		$12,806.45
Less Accounts Payable		300.00
		$12,506.45
Less Reserve for Dues to Woman's Auxiliary to American Medical Association		4,704.00
Amount to be budgeted		$ 7,802.45

EXPENSES FOR YEAR

Officers—		
President:		
Supplies, clerical help, postage, telephone, and telegraph	$ 500.00	
Discretionary Fund	2,000.00	
President-Elect	200.00	
First Vice-President	50.00	
Second Vice-President	50.00	
Third Vice-President	50.00	
Fourth Vice-President	50.00	
Fifth Vice-President	50.00	
Recording Secretary	50.00	
Corresponding Secretary	50.00	
Publicity Secretary	25.00	
Treasurer	250.00	
Parliamentarian	5.00	
		$3,330.00
Committee Chairmen—		
Historian	$ 75.00	
Library	15.00	
Student Loan	15.00	
Memorial Fund	15.00	
Revisions	10.00	
Bulletin	15.00	
Workshop	75.00	
Nominating	20.00	
Finance	20.00	
Nurse Recruitment	75.00	
Reference	10.00	
Memorial Service	15.00	
Civil Defense	25.00	
Mental Health	25.00	
American Medical Education Foundation	50.00	
Program	75.00	
Today's Health	10.00	
		545.00
Council Women (15)—		
Office Expense and District Travel Fund ($25 each)	$ 375.00	
		375.00
General Expense—		
Printing	$ 300.00	
Emergency	2,000.00	
Miscellaneous	1,252.45	
		3,552.45
Amount Budgeted		$7,802.45

Special Fund

These funds are not specifically budgeted but are used to cover the expenses of the following:

Public Relations
Convention
Essay Contest
President's Pin
News Letter

President's and President-Elect's expense to AMA convention and fall conference. (The expense to be equivalent to round trip fare by railroad, first class, plus roomette or lower berth, and single room for the duration of the convention and conference.)

Salary of either part or full time secretary for the Auxiliary at the central office in Austin if one is obtained.

The President then asked the Board to consider the matter of selecting delegates to represent the State Auxiliary at the 1954 Convention of the Woman's Auxiliary to the American Medical Association. She stated Texas may send forty-four delegates, one for each one hundred members. The motion was made by Mrs. Scott C. Applewhite, San

Antonio, and seconded by Mrs. J. L. Jinkins, Galveston, that the selection of delegates be left to the discretion of the President, Mrs. Latimer. The motion carried. Mrs. Latimer asked Mrs. Joseph H. McCracken, Jr., Dallas, President-Elect, to assist her with her job as President of the Texas delegation by serving as the dean of delegates.

An informal discussion on proposed revisions to the national auxiliary's constitution ensued. It was agreed that the Texas delegates, upon arrival at the national convention, should receive information concerning the proposed changes.

Mrs. Scott C. Applewhite, San Antonio, moved that the Texas Auxiliary endorse the name of Mrs. Mason Lawson, Little Rock, Ark., for President-Elect of the Woman's Auxiliary to American Medical Association. The motion was seconded by Mrs. E. W. Coyle, San Antonio, and carried. The Corresponding Secretary was instructed to send a letter of endorsement to the proper national committee.

Election of Nominating Committee

The acting Parliamentarian, Mrs. O. W. Robinson, Paris, read from the by-laws concerning the election of a Nominating Committee. The following members were elected to serve on this committee: Mrs. E. W. Coyle, Chairman, San Antonio; Mrs. J. V. Blair, Corpus Christi; Mrs. Jacob F. Schultz, Houston; Mrs. August J. Streit, Amarillo; Mrs. L. S. Thompson, Dallas; Mrs. Andrew S. Tomb, Victoria; and Mrs. Newton F. Walker, El Paso.

Reporting for the Courtesy Resolutions Committee, Mrs. E. H. Marek, Yoakum, read the following introduction before presenting the Resolutions: "Our handshakes, smiles, and words are unable to convey the full measure of gratitude in our hearts."

Whereas, We miss the presence of our friends, particularly those who have contributed effectively to our program over a long period of time,

THEREFORE BE IT RESOLVED: That we forward expressions of love and of our feelings of loss by their absence to our beloved past presidents of Texas and to Mrs. Leo J. Schaefer, Salina, Kan., President of the Woman's Auxiliary to the American Medical Association, and

BE IT ALSO RESOLVED: That we express our appreciation to that silent partner Dr. E. W. Coyle, San Antonio, for the major share of his wife's time; to her for her unselfish gifts of time and work during the past year; and to Mrs. John L. Pridgen, San Antonio, chairman for this delightful breakfast which concludes for us another outstanding convention in historic San Antonio. We shall always cherish the thoughts of exquisite flowers, the unusual homes on King William Street, unique La Villita, and every other detail which was executed for our pleasure and comfort by the Bexar County Auxiliary. We depart with happy memories of friendly relations and of the lasting accomplishments of our organization and with fervent wishes that we may return in the not too distant future.

MRS. CECIL O. PATTERSON, Dallas, Chairman,
MRS. ROBERT F. THOMPSON, El Paso,
MRS. MARVIN DUCKWORTH, Cuero,
MRS. E. H. MAREK, Yoakum.

The President urged all members to attend the fall Executive Board and County Presidents Workshop meeting to be held September 22 and 23, 1954, at the headquarters building of the Texas Medical Association in Austin.

There being no further business, Mrs. Latimer declared the meeting adjourned.

MRS. P. M. KUYKENDALL, Ranger,
Recording Secretary.

MRS. MARK H. LATIMER

Mrs. Mark H. Latimer, the thirty-seventh President of the Woman's Auxiliary to the Texas Medical Association, comes to her high office well prepared in every way. She has marked qualities of leadership and a personality that will enable her to win the attention, the confidence, and the allegiance of all Auxiliary members.

Charlotte was born in Topeka, Kan., the daughter of Mr. and Mrs. Walter M. Knowd; they moved to Texas when she was 2 years old. She received both her bachelor of arts and master of arts degrees from the University of Texas. She taught in Temple High School, was a chemistry laboratory instructor at the University of Texas, and taught organic chemistry at Texas Dental College. Mrs. Latimer is a Phi Beta Kappa, a member of Alpha Phi Epsilon honorary literary fraternity, and a member of Delta Zeta sorority.

Charlotte Knowd was married in 1929 to Dr. Mark H. Latimer, Houston surgeon. Dr. Latimer received his bachelor of business administration degree from the University of Texas, his doctor of medicine degree from the University of Texas School of Medicine. He did postgraduate work at the University of Pennsylvania School of Medicine. He is a fellow of the American College of Surgeons. He now

MRS. MARK H. LATIMER

teaches anatomy at Baylor University College of Medicine. They are both active members of the River Oaks Baptist Church, where Mrs. Latimer has taught in the Senior High Department of the Sunday School.

The couple have no children, but five godchildren and a 6 year old niece, Penny, who spends much time with them. Mrs. Latimer's mother, Mrs. Walter Knowd, is living near them in Houston.

Although a busy wife, Mrs. Latimer finds time to do many worth-while things. She works in Occupational Therapy, Women in Yellow at Jefferson Davis Hospital, Gray Ladies at the Veterans Administration Hospital, Blue Bird, and Shrine Crippled Children's Hospital.

For their hobby Dr. Latimer finds land, improves it, and builds without an architect or contractor; then Mrs. Latimer decorates and landscapes the result. She studied interior

decorating at Moor Institute in Philadelphia while Dr. Latimer was studying there.

Mrs. Latimer has held many offices in her county and district medical auxiliaries and held the following state offices successively from 1941 to 1951: General Chairman of the State Convention, Council Woman of the Ninth District, Recording Secretary (two years), Fourth Vice-President and Program Chairman, member of Nominating Committee, Historian, chairman of the Bulletin Committee, Corresponding Secretary, and Council Woman of the Ninth District. During 1953-1954 she was President-Elect. With this wealth of experience and her natural ability, she will undoubtedly lead the Auxiliary wisely and well.

With all of her accomplishments and honors, Mrs. Latimer is modest, understanding, and sympathetic and is ever interested in better health for all mankind. The Woman's Auxiliary to the Texas Medical Association is fortunate indeed to have such a President. It may well be said of her: "She stretcheth out her hand to the poor; yea, she reacheth forth her hand to the needy. . . . Strength and honor are her clothing; and she shall rejoice in time to come. She openeth her mouth with wisdom; and in her tongue is the law of kindness. She looketh well to the ways of her household, and eateth not the bread of idleness. . . . Many daughters have done virtuously, but thou excellest them all." (Proverbs 31:20-29.)

DISTRICT AUXILIARIES

The Seventh District Auxiliary met April 20 at the home of Mrs. C. H. McCuistion in Austin and elected Mrs. A. A. Ross, Lockhart, president of the district. After the business meeting, Mrs. Homer Garrison, Austin, gave a book review of "Dear Kate."

The Eleventh District Auxiliary met on April 15 in Crockett, with the Anderson-Houston-Leon Counties Auxiliary as hostess. Officers installed were Mrs. C. H. Stripling, Jacksonville, council woman; Mrs. J. E. Ross, Henderson, vice-president; Mrs. H. F. Rives, Jacksonville, corresponding secretary and treasurer; Mrs. C. E. Willingham, Tyler, recording secretary; and Mrs. R. T. Travis, Jacksonville, reporter. The Eleventh District Society and Auxiliary were entertained at the home of Dr. and Mrs. John Dean, Jr., Crockett.

DEATHS

J. L. SPIVEY

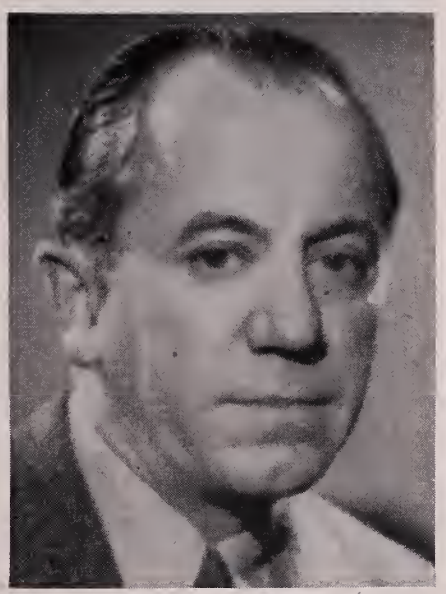
Dr. James Langdon Spivey, Wichita Falls, Texas, died in a hepatic coma on April 19, 1954, in Wichita Falls.

Born in Bellevue on December 16, 1894, Dr. Spivey was the son of Langdon Swilley and Leah (Melton) Spivey. He was valedictorian of the Bellevue High School class of 1911 and entered the old Polytechnic College in Fort Worth. He was graduated with honors from Southwestern University, Georgetown. Dr. Spivey attended the University of Texas School of Medicine, Galveston, and was graduated from the Columbia University College of Physicians and Surgeons, New York, in 1920. Having interned at Bellevue Hospital, New York, Dr. Spivey also took two years of residency there. He practiced in Fort Worth for twenty-five years and was staff physician at the Wichita Falls State Hospital for five years.

Dr. Spivey had been a member of the Texas and American Medical Associations almost continuously since 1924 through Tarrant County Medical Society. He was elected an honorary member of the Texas Medical Association in 1948. He was a former fellow of the American Academy of Pediatrics, a member of the American Psychiatric Association, a member of the Fort Worth Academy of Medicine, and a member of the Texas and Fort Worth Pediatric Societies while practicing in Fort Worth.

A member of Phi Alpha Sigma medical fraternity, Dr. Spivey was a member of Alpha Chi honorary fraternity and Kappa Sigma social fraternity. He was a member of the Episcopal Church. Dr. Spivey was a former member of the Fort Worth Boat Club, being a sailing enthusiast. He also liked to play golf and to fish. Dr. Spivey, active in work with the Cub Scouts and the YMCA, enjoyed working with children and for their betterment. He was in the Army as a medical student during World War I.

Dr. Spivey is survived by his wife, the former Miss Edwina Baskin, whom he married on January 1, 1926, in Fort Worth. Also surviving are a daughter, Mrs. Mary Madeline Lyon, Oklahoma City; a son, Lieut. James Langdon Spivey, Jr., serving with the United States Navy, San Diego, Calif.; four sisters, Mrs. Mattie Richter, Taylor; Mrs. Nora Ford, Dallas; Mrs. May Hurdleston, Marietta, Okla.; and Mrs. Ruth Alcorn, Ardmore, Okla.; two brothers, S. P. Spivey, Ardmore, and F. H. Spivey, Courtney, Okla.; and two grandchildren, Mark Lyon and Madeline Lyon, Oklahoma City.



DR. J. L. SPIVEY

J. P. GILL

Dr. James P. Gill, San Antonio, Texas, died on April 4, 1954, in a San Antonio hospital after a short illness.

Born in Dallas on March 4, 1900, he attended Southern Methodist University, Dallas, and was graduated from Vanderbilt University School of Medicine, Nashville, in 1926. He interned at Station Hospital, Fort Sam Houston; and he was a graduate of the Army Medical and Field Service Schools. He was a captain in the regular Army until 1931,

when he resigned. He practiced in San Antonio until 1940, when he moved to Beeville. He entered the Army again in 1941 as a colonel and was in charge of the Fifth Medical Supply Depot, Honolulu, during World War II. He began practicing in San Antonio again in 1946, where he was associated with the late Dr. W. D. Gill, specializing in eye, ear, nose, and throat.

A member of the Texas Medical Association through Bexar County Medical Society, Dr. Gill was a member of the Southern and American Medical Associations. He was a member of the Bexar County Health Board and the San Antonio Eye, Ear, Nose, and Throat Society. He was a

DR. JAMES P. GILL

thirty-second degree Mason, a Shriner, a member of the American Legion, and a member of the Presbyterian Church.

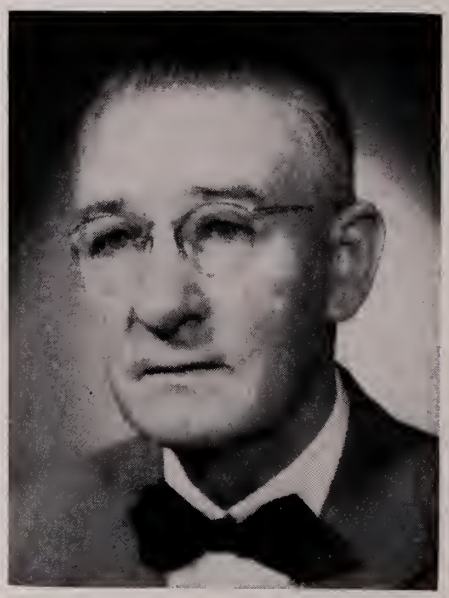
Survivors include his wife, Mrs. Torrie Gill, San Antonio; a brother, Dr. E. King Gill, Corpus Christi; and a niece, Mrs. C. D. Nicholas, Houston.

C. N. MEADOR

Dr. Clarence Nelson Meador, Corpus Christi, Texas, died April 17, 1954, at his home of coronary occlusion.

Born on May 23, 1889, in Kingman, Kan., Dr. Meador was the son of Mr. and Mrs. David Hester Meador. He attended high school at Epworth Methodist University-Academy, Oklahoma City; received a bachelor of arts degree from Methodist University, Guthrie, Okla., in 1913; and was graduated from Northwestern University Medical School, Chicago, in 1917. He was a lieutenant in the Navy from 1917 to 1922. He did postgraduate work at the United States Naval Hospital and Walter Reed General Hospital, Washington, D. C., and served at the United States Naval Hospital at Mare Island, Calif., and Norfolk, Va., and in hospitals in Lock Foyle, Ireland, and London during this time. Dr. Meador practiced in Anadarko, Okla., from 1922 until 1931, when he moved to Corpus Christi.

A member of the Texas and American Medical Associations through Nueces County Medical Society from 1936 until this year. Dr. Meador had been president of the Fred Roberts Memorial Hospital staff in 1938, and he had been Caddo County health officer in Oklahoma in 1927. He was a member of the Corpus Christi and San Antonio Eye, Ear, Nose, and Throat Societies and was affiliated with an eye, ear, nose, and throat society in London when he was there. He was a member of the Corpus Christi Kiwanis Club and a deacon in the First Baptist Church.

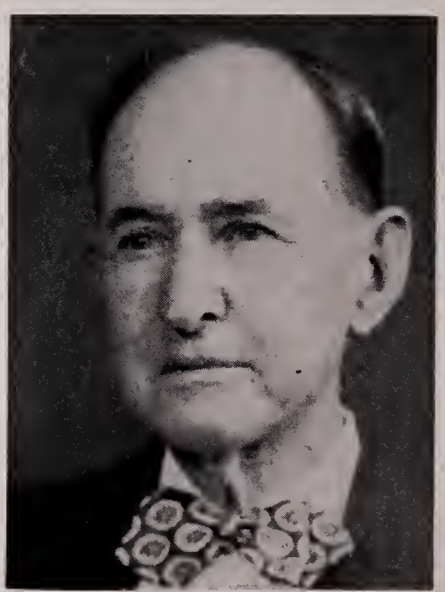


DR. C. N. MEADOR

Dr. Meador was married to the former Miss Edna Clay in Bowie on October 8, 1931. She survives, as do a daughter, Mrs. Bill Petty, and a son, David Charles Meador, all of Corpus Christi.

T. R. BASSETT

Dr. Thomas Richard Bassett, Mount Pleasant, Texas, died in a Dallas hospital on April 19, 1954, of arteriosclerosis.



DR. T. R. BASSETT

The son of Mr. and Mrs. John Bassett, Dr. Bassett was born September 29, 1873, in Gilmer. He attended public school in Gilmer and medical school in Memphis and Nash-

ville; he was graduated from the old Southwestern Medical School in Dallas, now Baylor University College of Medicine, Houston, in 1901.

Beginning his practice in Harleton in 1902, Dr. Bassett moved to Mount Pleasant in 1919 and practiced there until a year ago when illness forced him into semiretirement. He had served Titus County as health officer for several terms.

A member of the Texas Medical Association and the American Medical Association continuously throughout his career, Dr. Bassett was president of Titus County Medical Society in 1942 and 1943. He was a member of the Church of Christ.

Dr. Bassett and the former Miss Georgia Alice Wilkes were married on July 2, 1899, in Mount Pleasant. She survives, as do a daughter, Mrs. Charles I. Lide, Mount Pleasant; a sister, Mrs. W. L. Vivian, Gilmer; two grandchildren; and four great-grandchildren.

J. M. CAMERON

Dr. James Malcolm Cameron, Corpus Christi, Texas, died April 25, 1954, at a local hospital of a heart disease.

Born August 31, 1901, in Tavistock, Ontario, Canada, Dr. Cameron was the son of Charles and Ellen J. Cameron. He attended public schools in Toronto, Canada, and was graduated from the University of Toronto Faculty of Medicine in 1925 and served an internship at St. Joseph's Hos-

DR. J. M. CAMERON

pital in Reading, Pa. He received a masters degree in public health at Harvard School of Public Health, Boston, in 1932. He had practiced in Canada and in Robesonia, and Altoona, Pa.; Ponca City, Okla.; and St. Joseph, Mo., with emphasis on public health and industrial medicine. He came to Corpus Christi in 1950 as director of the City-County Health Unit.

Dr. Cameron was a member of the Missouri Medical Association while practicing there and had been a member of the Texas and American Medical Associations through Nueces County Medical Society since 1950. He was also a member of the American Public Health Association and Delta Omega, honorary public health society. He was president of the state health officers' section of the Texas Public Health Association in 1952. He was a Mason and a member of the Presbyterian Church.

Dr. Cameron was married on August 30, 1930, to the former Miss Dorothy Darrough, in Lebanon, Ind. She survives, as do his mother, Toronto; and a brother, A. J. Cameron, San Carlos, Calif.

L. T. PRUIT

Dr. Lee Tinkle Pruit, Beaumont, Texas, died on April 4, 1954, in Beaumont of a cerebral hemorrhage.

The son of Dr. and Mrs. J. N. Pruit, Dr. Pruit was born October 4, 1898, in Jacksonville. He attended old Alexander College, Jacksonville, and Baylor University, Waco. He was graduated from the University of Louisiana School of Medicine, New Orleans, in 1923. He interned and took his residency at Scott and White Hospital and Clinic, Temple, and was a member of the staff there from 1927 until 1933. He practiced in Beaumont from 1933 until the time of his

DR. LEE T. PRUIT

death, excepting the years of 1942 to 1946 when he was in the Army Medical Corps. He attained the rank of colonel while serving in Europe.

A member of the Texas Medical Association and the American Medical Association since 1926, Dr. Pruit was a fellow of the American College of Physicians, a diplomate of the American Board of Internal Medicine, a member of the Texas Academy of Internal Medicine, a fellow of the Royal Society of Medicine (England), a fellow of the American College of Cardiology, and a member of the Texas Heart Association and the American Heart Association, the Texas Rheumatism Association, and the Texas Club of Internists. He was a member of the Rotary Club, Masonic Lodge, and Methodist Church.

Dr. Pruit and the former Miss Victoria Welge were married on November 17, 1933, in Temple. He is survived by his wife; one brother, William Wall Pruit, Shreveport, La.; and three sisters, Mrs. Roy Hunsinger, Alice; Mrs. Tom Callier, Crockett; and Mrs. Russell Davis, San Antonio.

A. B. WORSHAM

Dr. Archer Ben Worsham, Sulphur Springs, Texas, died on March 16, 1954, in a Greenville hospital of carcinoma of the liver.

The son of William A. and Clara (Moore) Worsham, Dr. Worsham was born at Gaffords Chapel on June 20, 1886.

He attended Gaffords Chapel schools and the Texas State Normal School, Commerce. Dr. Worsham was graduated in 1914 from Southern Methodist University Medical Department, Dallas. He then began practicing in Brashear and in 1917 joined the Army, serving as a captain in Europe during World War I. He moved to Dawson in 1918 and practiced there until 1943, when he opened the Worsham Clinic at Sulphur Springs.

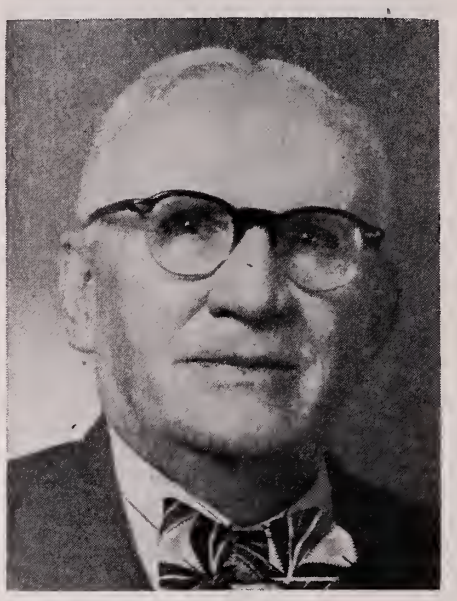
Dr. Worsham had been a member of the Texas and American Medical Association almost continuously since 1915, being president of Hopkins-Franklin Counties Medical Society in 1948. He had served Hopkins County as health officer. Dr. Worsham was a member of the Masonic Lodge, the Shrine, the Lions Club, and the Methodist Church.

He is survived by his wife, the former Miss Betty Anderson, whom he married February 22, 1917, in Purdon. Also surviving are two daughters, Mrs. Aline Lewis, Murchison, and Mrs. Jim Boswell, Austin; three sons, Laird E. Worsham, serving with the Navy in Quantico, Va.; A. B. Worsham, Jr., Martin Springs; and Joe Allen Worsham, Sulphur Springs; and two sisters, Mrs. Marvin Williams, Gaffords Chapel, and Mrs. Will McKay, Martin Springs.

J. A. ALLISON

Dr. Joseph Alec Allison, Grapevine, Texas, died on April 20, 1954, of coronary thrombosis.

The son of Thomas Jefferson and Susan (Stephens) Allison, Dr. Allison was born September 21, 1872, in Alto. Dr. Allison attended the old Add Ran Christian College, Thorp Springs, and attended the Kentucky School of Medicine, Louisville. He was graduated in 1898 from the old Fort Worth School of Medicine, which later merged with



DR. JOSEPH A. ALLISON

Baylor University College of Medicine. He took postgraduate work in surgery at Chicago, St. Louis, and New Orleans.

A member of the Texas and American Medical Associations continuously since 1904, Dr. Allison was elected to honorary membership in the state Association in 1951.

Dr. Allison was physician and surgeon to Singletary's Saw Mill, Alto, from 1899 to 1903. He practiced in Alto until 1910, when he moved to Henrietta. He moved in 1928 to Mercedes, practicing there for a year before settling in 1929 in Grapevine, where he practiced until the time of his death.

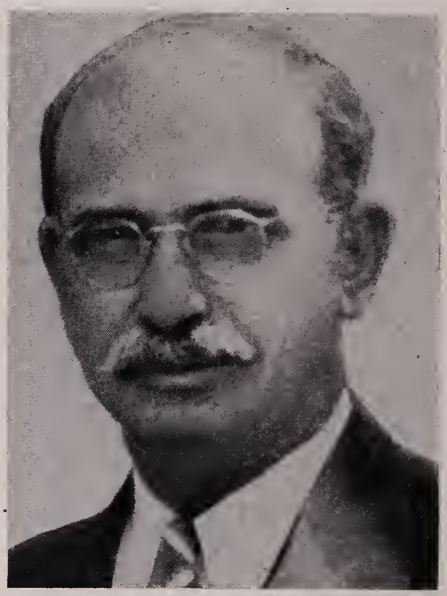
Dr. Allison had been a member of the Masonic Lodge since 1894, and he was a member of the Church of Christ.

The former Miss Laura Cunningham and Dr. Allison were married on April 3, 1901, in San Pedro. He is survived by his wife; a son, Dr. Joe M. Allison, Grapevine; and four grandchildren, Miss Mary Jane Barr and Misses Rose Ann, Elaine, and Joyce Allison, all of Grapevine.

A. N. PIKE

Dr. Arthur Nolan Pike, Iredell, Texas, died on March 4, 1954, of coronary thrombosis at his home.

The son of J. C. and Nancy Pike, Dr. Pike was born on December 31, 1884, in Alabama, but he moved to Bosque County and then Hamilton County with his family when a child. He attended the Hico Public Schools and was graduated in 1906 from the Fort Worth School of Medicine, which later merged with Baylor University College of



DR. ARTHUR N. PIKE

Medicine. He practiced in Iredell from the time of his graduation from medical school until his death.

A member of the Texas and American Medical Associations through Bosque County Medical Society almost continuously throughout his career, he was elected an honorary member of the state and county organizations in 1950. Dr. Pike was president of the Bosque County Medical Society in 1940 and secretary in 1943. He had been Bosque County health officer and local surgeon for the Missouri-Kansas-Texas Railroad. For years he was a trustee for the Iredell public schools and at the time of his death he was chairman of the county school board. During World War II he was a member of the Bosque County Ration Board and the War Manpower Board. Dr. Pike was a member of the Masonic Lodge and the Methodist Church.

Dr. Pike and the former Miss Katie E. Dozier were married on December 8, 1909, in Iredell. She survives, as do one daughter, Mrs. J. L. Goodman, Pecos; one son, Albert N. Pike, Iredell; his father, J. C. Pike, Dallas; two brothers, Roland L. Pike, Borger, and Dan Pike, Shamrock; four sisters, Mrs. Nannie Bowen, Dallas; Mrs. Ollie Schenck, San Diego, Calif.; Mrs. Jessie Smith, Shamrock; Mrs. J. G. Carr, Austin; and two grandchildren, Gay Goodman, Pecos, and A. Nolan Pike, Iredell.

MEMBERSHIP

Woman's Auxiliary to the Texas Medical Association

MAY, 1954

The membership list which follows is compiled from names sent by county auxiliaries to the State Treasurer. The names are listed by county auxiliary within the fifteen districts. The number after each county listed below indicates the district in which the county is located.

Anderson—11
Andrews—2
Angelina—10
Aransas—6
Archer—13
Armstrong—3
Atascosa—5
Austin—9
Bailey—3
Bandera—5
Bastrop—7
Baylor—13
Bee—6
Bell—12
Bexar—5
Blanco—7
Borden—2
Bosque—12
Bowie—15
Brazoria—8
Brazos—12
Brewster—1
Briscoe—3
Brooks—6
Brown—4
Burleson—9
Burnet—7
Caldwell—7
Calhoun—8
Callahan—13
Cameron—6
Camp—15
Carson—3
Cass—15
Castro—3
Chambers—10
Cherokee—11
Childress—3
Clay—13
Cochran—3
Coke—4
Coleman—4
Collin—14
Collingsworth—3
Colorado—8
Comal—5
Comanche—4
Concho—4
Cooke—14
Coryell—12
Cottle—3
Crane—4
Crockett—4
Crosby—3
Culberson—1
Dallam—3
Dallas—14
Dawson—2
Deaf Smith—3
Delta—14
Denton—14
De Witt—8
Dickens—2
Dimmit—5
Donley—3
Duval—6
Eastland—13
Ector—2
Edwards—5
Ellis—14
El Paso—1
Erath—12
Falls—12
Fannin—14
Fayette—8
Fisher—2
Floyd—3
Foard—3
Fort Bend—8
Franklin—14
Freestone—11
Frio—5
Gaines—2
Galveston—8
Garza—2
Gillespie—5
Glasscock—2
Goliad—8
Gonzales—5
Gray—3
Grayson—14
Gregg—15
Grimes—9
Guadalupe—5
Hale—3
Hall—3
Hamilton—12
Hansford—3
Hardeman—3
Hardin—10
Harris—9
Harrison—15
Hartley—3
Haskell—13
Hays—7
Hempbill—3
Henderson—11
Hidalgo—6
Hill—12
Hockley—3
Hood—12
Hopkins—14
Houston—11
Howard—2
Hudspeth—1
Hunt—14
Hutchinson—3
Irion—4
Jack—13
Jackson—8
Jasper—10
Jeff Davis—1
Jefferson—10
Jim Hogg—6
Jim Wells—6
Johnson—12
Jones—13
Karnes—5
Kaufman—14
Kendall—5
Kenedy—6
Kent—2
Kerr—5
Kimble—4
King—2
Kinney—5
Kleberg—6
Knox—13
Lamar—14
Lamb—3
Lampasas—7
La Salle—5
Lavaca—8
Lee—7
Leon—11
Liberty—10
Limestone—12
Lipscomb—3
Live Oak—6
Llano—7
Loving—1
Lubbock—3
Lynn—2
McCulloch—4
McLennan—12
McMullen—6
Madison—9
Marion—15
Martin—2
Mason—4
Matagorda—8
Maverick—5
Medina—5
Menard—4
Midland—2
Milam—12
Mills—4
Mitchell—2
Montague—13
Montgomery—9
Moore—3
Morris—15
Motley—3
Nacogdoches—10
Navarro—12
Newton—10
Nolan—2
Nueces—6
Ochiltree—3
Oldham—3
Orange—10
Palo Pinto—13
Panola—11
Parker—13
Parmer—3
Pecos—1
Polk—9
Potter—3
Presidio—1
Rains—14
Randall—3
Reagan—4
Real—5
Red River—15
Reeves—1
Refugio—6
Roberts—3
Robertson—12
Rockwall—14
Runnels—4
Rusk—11
Sabine—10
San Augustine—10
San Jacinto—9
San Patricio—6
San Saba—4
Schleicher—4
Scurry—2
Shackelford—13
Shelby—10
Sherman—3
Smith—11
Somervell—12
Starr—6
Stephens—13
Sterling—4
Stonewall—2
Sutton—4
Swisher—3
Tarrant—13
Taylor—13
Terrell—5
Terry—2
Throckmorton—13
Titus—15
Tom Green—4
Travis—7
Trinity—9
Tyler—10
Upshur—15
Upton—4
Uvalde—5
Val Verde—5
Van Zandt—14
Victoria—8
Walker—9
Walker—9
Ward—1
Washington—9
Webb—6
Wharton—8
Wheeler—3
Wichita—13
Wilbarger—13
Willacy—6
Williamson—7
Wilson—5
Winkler—1
Wise—13
Wood—11
Yoakum—2
Young—13
Zapata—6
Zavala—5

>President of county auxiliary.

FIRST DISTRICT

Mrs. A. J. Eck
El Paso
Council Woman

EL PASO COUNTY AUXILIARY*

Awe, Mrs. Chester D., 4430 Trowbridge
Ayub, Mrs. Pablo, 2313 N. Ochoa
Barrett, Mrs. Frank O., 2733 Gold
Basom, Mrs. W. Compere, 3237 Aurora
Bell, Mrs. Herbert J., 3920 Idalia
Bennett, Mrs. J. Travis, 2611 Altura
Bennett, Mrs. Ray J., 1409 Elm
Bernard, Mrs. Jack A., 1502 N. El Paso
Black, Mrs. Arthur P., 2735 Federal
Black, Mrs. Gordon L., 7546 Dale Rd.
Boehler, Mrs. Clement C., 3015 Silver
Bornstein, Mrs. Fred, 7852 La Senda
Boverie, Mrs. Robert F., 4430 Oxford
Bozzell, Mrs. James D., 601 Turney Blvd.
Breck, Mrs. Louis W., 2726 Richmond
Brunner, Mrs. George, 908 Winter
Budwig, Mrs. Ira A., 5001 Garry Owen Rd.
Burdick, Mrs. Ward, 1140 E. Rio Grande
Byrne, Mrs. Basil K., 5028 Love Rd.
Cameron, Mrs. David M., 4700 Hastings
Cardwell, Mrs. Robert J., 2021 N. Stanton
Carpenter, Mrs. Gray E., 3244 Richmond
Carter, Mrs. Joe C., 1512 Elm
Causey, Mrs. Grady, 1406 Montana
Caylor, Mrs. Robert W., 7749 Rosedale Rd.
Cohen, Mrs. Manley B., 810 Winter
Cooley, Mrs. Ben H., 2020 Washington
Cooper, Mrs. Arlin B., 7408 Franklin Rd.
Craige, Mrs. Branch, 2432 Savannah
Cummins, Mrs. Erwin J., 173 Coronado Dr.
Curtis, Mrs. Wickliffe R., 1501 Rim Rd.
Davis, Mrs. William J., Rt. 1, Box 80A, Anthony, N. Mex.
Deter, Mrs. Russell Lee, 4428 Hastings
Dietrich, Mrs. Hervey W., 4534 Trowbridge
Dutton, Mrs. Lorraine Orr, Rt. 2134, 281D, Country Club Rd.
Eck, Mrs. Andrew J., 7640 N. Loop Rd.
Egbert, Mrs. Orville, 3000 Federal
Eidinoff, Mrs. Harold, 2701 N. Kansas
Ellis, Mrs. Jack, 2922 Copper
Elsberg, Mrs. Charles P., 3705 Chester
Epstein, Mrs. I. M., 5111 Timberwolf Dr.
Evans, Mrs. F. Green, 701 Blacker
Evans, Mrs. Ward, 1007 Galloway
Ewalt, Mrs. Donald H., 2809 Wbeeling
Feener, Mrs. L. C., 911 Kerbey
Fernandez, Mrs. Carlos, 38 Half Moon Rd.
Floyd, Mrs. Joe R., 2809 Richmond
Gaddis, Mrs. William R., 3116 Federal
Gaddy, Mrs. S. J., 3101 Savannah
Galatzan, Mrs. Joe S., 520 Cincinnati
Gallagher, Mrs. Paul, 1145 E. California
Garrett, Mrs. Henry D., 2722 Louisville
Gibson, Mrs. H. M., 2514 Altura
Golding, Mrs. Frank C., 2409 Savannah
Goodloe, Mrs. B. Lynn, 4209 Hastings
Gorman, Mrs. James J., 3100 Federal
Green, Mrs. J. Leigbton, 3012 Silver
Hart, Mrs. Maynard S., 3033 Federal
>Hatfield, Mrs. Haskell D., 1805 N. Stanton
Hendricks, Mrs. C. H., 3601 McKinley
Higdon, Mrs. D. A., 1305 Los Angeles
Hinton, Mrs. Joseph Houston, 1701 Elm
Homan, Mrs. Ralph H., 2920 Silver
Homan, Mrs. Robert B., Jr., 3117 Copper
Hunter, Mrs. C. D., 2200 Montana
Jamieson, Mrs. William R., 2308 N. Stanton
Johnstone, Mrs. John H., Box 426, Ysleta
Jones, Mrs. Edmund P., 1300 Cincinnati
Jones, Mrs. William Aubrey, 4 Half Moon Dr.
Jordan, Mrs. Gerald, 4517 Cumberland Circle
Jumper, Mrs. C. E., 1511 N. Virginia
Kearney, Mrs. William W., 5120 Timberwolf Dr.
Keller, Mrs. N. H., 700 Cincinnati
Laws, Mrs. James W., 701 N. St. Vrain
Leigh, Mrs. Harry, 2619 Altura
Leonard, Mrs. Morton H., 701 Blanchard
Liddell, Mrs. T. C., 2731 Richmond
Lombard, Mrs. Julian H., 4620 Emery Way
Long, Mrs. A. D., 1805 Elm
Luckett, Mrs. A. E., 15 Half Moon Dr.
Lynch, Mrs. Kelvin D., 235 Pennsylvania
Marsball, Mrs. Alex G., 2011 N. St. Vrain
Marshall, Mrs. Howard J., 3819 Hamilton
Martin, Mrs. John D., 3003 Louisville
Mason, Mrs. Claude H., Westside Rd.
McCamant, Mrs. Thomas J., 603 Gregory Way
McVaugh, Mrs. Charles C., 915 Bolivia
Milchen, Mrs. Carl, 504 Hunter Rd.
Miller, Mrs. Felix P., 2715 Richmond
Miskimins, Mrs. J. Harry, 2805 Lebanon
Molinar Z., Mrs. Ramon, 700 Baltimore
Molloy, Mrs. Max S., 502 Cincinnati
Morrison, Mrs. John E., 800 E. College
Morrow, Mrs. W. Grady, Jr., 913 Driver Circle
Mutnick, Mrs. Reuben D., 6313 Weems Way
Nering, Mrs. A. Robert, 800 Argentina
Outlaw, Mrs. P. R., 4305 Cambridge
Perry, Mrs. Alvin L., 194 Emery Way
Peticolas, Mrs. John D., 716 Chelsea Dr.
Postlewaite, Mrs. Jack, 5201 Flower
Prieto, Mrs. Philip M., 1601 N. Mesa
Ramey, Mrs. R. L., 1110 Montana
Ravel, Mrs. Vincent M., 1228 Baltimore
Rennick, Mrs. Charles F., 2018 N. Kansas
Rheinbeimer, Mrs. E. W., 3124 Aurora
Rice, Mrs. Herman, 704 Baltimore
Rigney, Mrs. Paul, 2718 Wheeling
Rissler, Mrs. Ross W., 18 Cumberland Circle
Robbins, Mrs. J. B., 408 Blacker
Rogde, Mrs. Jacob, 407 E. Blacker
Rogers, Mrs. S. Perry, 1140 Galloway
Rogers, Mrs. Will P., 901 Montana
Schuessler, Mrs. Willard, 3007 Copper
Schuster, Mrs. Frank P., 939 Rim Rd.
Schuster, Mrs. Stephen A., 1000 N. Mesa
Smitb, Mrs. Leslie M., 2400 Frankfort
Snidow, Mrs. Francis A., 3429 Lebanon
Spearman, Mrs. Maurice P., 1313 Rim Rd.
Spier, Mrs. Erich, 913 McKelligon
Stanfill, Mrs. Charles Mac, 3019 Altura
Stapp, Mrs. Celso C., Rt. 2, Box 285A
Stern, Mrs. J. Edward, 1706 N. Oregon
Stevens, Mrs. B. F., 217 E. Blacker
Stowe, Mrs. Jesson L., 624 E. College
Stratemeyer, Mrs. W. P., 316 Rose Lane
Terrell, Mrs. Scurry L., 2600 Richmond
Thomas, Mrs. Merle, 1214 Chadbourne
Thompson, Mrs. Robert F., 1227 Rim Rd.
Treece, Mrs. Angus A., Fabens

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AUXILIARY MEMBERS, 1954—*continued*

Tubbs, Mrs. William M., 3031 Altura
Turner, Mrs. George (Hon.), 3009 Silver
Vance, Mrs. James, 1717 E. Mesa
Vandevere, Mrs. William E., 220 Blacker
Varner, Mrs. Harry H., 413 Lindbergh Dr.
Villareal, Mrs. Andres, 1330 Madeline
Villareal, Mrs. Leopoldo, 709 E. College
Vinikoff, Mrs. M. R., 1221 Baltimore
Von Briesen, Mrs. Delphin, 3020 Wheeling
Walker, Mrs. Newton F., 916 Blanchard
Webb, Mrs. Charles E., 401 Buena Vista Dr.
Wilcox, Mrs. Leigh Edgar, 3133 Federal
Wollmann, Mrs. Walter W., 4785 Cumberland
Worsham, Mrs. B. M., 1325 Montana

PECOS-JEFF DAVIS-PRESIDIO-BREWSTER COUNTIES AUXILIARY

Blackwell, Mrs. Jesse H., Marfa
Carter, Mrs. John, Sanderson
Gipson, Mrs. Jim F., Fort Stockton
Hoffman, Mrs. George A., Fort Stockton
>Lockhart, Mrs. William E., Alpine
O'Donnell, Mrs. John, Alpine
Oswalt, Mrs. Charles E., Jr., Fort Stockton
Searles, Mrs. John P., Marfa
Sherrod, Mrs. Alan V., Iraan
Sibley, Mrs. D. J., Jr., Fort Stockton
Stover, Mrs. Walter H., Marfa
Swanson, Mrs. J. D., Sanderson
Wright, Mrs. Joel, Alpine

REEVES-WARD-WINKLER-LOVING-CULBERSON-HUDSPETH COUNTIES AUXILIARY

Applegate, Mrs. F. M., Box 1238, Monahans
Avery, Mrs. H. F., Pecos
Barnett, Mrs. Arthur, 306 S. Water, Monahans
Bell, Mrs. Darrell L., Bell Hospital, Monahans
Black, Mrs. W. D., Barstow
Breeden, Mrs. L. G., Wink
Camp, Mrs. Jim, 601 S. Hickory, Pecos
Dampeer, Mrs. John, 814 Martin, Kermit
Del Campo, Mrs. Dante, Pecos
Dunn, Mrs. John, Country Club Dr., Pecos
Gibson, Mrs. J. V., Kermit
Hay, Mrs. Bruce, 1706 W. 4th, Pecos
Heath, Mrs. Joe D., Box 1628, Kermit
Kunstadt, Mrs. Paul, 1002 Hoxie, Monahans
Lindley, Mrs. Harold, 410 S. Hickory, Pecos
Martin, Mrs. H. W., 1702 Washington, Pecos
>McClure, Mrs. W. H., 801 S. Avenue C, Kermit
Munk, Mrs. Otto, 1102 S. Hoxie, Monahans
Nelson, Mrs. Ernest J., 1935 Adams, Pecos
Prout, Mrs. Fred J., Box 1146, Monahans
Roberts, Mrs. Rufas, 1415 W. 7th, Pecos
Schmidt, Mrs. E. W., 1810 Washington, Pecos
Wight, Mrs. B. A., 113 S. Mulberry, Kermit

SECOND DISTRICT

Mrs. Thomas P. Marinis
Midland
Council Woman

ANDREWS-ECTOR-MIDLAND COUNTIES AUXILIARY*

Autry, Mrs. Paul G., 1300 W. Texas
Barganier, Mrs. John H., 3003 Eastover Dr., Odessa
Bauman, Mrs. John E., 1000 W. 21st, Odessa
Bobo, Mrs. Tom C., 807 W. Wall
Boles, Mrs. Truett C., 900 W. Indiana
Boone, Mrs. Martin H., 3212 Delano
Buck, Mrs. Marion O., Midland
Carson, Mrs. Willis T., 1707 Ridgecrest, Odessa
Chapple, Mrs. James, Douglas St.
Colquitt, Mrs. L. A., 308 N. Alleghaney, Odessa
Connelly, Mrs. William E., 213 W. 17th, Odessa
Connery, Mrs. David B., 2006 W. Ohio
Dickerson, Mrs. M. S., 610 W. Missouri
Driscoll, Mrs. Edward T., 2010 W. Illinois
Elliott, Mrs. Vance J., 1502 N. Dotsy, Odessa
Finch, Mrs. Albert B., 1202 E. 17th, Odessa
Gaarde, Mrs. Fred W., 2204 Bedford Dr.
Green, Mrs. Wilbur K., 1004 W. 23rd, Odessa
Greenlees, Mrs. David L., 1005 W. 23rd, Odessa
Hays, Mrs. Alan L., 312 Monticello, Odessa
Headlee, Mrs. Emmett V., Box 3112, Odessa
Hestand, Mrs. Haskell E., 601 N. Washington, Odessa
Holt, Mrs. W. D., 1404 W. Ohio
Horton, Mrs. George W., 1800 N. Lincoln, Odessa
Hutchison, Mrs. Z. W., Andrews
Johnson, Mrs. Homer B., 401 W. Broadway
Lang, Mrs. Garland H., 2007 Bedford Dr.
Leggett, Mrs. L. Waldo, 901 W. Storey
Leigh, Mrs. Henry T., 2010 Bedford Dr.
Lekisch, Mrs. Kurt, 1304 W. Texas
Lillie, Mrs. Gordon V., 1417 N. Golder, Odessa, Military Service
>Loring, Mrs. Milton J., 2001 Harvard
Lunn, Mrs. Wayne W., 910 W. 25th, Odessa
Marinis, Mrs. Thomas P., 1610 W. Louisiana
Mast, Mrs. Clarence S., 1701 W. Storey
Mast, Mrs. Henrie E., 1600 W. Kansas
Mast, Mrs. John R., 1400 Bedford Dr.
McCrimmon, Mrs. H. P., 3133 E. County Rd., Odessa
McCullough, Mrs. E. W., 605 W. Nobles
Melton, Mrs. T. June, 405 W. Broadway
Nichols, Mrs. M. M., 3210 Mariana
Novak, Mrs. Theodore W., 1500 E. 36th, Odessa
Oehlschlager, Mrs. F. Keith, 316 Casa Grande, Odessa
Parks, Mrs. Walter S., Jr., 1200 W. Kansas
Penn, Mrs. R. L., 103 Cowden
Rader, Mrs. J. Paul, 1701 Walnut, Odessa
Rainer, Mrs. James W., 106 Conet Dr., Odessa
Ramsey, Mrs. Richard, Andrews
Roden, Mrs. J. S., 2203 Princeton
Shapira, Mrs. Jake, 1006 North A
Thorton, Mrs. Elbert, 500 N. Dotsy, Odessa
Tull, Mrs. R. H., Jr., 2011 W. Ohio
Walker, Mrs. Glenn H., 2623 Delano
Walton, Mrs. Jack R., 1208 W. Michigan
Wiesner, Mrs. William A., 3137 E. County Rd., Odessa
Wood, Mrs. J. K., 1711 N. Graham, Odessa

*Address is Midland unless otherwise stated.

BORDEN-SCURRY-KENT-GARZA-KING-STONEWALL COUNTIES AUXILIARY*

Battenfield, Mrs. John V., 2906 32nd
Cockrell, Mrs. C. R., 2311 30th
Dillaha, Mrs. Carl, 2906 Avenue S
Hartley, Mrs. Thomas, 3725 Avenue V
Jones, Mrs. Wilton N., 3789 Sunset Dr.
Middlebrook, Mrs. F. M., 2602 Avenue R
Stennis, Mrs. Hugh, 911 26th
Ward, Mrs. Harry W., 1811 19th
>Wasson, Mrs. Robert Fleming, 2811 Avenue S

DAWSON-LYNN-TERRY-GAINES-YOAKUM COUNTIES AUXILIARY

Black, Mrs. W. D., Lamesa
Daniell, Mrs. A. H., Brownfield
Dow, Mrs. H. D., Seminole
Frazier, Mrs. S. Z., Lamesa
Hill, Mrs. W. C., Brownfield
Koberg, Mrs. F. J., Seminole
Lehman, Mrs. J., O'Donnell
McKay, Mrs. V. J., Lamesa
Price, Mrs. N. H., Lamesa
Prideau, Mrs. T., Lamesa
Seale, Mrs. F. E., Lamesa
Sibley, Mrs. G. W., Denver City
>Thomas, Mrs. C. S., Tahoka
Treadway, Mrs. T. L., Brownfield
Watts, Mrs. M. A., Denver City

HOWARD-MARTIN-GLASSCOCK COUNTIES AUXILIARY†

Carson, Mrs. Arch, 102 Canyon Dr.
Cowper, Mrs. R. B., 902 Mountain Dr.
Fish, Mrs. J. H., 907 Mountain Dr.
Friedwald, Mrs. Vincent, 817 W. 18th
Hall, Mrs. G. T., 704 Texas Blvd.
Hogan, Mrs. J. E., 509 Westover Rd.
Lurting, Mrs. Fredrick, 608 W. 16th
Malone, Mrs. P. W., 503 Edwards Blvd.
>Marcum, Mrs. C. B., 805 W. 15th
Mays, Mrs. Floyd, 603 W. 16th
Peacock, Mrs. George, 529 Hillside Dr.
Sloan, Mrs. Roy, State Hospital
Swift, Mrs. Ed, 603 Edwards Circle
Talbot, Mrs. Milton, 607 Edwards Circle
Thomas, Mrs. Clyde, 400 Washington Blvd.
Williamson, Mrs. T. J., Silver Heels
Wood, Mrs. G. H., 1500 Runnels
Woodall, Mrs. J. M., 701 W. 17th

NOLAN-FISHER-MITCHELL COUNTIES AUXILIARY‡

Barker. Mrs. Frank, 1102 E. 14th
Loeb, Mrs. Sam, 1101 Pine
Peters, Mrs. R. O., 800 Silas
Price, Mrs. Robert L., 706 Silas

*Address is Snyder unless otherwise stated.
†Address is Big Spring unless otherwise stated.
‡Address is Sweetwater unless otherwise stated.

Richardson, Mrs. J. K., 1301 E. 13th
Supowit, Mrs. Saul Frank, 704 Thomas
>Young, Mrs. T. D., 1607 Santa Fe

THIRD DISTRICT

Mrs. William C. Barksdale
Borger
Council Woman

ARMSTRONG-DONLEY-CHILDRESS-COLLINGSWORTH-HALL COUNTIES AUXILIARY

Butler, Mrs. Robert G., 1003 Avenue M, N. W., Childress
Cariker, Mrs. Fred H., 409 Second St., N. E. Childress
Dryden, Mrs. Charles B., Box 1129, Memphis
Fox, Mrs. G. C., 311 Avenue D, N. W., Childress
Fox, Mrs. Jack, 210 Fourth St., S. E., Childress
Goodall, Mrs. O. R., Memphis
Headlee, Mrs. Robert E., 107 Avenue C, N. E., Childress
Holcomb, Mrs. Carter, 1307 West Avenue, Wellington
Jernigan. Mrs. J. H., 200 Third St., S. E., Childress
Jeter, Mrs. P. R., 505 Avenue G, S. E., Childress
Jones, Mrs. E. K., 1610 Dalhart St., Wellington
Jones, Mrs. E. W., 1307 Amarillo St., Wellington
Odom, Mrs. J. A., Memphis
Watkins, Mrs. Dale V., Box 584, Wellington
Wattam, Mrs. J. M., Wellington
>Wilson, Mrs. Hulda, Memphis

DALLAM-HARTLEY-SHERMAN-MOORE COUNTIES AUXILIARY

Askins, Mrs. John Robert, 111 Cedar, Dumas
Blaschke. Mrs. John Ahrns, 1002 Denrock, Dalhart
>Coventry, Mrs. William Vaden, 129 Pine, Dumas
Cunningham, Mrs. John Henry, 513 Keeler, Dalhart
Glenn. Mrs. James Clarence, 605 Denver, Dalhart
Meredith, Mrs. Duane William, 212 Bruce, Dumas
Moore, Mrs. Victor Rhoades, Box 1108, Dalhart
Pearson, Mrs. Huston, Box 445, Stratford
Pieratt, Mrs. Karl Wayne, 124 Amherst Ave., Dumas
Richardson, Mrs. Oswald Joseph, 1009 Porter, Dumas
Wright, Mrs. Byron W., 214 E. 4th, Dumas

GRAY-WHEELER-HANSFORD-HEMPHILL-LIPSCOMB-ROBERTS-OCHILTREE-HUTCHINSON-CARSON COUNTIES AUXILIARY*

Ashby, Mrs. Charles H , Rose Bldg.
Bagwell, Mrs. R. Wayne, 1307 Francis, Borger
Barksdale, Mrs. William C., 409 W. Jackson, Borger
Brindley, Mrs. Claunch G., 1063 Coronado Circle, Borger
Brooks, Mrs. William W., 510 Crockett, Borger
Brothers, Mrs. Joe F., 1100 W. Jackson, Borger
Brown, Mrs. Malcolm, Combs-Worley Bldg.
Daugherty, Mrs. Roy, 303 Ozsmer, Borger
Dils, Mrs. G. C., 18 Addinsell, Phillips
Donaldson, Mrs. Joe R., Hughes Bldg.
Elder, Mrs. J. Foster, Hughes Bldg.
Falkenstein, Mrs. Richard D., Hughes Bldg.
Gates, Mrs. Phillip A., Rose Bldg.
Hamra, Mrs. Henry M., 508 Crockett, Borger
Hanson, Mrs. Arthur F., 601 N. Coble, Borger
Hanson, Mrs. Larry, 403 W. Grand, Borger
High, Mrs. Clifton E., Box 1701
Hollingsworth, Mrs. H. W., 25 S. Addinsell, Phillips
Hrdlicka, Mrs. George R., Hughes Bldg.
Jones, Mrs. Calvin, Rose Bldg.
>Kelley, Mrs. Frank W., 516 W. Kentucky
Kengle. Mrs. George L., Perryton
Key, Mrs. Julian, Pampa
Kimball, Mrs. Melvin C., Box 391, Phillips
Lang, Mrs. Carl M., Hughes Bldg.
Laycock, Mrs. Raymond W., 516 W. Kentucky
Massad, Mrs. Woodrow W., 1608 Boyd, Borger

*Address is Pampa unless otherwise stated.

AUXILIARY MEMBERS, 1954—*continued*

McDaniel, Mrs. MacField, 808 W. Francis
Nicholson, Mrs. Harold E., Sr., Wheeler
Overton, Mrs. Marvin C., Jr., Hughes Bldg.
Pearson, Mrs. D. B., Jr., Perryton
Pennal, Mrs. Hugh A., 300 Bryan, Borger
Petty, Mrs. Lester A., 321 W. Grand, Borger
Purviance, Mrs Walter, 808 W. Francis
Smith, Mrs. Willard H. 506 Crockett, Borger
Stephens, Mrs. Walton G., 918 S. McGee, Borger
Williams, Mrs. Edward S., 1204 Charles
Wyatt, Mrs. Malcolm W., Hughes Bldg.

HARDEMAN-COTTLE-FOARD-MOTLEY COUNTIES AUXILIARY

George, Mrs. Joseph M., Quanah
Harmon, Mrs. F. C., Jr., Paducah
>Pate, Mrs. C. C., Paducah
Stanley, Mrs. G. S., Matador
Taylor, Mrs. John M., Quanah
Vestal, Mrs. E. A., Quanah

LUBBOCK-CROSBY COUNTIES AUXILIARY*

Anderson, Mrs. William F., 2802 23rd
Arnett, Mrs. Sam C., Jr., 4903 21st
>Barsh, Mrs. Albert G., 2511 22nd
Batson, Mrs. Carey B., 4610 18th
Bess, Mrs. Howard H., 4203-A Canton
Blake, Mrs. Emerson M., 3311 20th
Bronwell, Mrs. Alvin W., 2819 23rd
Canon, Mrs. Robert T., 2613 19th
Carnrick, Mrs. Millard, Jr., 3009 28th
Cashion, Mrs. William R., 3022 21st
Chalk, Mrs. John R., 3709 27th
Clark, Mrs. Vester V., Buffalo Rd.
Cobb, Mrs. John L., 4412 17th
Croom, Mrs. William S., 1506 Avenue U
Cross, Mrs. Denzil B., 3001 20th
Daniel, Mrs. Arthur L., 3418 33rd
Donaldson, Mrs. J. D., Jr., 2428 22nd
Dunn, Mrs. Sam G., 4707 19th
Duran, Mrs. C. Armando, 810 13th
Ellis, Mrs. N. A., 3501-B Oxford
English, Mrs. Otis W., 2809 19th
Ewing, Mrs. Mahon M., 1907 32nd
Fiel, Mrs. Charles A., 3701 19th
Goodwin, Mrs. Frank C., 2319 30th
Gordon, Mrs. William H., 4412 16th
Griffin, Mrs. Harold B., 3307 27th
Hale, Mrs. Lee E., 1902 28th
Hall, Mrs. James T., 2610 25th
Hand, Mrs. Orra R., 4611 18th
Harris, Mrs. Joseph R., Jr., 1211 Avenue O
Hays, Mrs. Harvey, Jr., 1308 58th Place
Healy, Mrs. Maurice J., 3607 27th
Hess, Mrs. Wallace I., 2611 23rd
Hudgins, Mrs. Frank W., 3213 23rd
Hull, Mrs. Orville B., 2515 25th
Hunt, Mrs. Ewell L., 4725 19th
Hutchinson, Mrs. Ben B., 3121 20th
Hutchinson, Mrs. James T., 3505 19th
Jaynes, Mrs. Stanley H., Slaton
Jenkins, Mrs. Byron Arthur, 3412 37th
Kallina, Mrs. Frederick P., 3306 28th
Key, Mrs. Olan, 4901 22nd
Krueger, Mrs. Julius T., 2703 19th
Lane, Mrs. Ralph, 2429 24th
Lewis, Mrs. Richard Q., 3719 26th
Loveless, Mrs. Roy G., 4909 19th
Malone, Mrs. Frank B., 2435 21st
Mayfield, Mrs. Ivan G., 1411 24th Place
McCarty, Mrs. Robert H., 1915 28th
McClure, Mrs. Edwin E., 2625 27th
McSween, Mrs. Magnus J., Slaton
Morris, Mrs. James G., 2624 28th
Moss, Mrs. C. Basil, 2601 45th
Nash, Mrs. Charles H., Jr., 3517 32nd
O'Loughlin, Mrs. Richard K., 3606 28th
Payne, Mrs. Clifford E., 4601 17th
Pennington, Mrs. Hugh A., 4118 33rd
Poole, Mrs. Warren B., 4512 19th
Ratcliff, Mrs. Charles E., 2507 31st
Rhoades, Mrs. Dale R., Crosbyton
Riddel, Mrs. Roy, Jr., 2436 22nd
Roundtree, Mrs. John B., Jr., 4503 18th
Selby, Mrs. John H., 3107 27th
Sheffield, Mrs. Roy S., 3415 26th
Smith, Mrs. Gerald S., 2821 32nd
Smith, Mrs. Lynwood B., 3520 40th
Smith, Mrs. William C., 3605 26th
Spikes, Mrs. Lowell W., Ralls
Stewart, Mrs. Allen T., 3120 21st
Stiles, Mrs. James Hooper, 3002 22nd
Surman, Mrs. Arnold C., Post
Talbert, Mrs. Thomas L., Slaton
Taylor, Mrs. Otis, Jr., 2501 31st
Tubbs, Mrs. Harry A., Post
Upshaw, Mrs. Leon R., 2601 32nd
Wallace, Mrs. Grady M., 2623 31st
Warshaw, Mrs. Harold, 3801 32nd
Watkins, Mrs. Mina D., 3302 23rd
Williams, Mrs. David C., Post

*Address is Lubbock unless otherwise stated.

POTTER COUNTY AUXILIARY*

Archer, Mrs. John R., 3310 Lynnette
Askew, Mrs. W. L., 2402 Tyler
Black, Mrs. Ross P., 2605 Hayden
Blackwell, Mrs. Ben T., 4409 Woflin
Bordelon, Mrs. Howard, 4126 Cimarron
Broyles, Mrs. Sam K., 2618 Washington
Budd, Mrs. Wilbur Q., 1607 Van Buren
Campbell, Mrs. William J., 1516 Lipscomb
Carroll, Mrs. James Ralph, 3201 Hughes
Chase, Mrs. Gaylord R., 2223 Hughes
Churchill, Mrs. Thomas P., 2116 Ong
Citron, Mrs. Ralph, 2809 Hayden
Claybourne, Mrs. Norman L., 3807 W. Lawn
Cole, Mrs. Marion W., 3707 N. Cimarron
Crumley, Mrs. Fred J., 2604 Travis
>Dine, Mrs. William C., 306 Sunset
Duncan, Mrs. Frank B., 1510 Crockett
Duncan, Mrs. R. A., 2102 Tyler
Ellis, Mrs. John Victor, 2007 W. 7th
Flamm, Mrs. Kenneth R., 4406 W. 3rd
Gallagher, Mrs. R. P., 3101 Van Buren
Garre, Mrs. Peter R., 4214 Gem Lake Rd.
Gist, Mrs. Robert D., 2615 Hayden
Gleason, Mrs. Robert L., 2019 Jackson
Goldston, Mrs. Alton B., 2805 Hayden
Greer, Mrs. Rex E., 908 Broadmoor
Harkleroad, Mrs. Frank S., 928 Bowie
Hatchett, Mrs. Capres S., 2610 Hughes
Hegedus, Mrs. W. J., 1811 Austin
Hyde, Mrs. Robert F., Military Service
Intress, Mrs. Robert H., 2237 Peach Tree
Jackson, Mrs. Harvey K., 4216 W. 13th
Jacobson, Mrs. M. E., 1504 Travis
Johnson, Mrs. H. Fred, 3400 Moss Lane
Johnson, Mrs. James L., 1512 Bryan
Johnson, Mrs. Jeremiah B., 4300 Woflin
Kelley, Mrs. Francis J., 1606 Julian
Keys, Mrs. Richard, 2201 Hughes
Klingensmith, Mrs. William R., Jr., 3102 Monroe
Klingensmith, Mrs. William R., Sr., 1413 Lipscomb
Latson, Mrs. Harvey, 1615 Austin
Laur, Mrs. William E., 2015 Milam
Lemmon, Mrs. J. R., 2219 Crockett
Lipscomb, Mrs. Joe L., 107 Palomino Rd.
Livengood, Mrs. Gerald S., 1907 Crockett
Lokey, Mrs. Early B., 2304 Julian Blvd.
Loving, Mrs. Dan, 1616 Hughes
Marclay, Mrs. David, 2025 Parker
Marsalis, Mrs. Don S., 1502 Bowie
McKay, Mrs. Edward D., 3410 Hughes
Mok, Mrs. Wa T., 1408 Hughes
Mullins, Mrs. William B., 2110 Parker
Murphy, Mrs. Weldon O., 3011 Ong
Owens, Mrs. Guy, 109 Sunset
Patton, Mrs. David M., 2405 Bowie
Patton, Mrs. Louis K., 2613 Hughes
Payne, Mrs. Ralph B., 87 N. Avondale
Pickett, Mrs. John M., 125 N. LaSalle
Potter, Mrs. W. A., 2004 Jackson
Puckett, Mrs. Bascom M., 2122 Monroe
Puckett, Mrs. Howard E., 2412 Lipscomb
Rasco, Mrs. Isaac, 1408 Harrison
Reed, Mrs. Emil P., 1200 Bowie
Reed, Mrs. Holly W., 3607 Julian
Reid, Mrs. Howard C., 1607 Parker
Robberson, Mrs. Jason H., 1001 Avondale
Rook, Mrs. Rex, 2201 Crockett
Rowley, Mrs. Elmer A., 1004 Crockett
Royce, Mrs. George T., 2024 Ong
Sadler, Mrs. Charles, 1611 Parker
Scott, Mrs. Wilbur E., 2607 Parker
Shelton, Mrs. James, 4231 W. 2nd
Stout, Mrs. W. W., 1101 Avondale
Streit, Mrs. August J., 3012 Hayden
Swindell, Mrs. R. R., 2218 Hayden
Thomas, Mrs. Edward F., 35 Oldham Circle
Van Sweringen, Mrs. Walter, 1227 Bonham
Vaughn, Mrs. John, 1607 Van Buren
Vineyard, Mrs. R. L., 1801 Harrison
Waddill, Mrs. George, 2222 Harrison
Walkes, Mrs. E. E., 1213 Georgia
Watkins, Mrs. Walter C., Rt. 1, Box 708, Bell Ave.
Werner, Mrs. Jan R., 2827 Bowie
Wertz, Mrs. Royal, 4400 W. 3rd, Rt. 4, Box 133
Wheir, Mrs. William H., 1210 Georgia
White, Mrs. J. B., 2035 Ong
Winsett, Mrs. A. E., 2208 Hughes
Winsett, Mrs. Merrill, 2212 Bowie
Witcher, Mrs. Jones, 112 N. Beverly
Witt, Mrs. John E., 134 N. LaSalle
Wolf, Mrs. Horace, 4507 W. 3rd
Wolfson, Mrs. Charles, 2016 Milam
Yeakel, Mrs. Victor, 2905 Washington

*Address is Amarillo unless otherwise stated.

MEMBERS-AT-LARGE, THIRD DISTRICT

Donnell, Mrs. R. E., 2507 W. 11th, Plainview
Hansen, Mrs. J. H., 903 Milwaukee, Plainview
Heye, Mrs. R. G., 2502 W. 11th, Plainview
Maurer, Mrs. Ralph E., 501 E. 13th, Littlefield
Neblett, Mrs. R. A., Canyon
Nester, Mrs. Charles, Canyon
Nowlin, Mrs. William Carl, 101 E. 17th, Littlefield
Roberts, Mrs. Roy, Plainview
Schlecte, Mrs. M. C., 1004 Travis, Plainview
Snyderman, Mrs. Henry, 1909 W. 10th, Plainview
Still, Mrs. Oscar W., 318 E. 9th, Littlefield

FOURTH DISTRICT

Mrs. Oscar N. Mayo
Brownwood
Council Woman

BROWN-COMANCHE-MILLS-SAN SABA COUNTIES AUXILIARY*

Allen, Mrs. Homer Bryan, 2210 First
Allen, Mrs. Homer Bryan, Jr., 2405 First
Benson, Mrs. William F., 2204 Vincent
Bullard, Mrs. Chester C., 1616 Austin Ave.
Cadenhead, Mrs. Earnest F., 2401 Coggin Ave.
Childers, Mrs. M. A., Goldthwaite
Dingle, Mrs. William P., 1400 Cottage
Galbreath, Mrs. John C., 2511 Elizabeth Dr.
Gold, Mrs. Philip S., 1900 Eleventh
Hallum, Mrs. Roy G., 2000 Eleventh
Hughes, Mrs. Sidney W., 2205 Berkley
Jenson, Mrs. Andrew O., 1906 Austin Ave.
Lobstein, Mrs. Henry L., 1007 Coggin Ave.
>Locker, Mrs. Braswell, Circle L Ranch, Rt. 3
Locker, Mrs. H. L., 1105 Durham
Mayo, Mrs. Oscar N., 2108 Southside Dr.
Pope, Mrs. Fielding M., 2512 Durham
Snyder, Mrs. Ned A., 2609 Elizabeth Dr.
Spencer, Mrs. Fred D., 2201 First
Stephens, Mrs. J. B., Bangs
Walker, Mrs. J. B. N., 2001 Eleventh
Waller, Mrs. A. L., 2208 First
Wheelis, Mrs. Paul M., 1914 Austin
Wilson, Mrs. Francis W., 2309 Avenue D

COLEMAN COUNTY AUXILIARY

Burke, Mrs. Frank M., 311 W. College, Coleman
Henner, Mrs. Charles N., Santa Anna
Jennings, Mrs. William L., Austin St., Coleman
Lovelady, Mrs. R. R., 302 Hollywood, Coleman
>Mann, Mrs. Morris D., 305 Santa Anna Ave., Coleman
Moody, Mrs. Charles O., 815 Commercial Ave., Coleman
Weaver, Mrs. Manly E., 400 E. 7th St., Coleman
Young, Mrs. J. C., 507 W. Elm St., Coleman

CRANE-UPTON-REAGAN COUNTIES AUXILIARY

Gossett, Mrs. James, Rankin
Maynard, Mrs. B. J., Crane
Terry, Mrs. John E., Crane
>Wright, Mrs. J. L., Big Lake

RUNNELS COUNTY AUXILIARY

Bailey, Mrs. Charles F., Ballinger
Chandler, Mrs. Oren H., Ballinger
>Downing, Mrs. Lloyd L., Ballinger
Green, Mrs. John E., Ballinger
Jones, Mrs. Murrell D., Ballinger
Rives, Mrs. C. T., Winters

TOM GREEN-COKE-CROCKETT-CONCHO-IRION-STERLING-SUTTON-SCHLEICHER COUNTIES AUXILIARY†

Alexander, Mrs. Eugene P., 2838 Colorado
Anderson, Mrs. Wilson D., 2213 Dallas
Arledge, Mrs. Robert M., 523 Angelo Blvd.
Barry, Mrs. J. Douglas, 218 Hobbs
Boster, Mrs. Ray W., 1705 S. Madison
Boyd, Mrs. R. B., 2507 W. Avenue L
Brask, Mrs. H. Kermit, 1411 Shafter
Brauns, Mrs. Wilhelm H., 1636 Shafter
Browne, Mrs. Charles F., Sonora

*Address is Brownwood unless otherwise stated.

†Address is San Angelo unless otherwise stated.

AUXILIARY MEMBERS, 1954—*continued*

Butner, Mrs. Wendell B., 2306 W. Avenue K
Byars, Mrs. Perry J. C., 109 Churchill Blvd.
Cbase, Mrs. Ralph R., 1901 Rosement
Coleman. Mrs. T. Gabe, 2210 W. Avenue L
Cornelison, Mrs. Joe L., 201 Glenmore Dr.
Eckhardt, Mrs. Gus F., 1530 S. Monroe
Engelking, Mrs. Charles G., 2540 W. Avenue K
Everhart, Mrs. Merrill W., 2704 Douglas Dr.
Finks, Mrs. Robert M., 1510 Paseo de Vaca
>French, Mrs. Cecil M., 400 S. Madison
Hershberger, Mrs. Lloyd R., 1510 Grierson
Howell, Mrs. John F., Sonora
Hutchins, Mrs. F. Leon, 2202 Dallas
Irvine, Mrs. George N., Jr., 112 Hobbs
Johnson, Mrs. Clay H., 2201 W. Avenue J
Knight, Mrs. Maynard, 2619 Live Oak
Kunath, Mrs. Carl A., 2535 W. Avenue J
Landy, Mrs. Aaron E., 1427 S. Madison
Lewis, Mrs. Aubrey L., 123 E. Beauregard
Madding, Mrs. Gordon F., 1325 S. Madison
Martin, Mrs. Scott H., 2201 Abilene
Mitcbell, Mrs. W. Grady, 121 N. Washington
Moon, Mrs. Roy E., 544 S. Parkway
Nesrsta, Mrs. George L., 1412 S. Madison
Porter, Mrs. William L., 2521 W. Avenue K
Powers, Mrs. Rufus L., 1912 Jade Dr.
Rape, Mrs. J. Marvin, 1521 W. Harris
Reilly, Mrs. Daniel R., 112 S. Filmore
Sattenspiel, Mrs. Edward, 2705 Shamrock
Schulze, Mrs. Victor E., Christoval Rd.
Smith, Mrs. Jerome, 1300 Paseo de Vaca
Smith, Mrs. W. Lacey, 1430 W. Avenue J
Tester, Mrs. Lewis K., 1327 Mackenzie
Thompson, Mrs. Chase S., 608 E. Parkway
Wall, Mrs. D. D., 1434 Paseo de Vaca
White, Mrs. James N., 2627 Circle J
Winklemann, Mrs. Eugene C., 2603 Jann Dr.
Womack, Mrs. Clifford T., 208 N. Madison
Wood, Mrs. Marion L., 1812 Jade Dr.

MEMBERS-AT-LARGE, FOURTH DISTRICT

Hallum, Mrs. B. A., Jr., 1807 S. Pine, Brady

FIFTH DISTRICT

Mrs. John C. Parsons
San Antonio
Council Woman

ATASCOSA COUNTY AUXILIARY

Austin, Mrs. John David, Box 266, Pleasanton
Faggard, Mrs. John McLain, Box 584, Poteet
Joyce, Mrs. Walter Harris, Lytle
Mann, Mrs. Robert Earl, Box 538, Pleasanton
>Ogden, Mrs. U. B., Box 568, Pleasanton
Ware, Mrs. Thomas Preston, Box 193, Poteet

BEXAR COUNTY AUXILIARY*

Adams, Mrs. R. Stuart, 336 E. Lullwood
Adelman, Mrs. Jack, 414 Quentin
Aderhold, Mrs. James P., 131 E. Elsmere
Albert, Mrs. Arnold, 542 Channing
Albert, Mrs. Monroe, 431 Cosgrove
Alexander, Mrs. Charles B., 2109 W. Gramercy
Allen, Mrs. S. W., 141 E. Gramercy
Allin, Mrs. Willis, 402 Garrity
Altgelt. Mrs. Daniel D., 219 W. Gramercy
Altgelt, Mrs. James, 510 W. Lynwood
Alvis, Mrs. Milton E., 303 Belvidere
Applewhite, Mrs. Scott C., 81 Milbrook Rd., Hamlin, Conn.
Arendt, Mrs. E. J., 625 Shook Ave.
Atkinson, Mrs. Donald T., Rt. 2, Box 167-A
Atmar, Mrs. R. C., 210 W. Hollywood
Barnett, Mrs. John L., 116 Wildrose
Bates, Mrs. LeRoy E., 123 Park Dr.
Beacb, Mrs. Asa, 129 E. Summit
Bean, Mrs. J. Allen, 251 E. Elmview
Beck, Mrs. Lewis Krams, 1420 N. McCullough
Berchelmann, Mrs. David A., 223 Shadwell
Bernard, Mrs. George E., 1925 Hicks
Berry, Mrs. Lloyd E., 211 E. Hermosa Dr.
Blair, Mrs. James R., Jr., 700 Wiltshire
Block, Mrs William J., Jr., 354 Carnahan
Bloom, Mrs. Bernard H., 243 Stanford Dr.
Boccelato, Mrs. S. L., 201 Jeanette
Boehs, Mrs. Charles J., 135 W. Hollywood
Bohmfalk, Mrs. John H., 226 W. Hermine
Bondurant, Mrs. W. W., Jr., 430 College
Borsheim, Mrs. Raymond S., 701 Terrell Rd.
Bosshardt, Mrs. Carl E., 200 W. Rosewood
Bosshardt, Mrs. Charles E., 227 Claudia
Bowen, Mrs. R. E., 1849 W. Gramercy
Boyd, Mrs. G. D., 410 Thelma Dr.
Boysen, Mrs. A. E., 427 Thelma Dr.
Brendel, Mrs. William B., 331 Hillwood Dr.
Breuer, Mrs. Alfred, 1321 Wiltshire
Brown, Mrs. A. A., 233 Linda Dr.
Burg, Mrs. Edward M., 2167 W. Summit
Burk, Mrs. Joseph E., 1019 W. Agarita
Bush, Mrs. Howard M., 1540 W. Huisache
Butler, Mrs. T. B., 244 Belvidere
Buttery, Mrs. Harold, 130 E. Rosewood
Cade, Mrs. C. C., 307 E. Park Ave.
Cade, Mrs. W. H., 111 Canterbury Hill
Calder, Mrs. Royall M., 108 Geneseo Rd.
Carter, Mrs. James William, Jr., 222 Robin Hood
Case, Mrs. John B., 610 Wiltshire
Celaya, Mrs. Albert, 334 W. Mistletoe
Celaya, Mrs. Henry, 631 Ciruela St.
Center, Mrs. William M., 381 Meredith Dr.
Cerha, Mrs. Harry T., 601 Alexander Hamilton Dr.
Cbampion, Mrs. A. N., 417 E. Mandalay Dr.
Chankin, Mrs. Edgar D., 555 Senisa Dr.
Cbilders, Mrs. Herscbel N., 917 Vanderhoeven Dr.
Childers, Mrs. M. A., Jr., 101 Nacogdoches Rd.
Christian, Mrs. T. E., 450 Mary Louise Dr.
Clark, Mrs. Fletcher, Jr., 229 W. Rosewood
Clark, Mrs. Fletcher, Sr., 228 W. Lullwood
Coates, Mrs. Elmer T., 442 Garrity Rd.
Coffman, Mrs. Graham M., 1134 Garrity Rd.
Coleman, Mrs. Frederick, 304 Seeling
Cook, Mrs. Walter R., 352 Arcadia Pl.
Cooper, Mrs. Elmer E., 119 Wildwood Dr.
Cooper, Mrs. Fred B., 306 Mandalay Dr., E.
Cooper, Mrs. Melbourne J., 206 Primera Dr.
Copeland, Mrs. J. B., 322 W. King's Hwy.
Coyle, Mrs. E. W., 213 Grant Ave., Alamo Heights
Crews, Mrs. E. Rush, 232 Beverly Dr.
Crockett, Mrs. R. H., 1624 Avenue P, Huntsville
Cunningham, Mrs. S. P., 116 W. Woodlawn
Cutter, Mrs. I. T., 421 E. Olmos
Davis, Mrs. David F., 242 E. Rosewood
Davis, Mrs. Herman L., 1124 W. Gramercy
Davis, Mrs. Milton, 945 W. Huisache
Davis, Mrs. Raleigh, 636 Olmos Dr., E.
Davis, Mrs. Roy N., 150 Hathaway Dr., E., Apt. 5
Day, Mrs. Pbillip L., 137 Beverly Dr.
De Leon, Mrs. J. J., 511 Club Dr.
DePew, Mrs. Evarts V., 115 E. Agarita
Diseker, Mrs. Tbomas H., 324 Elizabeth Rd.
Dittman, Mrs. C. H., 1631 W. Huisache
Dodge, Mrs. Donald T., 615 Elizabeth Rd.
Dorbandt, Mrs. M. M., 1638 Santa Barbara
Dufner, Mrs. Romie M., 1024 Steves Ave.
Dumas, Mrs. E. D., 418 W. French Pl.
Duncan, Mrs. Everett T., 527 College
Dupre, Mrs. J. Rogers, 410 Kings Court
Ellis, Mrs. Sam, 567 Elizabeth Rd.
Elmendorf, Mrs. Hugo F,, Rt. 10, Box 403-0-111 Moss Dr.
Engelke, Mrs. Albert G., 205 Terrell Rd.
Fein, Mrs. Bernard T., 439 Mary Louise Dr.
Fetzer, Mrs. William J.. 220 W. Elsmere
Finsterwald, Mrs. James F., 206 Sherwood
Fisher, Mrs. Rowen E., 114 Park Hill Dr.
Folbre, Mrs. Thomas W., 408 Eldon Rd.
Franke, Mrs. Winthrop, 2512 Main Ave.
French, Mrs. Jack A., 160 W. Quill
Geissler, Mrs. Wallace H., Rt. 2, Box 327-Y-4
Gilbreath, Mrs. S. F., 115 Thelma
Gill, Mrs. James P., 2439 W. Huisache
Goeth, Mrs. Carl F., 204 W. Mulberry
Goeth, Mrs. R. A., 125 E. Huisache
Gonzales, Mrs. H. N., 221 W. Kings Hwy.
Gonzales, Mrs. Joaquin B., 302 Donaldson
Goode, Mrs. J. W., 134 E. Hermosa
Goodnight, Mrs. James E., 337 Wildrose
Goodpasture, Mrs. John E., 2407 W. Huisache
Goodwin, Mrs. Roy T., 124 Barilla
Gordon, Mrs. William H., Jr., 602 Blakely
Gorsuch, Mrs. Paul L., 564 Pershing Ave.
Gossett, Mrs. R. F., 625 Lamont
Grant, Mrs. Harold, 302 Thorman Pl.
Graves, Mrs. Amos, 222 Geneseo
Graves, Mrs. W. E., 804 W. Poplar
Greer, Mrs. Sam Jones, 927 Nix Prof. Bldg.
Haggard, Mrs. Frank N., (Hon.), 301 Encino Ave.
Hairston, Mrs. J. Thomas, 208 W. Craig
Haley, Mrs. Roscoe, 438 Thelma Dr.
Hargis, Mrs. Huard, 321 Inslee
Hargis, Mrs. W. H., 317 E. Summit
Hartman, Mrs. Albert, 148 Marcia Pl.
Hartman, Mrs. Ralph E., 176 E. Beverly Mae
Heaney, Mrs. John P., 127 Lilac Lane
Hebert, Mrs. Thomas, 336 E. Lullwood
Heck, Mrs. W. H., 421 Mary Louise Dr.
Heger, Mrs. Frank, 165 Thoraine
Hendrick, Mrs. James W., 332 Encino Ave.
Henning, Mrs. G. G., 403 Arcadia Pl.
Herff, Mrs. August F., 363 Terrell Rd.
Herff, Mrs. F. P., 210 Paseo Encinal
Hill, Mrs. Alfred H., 175 Primrose
Hill, Mrs Herbert, 121 Stanford Dr.
Hill, Mrs. Lucius D., 107 Dover Rd.
Hinchey, Mrs. John J., 210 W. Fair Oaks
Hollan, Mrs. O. Rogers, 226 Larkwood
Holshouser, Mrs. Charles A., 123 W. Kings Hwy.
Hooper, Mrs. Charles H., 230 Skyview Dr., W.
Hoskins, Mrs. Henry R., 334 Club Dr.
Howard, Mrs David Snow, 116 Sage Dr.
Howerton, Mrs. Ernest E., Rt. 2, Box 329-W
Hull, Mrs. Austin O., 4011 S. Presa
Hulse, Mrs. Charles A., 1523 W., Mistletoe
Hunt, Mrs. Kent N., 321 W. Summit
Jackson, Mrs. Dudley, Jr., 719 Elizabeth Rd.
Jackson, Mrs. Dudley, Sr., 208 Park Lane Dr.
Jackson, Mrs. L. B., 203 W. Mulberry
Jackson, Mrs. L. Walford, 1530 W. Gramercy
Jacob, Mrs. Norman, 318 Tuxedo
Jensen, Mrs. Andrew M., 103 Downing
Jensen, Mrs. Martin H., 330 Furr Dr.
Johnson, Mrs. Cbarles W., Boerne
Johnson, Mrs. Max E., 125 E. Kings Hwy.
Johnson, Mrs. Ted, 2938 W. Ashby
Johnson, Mrs. W. J., 106 E. Ridgewood Ct.
Johnson, Mrs. William J., 130 Lamont
Jones, Mrs. Dean, 2422 W. Magnolia
Jones, Mrs. George W., 110 Rosemont Dr.
Jones, Mrs. L. Bonham, 330 Shadwell
Judkins, Mrs. Oscar H., 240 W. Summit
Kahn, Mrs. I. S., 438 W. Elsmere Pl.
Kaliski, Mrs. Belle, 330 E. Craig
Kass, Mrs. Albert, 244 Tuxedo
Keedy, Mrs. David M., 111 Newberry Terrace
Kelley, Mrs. Cole, 402 Harrison
Kenney, Mrs. Nat Mitchell, 222 E. Poplar
King, Mrs. Thomas C., 502 Blakely
Kitowski, Mrs Vincent J., 101 Arvin Dr.
Klecka, Mrs. Theo A., 515 Rittiman Rd.
Kline, Mrs. Pbilip S., 250 Braban Blvd.
Koch, Mrs. Alvis A., 320 Primrose
Koontz, Mrs. Lee Allen, 424 Quentin
Kopecky, Mrs. Joseph, 627 Lamont
Kopecky, Mrs. J. Willis, 411 Harrison Ave.
Kopecky, Mrs. Leon C., 730 Evans
Kupper, Mrs. Roland C., 422 Harrison
Ladd, Mrs. Graham B., 211 Zambrano
Lahourcade. Mrs. F. E., 101 John Page
Lahourcade, Mrs. F. G., 135 Blakely
Leap, Mrs. Harry, 201 Ellwood
Lee, Mrs. Jack B., 104 Aylesbury Hill
Lehmann, Mrs. C. Ferd, 336 Terrell Rd.
Lemus, Mrs. Leopoldo, 2220 S. Flores
Leopold. Mrs. Henry N., 444 College
Letteer, Mrs. C. Ralpb, 345 Terrell Rd.
Letteer, Mrs. Josephine H., 225 Belvidere
Luedemann, Mrs. Waldo S., 503 Donaldson
Lundgren, Mrs. R. W., 711 Wiltshire
Lyon, Mrs. Ervin F., Jr., 2115 W. Gramercy
Levine, Mrs. Bernard, 410 E. Cheryl
Magrish, Mrs. Philip, 524 Mandalay Dr., E.
Manhoff, Mrs. Charles M., 123 Lilac Lane
Manhoff, Mrs. Louis J., Jr., 204 Wildwood, E.
Martin, Mrs. Frank M., 115 Dover Rd.
Martinez, Mrs. J. J., 902 W. Magnolia
Matthews, Mrs. John L., 114 E. Gramercy
Maurer, Mrs. Robert, 227 E. Lawndale
Maxwell, Mrs. Ernest A., 244 Luther
Maxwell, Mrs. W. W., 932 W. Woodlawn
McCabe, Mrs. Edward P., Jr., 2329 W. Huisache
McCamish, Mrs. E. W., 120 E. Magnolia
McComb, Mrs. Asher R., 510 Hathaway Dr., E.
McCorkle, Mrs. R. G., 6300 N. New Braunfels Ave.
McCreight, Mrs. Henry H., 2416 W. Woodlawn
McCurdy, Mrs. Marion W., 601 Mandalay Dr., E.
McGehee, Mrs. Charles L., 236 Quentin Dr.
McIntosh, Mrs. J. A., 208 W. Woodlawn
McKiskie, Mrs. Wendel E., 100 Senisa Dr.
McMahon, Mrs. David T., Jr., 788 Terrell Rd.
McMillan, Mrs. Orin P., 2540 W. Summit
Melenyzer, Mrs. Charles, 1723 N. Trinity
Merrick, Mrs. Edward H., 367 North Dr.
Milburn, Mrs. Conn L., 315 Terrell Rd.
Milburn, Mrs. Graham B., 701 Canterbury
Milburn, Mrs. Kennedy A., 347 Charles
Miller, Mrs. J. B., 132 W. Hollywood
Miller, Mrs. J. B., Jr., 117 Brittany Dr.
Mims, Mrs. James L., Jr., 2349 W. Huisache
Miniel, Mrs. Pedro, 121 Eller
Minter, Mrs. Merton M., 150 Oakmont
Mohle, Mrs. Chester L., 925 Contour
Monsalvo, Mrs. R. O., 264 Primera Dr.
Montgomery, Mrs. W. D., 205 Primera Dr.
Moore, Mrs. George B., Jr., 142 E. Elsmere
Moore, Mrs. John M., 227 Park Hill Dr.
Moore, Mrs. Oliver S., 1846 W. Magnolia
Moore, Mrs. S. Foster, Jr., 200 Paseo Encinal
Moore, Mrs. T. E., 110 E. Craig

*Address is San Antonio unless otherwise stated.

AUXILIARY MEMBERS, 1954—*continued*

Morris, Mrs. M. H., 140 Arvin Dr.
Moses, Mrs. Louis E., 434 Harmon Dr.
Mueller, Mrs. Edwin L., Jr., 223 E. Edgewood Pl.
Mueller, Mrs. Edwin L., Sr., 154 Barilla Pl.
Muldoon, Mrs. W. E., 308 Park Dr.
Munslow, Mrs. R. A., 1614 W. Magnolia
Nau, Mrs. Cornelius H., 219 Karen Lane
Neshit, Mrs. W. E., 221 W. Mistletoe
Nicholson, Mrs. J. R., Rt. 2, Box 178-A
Nishet, Mrs. Alfred A., 420 Park Dr.
Nitschke, Mrs. Richard E., 123 E. Edgewood
Nixon, Mrs. James W., 129 E. Gramercy
Nixon, Mrs. James W., Jr.. 260 Primera
Nixon, Mrs. P. L., Jr., 2000 W. Kings Hwy.
Nixon, Mrs. P. L., Sr., 202 E. Courtland
Nixon, Mrs. Robert R., 634 Clower
Norman, Mrs. Ruskin C., 235 Inslee
Novak, Mrs. Joseph J., 208 Placid
Oldham, Mrs. J. P.. 612 Goliad
Oliver, Mrs. David Rives, 135 Oakleaf Dr.
O'Neill, Mrs. Francis E., 204 Grandview
O'Neill, Mrs. James R., 236 Mandalay Dr., W.
Orlando, Mrs. A. M., 319 Buckingham
Owens, Mrs. Ross, 226 W. Gramercy
Palmer, Mrs. J. W., 106 Anne Lewis
Park, Mrs. J. Walter, 340 Tuttle Rd.
Parsons, Mrs. John C., 470 Furr Dr.
Partain, Mrs. Jack M., 211 Belvidere
Paschal, Mrs. Frank L., 403 Maverick
Paschal, Mrs. George H., 411 Maverick
Passmore, Mrs. B. H., 6620 Broadway
Passmore, Mrs. G. G., 329 Argyle
Peterson, Mrs. Robert C., 206 Irvington
Phillips, Mrs. Claude M., 444 Hammond Ave.
Pinson, Mrs. C. C., 910 Cambridge Oval
>Pipkin, Mrs. J. Lewis, 511 Brackenridge
Polka, Mrs. James B., Rt. 2, Box 341, North Loop Rd.
Pomerantz, Mrs. R. Bernard, 232 W. Hermine
Posey, Mrs. Frank M., Jr., 237 W. Agarita
Post, Mrs. S. Perry, 254 Cromwell
Poth, Mrs. Duncan O., 412 Hathaway Dr., W.
Potthast, Mrs. O. J., 419 King William
Pressly, Mrs. T. A., 604 Canterbury Hill
Pridgen, Mrs. James E., 512 Canterbury Hill
Pridgen, Mrs. John L., 227 W. Huisache
Pritchett, Mrs. Belvin, 231 North Dr.
Pyterek, Mrs. Arthur B., 326 S. Audubon Dr.
Rabel, Mrs. John E., 309 Thelma Dr.
Ramsdell, Mrs. M. A., 412 Harrison
Reeves, Mrs. George D., 6721 Broadway
Reily, Mrs. William A., 365 Club Dr.
Reiter, Mrs. Charles A., 412 Cloverleaf
Ressmann, Mrs. Arthur C., 203 Medford
Reveley, Mrs. Hugh, 215 John Adams
Reveley, Mrs. James E. L., 727 Chicago Blvd.
Ritch, Mrs. Allen, 221 Devine Rd.
Roan, Mrs. Omar, 107 Geneseo Rd.
Roberts, Mrs. R. A., 2401 W. Mulberry
Robertson, Mrs. Wilher F., 540 Lamont
Rogers, Mrs. Albert, 151 North Dr.
Rosenzweig, Mrs. M. M., 200 E. Wildwood
Ross, Mrs. R. R., Suite 716, St. Anthony Hotel
Rouse, Mrs. J. W. H., 238 Medford Ct.
Russ, Mrs. W. B., 1301 Belknap
Russell, Mrs. Dan A., 600 Patterson
Sacks, Mrs. A., 612 W. Magnolia
Sacks, Mrs. David R., 105 Nadine Rd.
Saegert, Mrs. A. H., 124 E. Edgewood
Sample, Mrs. Roy O., 207 Park Lane
Sandler, Mrs. Arthur S., 141 Windsor
Schiffer, Mrs. Sidney, 322 Senisa Dr.
Scull, Mrs. C. E., 115 Paseo Encinal
Scull, Mrs. Jack, 115 Paseo Encinal
Severance, Mrs. A. O., 151 Harrison
Sharp, Mrs. Thomas H., 126 Park Hill Dr.
Shaver, Mrs. Benjamin B., 117 Aribe Dr.
Shefts, Mrs. Lawrence M., 519 W. Ashby
Shepherd, Mrs. W. F., 1401 Highland
Shipman, Mrs. E. D., 551 Cincinnati Ave.
Shotts, Mrs. C. C., 521 College
Siever, Mrs. James, 525 Mandalay Dr., E.
Skinner, Mrs. L. C., 325 Kennedy
Skripka, Mrs. C. F., 1130 Avant Ave.
Smith, Mrs. John M., Jr., 130 Brittany
Snip, Mrs. Russell T., 900 Ivy Lane
Sorell, Mrs. Frank W., 421 W. Lynwood
Sransell, Mrs. Paul, 2446 W. Summit
Steed, Mrs. Frank, 433 Mary Louise
Steinherg, Mrs. F. W., 237 Castano
Stewart, Mrs. C. Scott, 225 W. Elmview
Stewart, Mrs. James K., 146 Oriole Lane
Stieler, Mrs. Albert, 315 Club Dr.
Stout, Mrs. B. F., 110 W. Lynwood
Stovall, Dr. Virginia S., 218 Morningside
Stozier, Mrs. William E., 730 Tuxedo
Straunch, Mrs. James H., 530 John Adams Dr.
Stuck, Mrs. Walter G., 312 Cardinal
Sugg, Mrs. W. R., 218 Morningside
Sutton, Mrs. Robert S., 327 Shadwell
Sweet, Mrs. Horace C., 233 W. Summit
Swinney, Mrs. Boen, 143 Bluehonnet Blvd.
Sykes, Mrs. E. Meredith, 201 Charles Rd.
Sykes, Mrs. Edwin M., Jr., 307 Lamont
Taylor, Mrs. C. W., 276 Mandalay Dr., W.
Taylor, Mrs. Sam H., 343 W. Hollywood
Templeton, Mrs. R. D., 350 Kendalia
Tennison, Mrs. Charles W., 221 Primrose
Thaggard, Mrs. Alvin, Jr., 123 Tuttle Rd.
Theisman, Mrs. Floyd H., 1403 W. Mistletoe
Thomas, Mrs. R. P., Menger Hotel
Thornton, Mrs. Melvin L., 422 Olney Dr.
Timmins, Mrs. Oliver H., Jr., 206 Lamont
Timmins, Mrs. O. H., Sr., 928 W. Agarita
Tippit, Mrs. Nathaniel G., 113 Harriett Dr.
Todd, Mrs. D. A., 305 Thelma Dr.
Trevino, Mrs. Saul, 1516 W. Magnolia
Tritt, Mrs. Earl F., 2043 W. Summit
Tucker, Mrs. Victor, 2110 W. Kings Hwy.
Urrutia, Mrs. Adolfo, 330 Rosemary
Venahle, Mrs. J. Manning, 139 E. Park Hill
Wald, Mrs. Donald, 146 Harrigan Ct., Apt. 1
Walker, Mrs. H. Vincent, 257 Lyman
Waller, Mrs. E., 207 Oakleaf
Walsh, Mrs. F. C., Hunt
Walthall, Mrs Walter, Rt. 13, Box 542, 151 Frederick Rd.
Watson, Mrs. I. Newton, 231 Bronson
Watts, Mrs. Jack, 433 W. Woodlawn
Weatherford, Mrs. E. W., 331 Castano
Weatherford, Mrs. Frank, 410 W. Lynwood
Weatherford, Mrs. Jack M., 727 Rittiman Rd.
Wehh, Mrs. John B., 2611 W. Gramercy
Weiss, Mrs. Victor J., 1419 Schley
Welch, Mrs. Eldred E., 489 Olmos Dr., E.
Whitacre, Mrs. Stanley, 1410 McKinley
Wiesner, Mrs. J. J., 211 Oakleaf Dr.
Wigodsky, Mrs. Herman, 300 Primera Dr.
Wilkinson, Mrs. John M., 363 Sutton Dr.
Williams, Mrs. Phillip T., Jr., 929 Manor
Williams, Mrs. V. H., 112 Cloverleaf
Winter, Mrs. J. W., 350 Terrell Rd.
Wolf, Mrs. William, 415 Paseo Encinal
Worsham, Mrs. John W., 310 Thelma Dr.
Wright, Mrs. Jack, 2301 W. Kings Hwy.
Wyatt, Mrs. Byron W., 117 Luther Dr.
Wyneken, Mrs. Leona L., 118 E. French Pl.
Zeitlin, Mrs. S. P., 125 Linda Dr.

COMAL COUNTY AUXILIARY

Bergfeld, Mrs. Jack A., 208 S. Sycamore, New Braunfels
Casto, Mrs. F. Frederick, 260 S. Seguin, New Braunfels
Hinman, Mrs. A. J., 161 S. Castell, New Braunfels
Karbach, Mrs. H. E., 487 W. San Antonio, New Braunfels
Karhach, Mrs. Walter F., Hinman Bldg., New Braunfels
Schaefer, Mrs. John K., 1036 N. Liherty, New Braunfels
Schleicher, Mrs. LeRoy C., 770 Roosevelt, New Braunfels
Sullivan, Mrs. William W., 515 Edgewater, New Braunfels
Wright, Mrs. Rennie, 150½ S. Seguin, New Braunfels

GONZALES COUNTY AUXILIARY

>Edwards, Mrs. H. S. Nixon
Elder, Mrs. N. A., Nixon
Price, Mrs. James, Gonzales
Shelhy, Mrs. David M., Gonzales
Von Werssowetz, Mrs. Odom F., Gonzales

GUADALUPE COUNTY AUXILIARY

>Goetz, Mrs. J. T., Seguin
Knolle, Mrs. Robert L., Seguin
Williams, Mrs. Jesse B., Seguin

KARNES-WILSON COUNTIES AUXILIARY

>Blake, Mrs. John V., Floresville
Bonestetter, Mrs. H. J., Kenedy
Boykin, Mrs. Soloman R., Floresville
Jones, Mrs. E. W., Kenedy
McKinney, Mrs. W. C., Runge
Mills, Mrs. William, Kenedy
Osoba, Mrs. W. G., Stockdale
Oxford, Mrs. J. W., Floresville
Shannon, Mrs. S. E., Karnes City

KERR-KENDALL-GILLESPIE-BANDERA COUNTIES AUXILIARY*

Bell, Mrs. William E., Circle Dr.
Black, Mrs. A. J., 704 Jefferson
Blackstone, Mrs. Mathis, 513 Lucile
Buswell, Mrs. Adah, 313 St. Peter
Contor, Mrs. Lester, Legion
Crumrine, Mrs. L. B., 505 Stonewall
Culver, Mrs. C. F., 408 Florence
Dyer, Mrs. E. L., Medina Rd.
Drane, Mrs. H. A., Goat Creek Rd.
Feller, Mrs. L. W., Fredericksburg
Gallatin, Mrs. H. H., 505 Elm St.
Green, Mrs. Mara, 512 Washington
Gregg, Mrs. William Earl, 607 W. Water
>Guill, Mrs. Russel, 612 Wheless
Horowitz. Mrs. Izaac, Legion
Jones, Mrs. Charles C., Jr., 720 W. Main
Jones, Mrs. Charles C., Sr., Comfort
Keidel, Mrs. Victor, Fredericksburg
Keyser, Mrs. L. L., Fredericksburg
Kirkham, Mrs. Judd, Legion
Knapp, Mrs. Dwight R., Junction Rd.
Mathews, Mrs. Choice B., 1000 Remschel
McClellan, Mrs. C. L., 1609 Main
McCullough, Mrs. David, 719 Jackson
Meador, Mrs. George D., Bandera
Packard, Mrs. Duan E., Medina Rd.
Perry, Mrs. J. Hardin, Fredericksburg
Pfeiffer, Mrs. H. G., Fredericksburg
Reid, Mrs. H. P., 624 Earl Garrett
Rosenblatt, Mrs. Joseph, Legion
Secor, Mrs. W. L., 608 Earl Garrett
Seidel, Mrs. Joshua, Starket Manor
Springall, Mrs. W. H., Fredericksburg
Sutch, Mrs. V. J., Legion
Thompson, Mrs. Sam E. (Hon.), Steepside

*Address is Kerrville unless otherwise stated.

LA SALLE-FRIO-DIMMIT COUNTIES AUXILIARY

McKinley, Mrs. Robert, Pearsall
>Myers, Mrs. Clyde P., Cotulla
O'Connor, Mrs. T. D., Pearsall
Wilson, Mrs. William, Carrizo Springs

MEDINA-UVALDE-MAVERICK-VAL VERDE-EDWARDS-REAL-KINNEY-TERRELL-ZAVALA COUNTIES AUXILIARY

Burditt, Mrs. Bucky Lee, 901 Griner St., Del Rio
Burditt, Mrs. W. B., Burditts' Dairy, Del Rio
>Cartall, Mrs. Louis M., 312 Nicholson, Del Rio
Cunningham, Mrs. G. B., 1103 N. High, Uvalde
Eads, Mrs. R. A., 1001 N. High, Uvalde
Gates, Mrs. Ellis F., 577 Ceylon, Eagle Pass
Good, Mrs. R. C., Eagle Pass
Graham, Mrs. R. L., 200 Edna, Del Rio
Graham, Mrs. Robert N., 200 Edna, Del Rio
Guice, Mrs. L. E., 336 Mulherry, Uvalde
Howard, Mrs. W. A., 1245 N. Park, Uvalde
Hyslop, Mrs. Henry, 1300 N. Main, Del Rio
Johnson, Mrs. Thomas M., Las Vacas Rd., Del Rio
Kaback, Mrs. Harry, 443 Monroe, Eagle Pass
LaForge, Mrs. Hershall, 411 N. Getty, Uvalde
Lewis, Mrs. B. O., Eagle Pass
McWilliams, Mrs. Rex W., 122 Hudson Dr., Del Rio
Merritt, Mrs. G. H., Rocksprings Rd., Uvalde
Montemayor, Mrs. Raul, Jr., 925 Second St., Eagle Pass
Montemayor, Mrs. Raul, Sr., 925 Second St., Eagle Pass
Peters, Mrs. Leo, Devine
Poindexter, Mrs. Carey A., 212 E. Maverick, Crystal City
Pratt, Mrs. Frank, Rocksprings
Samsel, Mrs. T. B., Crystal City
Spencer, Mrs. John C., Crystal City
Utterhack, Mrs. A. P., Brackettville
Williamson, Mrs. James D., Castroville

SIXTH DISTRICT

Mrs. S. W. Bohmfalk
Weslaco
Council Woman

BEE-LIVE OAK-McMULLEN COUNTIES AUXILIARY

Edmonson, Mrs. J. W., 103 E. Jones, Beeville
Kirkland, Mrs. L. W., 501 E. Hefferman, Beeville
Lancaster, Mrs. H. E., 1310 N. Adams, Beeville
McNeill, Mrs. S. E., 206 E. Hefferman, Beeville
Miller, Mrs. E. E., 1006 N. Adams, Beeville
>Reagan, Mrs. J. L., N. Adams, Beeville
Reagan, Mrs. J. W., 1400 E. Bowie, Beeville
Reagan, Mrs. T. B., Refugio Hwy., Beeville

AUXILIARY MEMBERS, 1954—*continued*

BROOKS-DUVAL-JIM WELLS COUNTIES AUXILIARY

Allison, Mrs. A. M., Box 1254, Alice
Bartlett, Mrs. Glenn, Falfurrias
Gonzalez, Mrs. J. C., Benavides
Haag, Mrs. E. L., Freer
Hocott, Mrs. J. F., Freer
Howard, Mrs. Glenn T., 1912 Alta Vista, Alice
Joseph, Mrs. P. S. (Deceased), 701 E. 2nd, Alice
Newkirk, Mrs. William, 1125 Josephine, Alice
Penly, Mrs. R. S., Falfurrias
Virgin, Mrs. E. P., 320 Kansas, Alice
Wilder, Mrs. Lowell, Falfurrias
Williams, Mrs. Harold, 1002 S. Cameron, Alice
Wyche, Mrs. G. G., Jr., 1808 Olmos, Alice
>Wyche, Mrs. G. G., Sr., 310 N. Wright, Alice

CAMERON-WILLACY COUNTIES AUXILIARY*

Amidon, Mrs. Charles, W. State Hwy.
Ashcraft, Mrs. E. J., 1710 Parkwood
Atchison, Mrs. Martin, 718 Bowie
Baden, Mrs. Erwine, 312 E. Gem Ave., Raymondville
Baden, Mrs. Wayne, E. McCharon Ave., Raymondville
Bedri, Mrs. M. R., 902 E. Parkwood
Benavides, Mrs. S. L., 335 E. Kimball, Raymondville
Bennock, Mrs. George, 446 E. Wood, Raymondville
Bernard, Mrs. R. C., 1201 N. First
Bleakney, Mrs. Phil, Olmito, Brownsville
Boice, Mrs. Edward H., N. Milam, San Benito
Bowyer, Mrs. Charles, 122 W. Ocean Blvd., Los Fresnos
Brown, Mrs. John F., 1040 N. Shore Dr., San Benito
Caldeira, Mrs. F. D., 106 W. Buchanan
Casey, Mrs. James D., 905 N. Shore Dr., San Benito
Cash, Mrs. Clarence M., 1040 N. Bowie, San Benito
Chase, Mrs. Ned, 127A Palo Blanco, San Benito
Clarke, Mrs. James Y., East Hwy., San Benito
Davis, Mrs. L. M., 709 E. Harrison
Duncan, Mrs. George, 1716 S. First
Gallaher, Mrs. George L., 802 W. Lincoln
Guilbeau, Mrs. Joseph A., 1002 N. Shore Dr., San Benito
>Goerger, Mrs. Verne, 300 E. Elm, Raymondville
Grimm, Mrs. John, 1106 Crockett
Hamilton, Mrs. O. A., 1202 E. Tyler
Harropp, Mrs. Louis, 113 N. Fourth
Hartman, Mrs. John, 1610 Revere Lane
Higgs, Mrs. Paul, Harlingen
Hockaday, Mrs. J. A., Hockaday Addition, Port Isabel
Hume, Mrs. Evan, 217 W. First, Brownsville
Jondahl, Mrs. Willis, 702 Crockett
Krishna, Mrs. I., 24 Resaca Blvd., Brownsville
LaMotte, Mrs. Thomas J., Palm Dr.
Lyle, Mrs. Charles F., West Hwy., San Benito
Miller, Mrs. Harry, Jr., Honeydale Rd., Brownsville
Moet, Mrs. J. L., E. Oleander, La Feria
Nickell, Mrs. David, 309 E. Arroyo Dr.
Olcott, Mrs. Cornelius, Palm Dr.
Packard, Mrs. John, 1302 S. First
Parker, Mrs. S. Mitchell, 1075 N. Bowie, San Benito
Pearson, Mrs. Bernard, Palm Dr.
Poole, Mrs. Pierre P., 1449 Lakeside Dr.
Retta, Mrs. George, 601 W. Cleveland
Rodriquez, Mrs. Hesiguio, 117 E. Bristol, Rio Hondo
Roth, Mrs. Karl, 78 Resaca Blvd., Brownsville
Scales, Mrs. Hunter L., 1150 N. Bowie, San Benito
Shafer, Mrs. Troy, 561 Lake Dr.
Sherman, Mrs. Kenneth, P. O. Box 826
Smith, Mrs. Robert N., 513 Lake Dr.
Spence, Mrs. Charles, 781 W. Gem, Raymondville
Strass, Mrs. Herbert, 310 W. Roosevelt
Tewell, Mrs. Howard, Jr., 418 Woodland Dr.
Watkins, Mrs. John, 522 E. Harrison
Welty, Mrs. John, 1623 Sam Houston Dr.
Willeforde, Mrs. George, 1701 S. First

*Address is Harlingen unless otherwise stated.

HIDALGO-STARR COUNTIES AUXILIARY*

Blocker, Mrs. William P., Donna
Bohmfalk, Mrs. Stanley W., 815 Oklahoma Ave., Weslaco
Carleton, Mrs. Thomas M., Donna
Caton, Mrs. McKee, 416 N. 15th
Clark, Mrs. Richard G., 1014 N. 5th
Dick, Mrs. D. L., 701 W. Caffery, Pharr
Duncan, Mrs. W. H., ½ mi. S. McColl
Edwards, Mrs. T. G., 1701 S. Missouri, Mercedes
Evans, Mrs. Sheridan S., 1513 Walnut
Fercher, Mrs. Henry, 521 S. 12th, Edinburg
Fitch, Mrs. James F., 1712 N. 8th
Frenzel, Mrs. Paul, 400 S. 5th, Donna
Frink, Mrs. Berton F., 221 S. 10th
Fry, Mrs. Wilburn, Jr., 203 N. 8th, Donna
Garcia, Mrs. Octavia, 3 mi. N. 10th
Glass, Mrs. T. W., 718 Texas, Weslaco
Graham, Mrs. Ronald, 510 W. Gore, Pharr
Hamme, Mrs. C. J., 2½ mi. E. State Hwy., Edinburg
Hamme, Mrs. R. E., 329 Enfield Rd., Edinburg
>Hatfield, Mrs. Walter H., P. O. Box 1590 (¼ mi. S. Jackson)
Johnston, Mrs. Robert H., 305 S. Missouri, Mercedes
Katribe, Mrs. Paul, 1605 N. 7th
Kellar, Mrs. Robert J., 716 Louisiana, Weslaco
Lancaster, Mrs. George M., 619 Kansas Ave., Weslaco
Lawler, Mrs. Marion R., 2 mi. W., 5½ mi. N., Mercedes
Long, Mrs. W. H., 407 W. Sam Houston, Pharr
Lubben, Mrs. J. F., Jr., 1102 Hackberry
Matthews, Mrs. John W., 920 S. 9th, Edinburg
Maxwell, Mrs. W. J., ¾ mi. S. Jackson Rd.
May, Mrs. Joe W., 304 Enfield Rd., Edinburg
Miller, Mrs. Charles, Jr., 330 W. Caffery, Pharr
Mock, Mrs. Duane, 921 San Antonio, San Juan
Munal, Mrs. H. Deane, 117 E. 12th, San Juan
Parker, Mrs. Sam T., 210 S. Canna, Pharr
Rabinowitz, Mrs. George, 1206 Highland Dr.
Ramirez, Mrs. Mario, Roma
Ranz, Mrs. Lillian, 1208 Jasmine
Shamburger, Mrs. W. H., Jr., 501 W. Gore, Pharr
Southwick, Mrs. Lloyd M., 2½ mi. W. State Hwy., Edinburg
Sybilrud, Mrs. Hjalmar W., 505 W. Caffery, Pharr
Terrell, Mrs. P. D., 1217 Highland Dr.
Westphal, Mrs. H. M., 1000 Texas, Weslaco
Whigham, Mrs. H. E., 609 Kendlewood
Whigham, Mrs. W. E., 718 N. 8th

KLEBERG-KENNEDY COUNTIES AUXILIARY†

Barnett, Mrs. L. M., 1031 Circle Dr.
Boyd, Mrs. N. D., 919 Lantana
Dunn, Mrs. S. Chester, Box 1311
>Ewert, Mrs. W. A., 704 E. Caesar
Ginther, Mrs. C. E., Bishop
Grief, Mrs. E. W., 613 S. Ragland
Jones, Mrs. A. C., Box 1190
Peace, Mrs. D. W., E. Caesar
Peace, Mrs. D. W., Jr., Bishop
Ramey, Mrs. L. E., 725 Alexander

NUECES COUNTY AUXILIARY‡

Abbey, Mrs. Joseph A., 429 Palmero
Ahern, Mrs. Gerald S., 432 Santa Monica
Aldis, Mrs. William, Military Service
Alsop, Mrs. Joseph F., 347 Santa Monica
Appel, Mrs. Myron H., 445 Ohio
Arnim, Mrs. Landon C., 123 Oleander
Ashmore, Mrs. Alvin J., 223 Chandler Lane
Barnard, Mrs. James L., 310 Jackson Pl.
Barnes, Mrs. George B., 617 McCall
Bernwanger, Mrs. Damon C., 1485 Daytona
Bickley, Mrs. Estel T., 211 Indiana
Blair, Mrs. John V., 3709 Upriver Rd.
Bounds, Mrs. Lloyd D., 1415 Second St.
Brown, Mrs. Walter C., 1413 Brentwood
Bryson, Mrs. J. Gordon, 337 Primrose
Cameron, Mrs. James M., 454 Louisiana
Carter, Mrs. N. D., 425 Del Mar

*Address is McAllen unless otherwise stated.

†Address is Kingsville unless otherwise stated.

‡Address is Corpus Christi unless otherwise stated.

Chriss, Mrs. John W., 3201 Robb Pl.
Clark, Mrs. Charles, 626 Vaky
Clark, Mrs. Dan H., 1012 Annapolis
Cline, Mrs. William B., 402 Pasadena
Collins, Mrs. C. B., 338 Louise
Colyer, Mrs. George E., 306 Clifford
Conolly, Mrs. Sidney M., 457 Delaine
Danford, Mrs. Edwin A., 230 Indiana
Dixon, Mrs. Chalmer D., 650 Rio Vista
Draper, Mrs. Leonidas M., 3213 Lawnview
Dunham, Mrs. R. Brown, 253 Rosebud
Eckhardt, Mrs. Kleberg, 3832 Denver
Edgerton, Mrs. George W., Jr., 3637 Victory Dr.
Edwards, Mrs. Thomas W., 244 Oleander
Ellis, Mrs. Frank A., 339 Cole
Fitzgerald, Mrs. Thomas F., 2814 Cuiper
Friedman, Mrs. Bernard B., 3402 Ocean Dr.
Furman, Mrs. McIver, 221 Jackson Pl.
Gaddis, Mrs. Herman W., 1409 Tarlton
Gaddy, Mrs. E. T., Corpus Christi
Garcia, Mrs. Hector, 634 Ohio
Gardner, Mrs. Joseph E., 321 Laurel
Garrett, Mrs. Leslie M., 2850 Topeka
>Giles, Mrs. E. Jackson, 144 Del Mar
Gill, Mrs. E. King, 224 Oleander
Glanz, Mrs. Sandford, 1049 Ponder
Gray, Mrs. Paul M., 3225 Lawnview
Griffin, Mrs. Harold E., 254 Rosebud
Groner, Mrs. Edwin G., 1453 Maryland
Grossman, Mrs. David N., 225 Leming
Grossman, Mrs. Saul, 155 Rossiter
Guttman, Mrs. Paul B., 328 Jackson
Guttman, Mrs. L. P., 3418 Ocean Dr.
Haynes, Mrs. Henry, Corpus Christi
Heaney, Mrs. Gordon, 150 Louisiana
Hearne, Mrs. C. A., 1425 Ocean Dr.
House, Mrs. Rex C., 657 Sorrell
Hubler, Mrs. William R., Military Service
Hudson, Mrs. Richard L., 1018 Chamberlain
Janssen, Mrs. L. William O., 2925 Ocean Dr.
Jasperson, Mrs. Clarence P., 3201 Shell Rd.
Jimenez, Mrs. Prospero, 216 Ocean View Pl.
Johnson, Mrs. Robert, 4814 Phillip Dr.
Kemp, Mrs. Kenneth J., 505 Naples
Kendrick, Mrs. Michael C., 323 Louise Dr.
Kennedy, Mrs. Hugh A., 601 Ohio
Kluth, Mrs. Fred C., 726 Harrison
Knapp, Mrs. Roger S., 621 Ohio
Koepsel, Mrs. Orlando S., 3801 Denver
Kurzner, Mrs. Meyer, 239 Circle Dr.
Landerman, Mrs. Joseph D., 4030 Ocean Dr.
Lane, Mrs. Alfred L., 241 Ocean View Pl.
Lang, Mrs. R. R., 2014 Seventeenth St.
Lemke, Mrs. Walter M., 3561 Denver
Little, Mrs. C. Robert, 3409 Ocean Dr.
Marler, Mrs. Otis E., 3502 Aransas
Martin, Mrs. Sterling, 128 Del Mar
McKemie, Mrs. Jack F., 302 Chenoweth
Meador, Mrs. Clarence N., 337 Naples
Mella, Mrs. Charles A., 225 Jackson Pl.
Metzger, Mrs. William R., 2840 S. Alameda
Moller, Mrs. Turner, 504 Morgan
Moody, Mrs. Foy, 4250 Ocean Dr.
Moon, Mrs. O. Bruce, 3761 Topeka
Morgan, Mrs. Charles G., 156 Santa Barbara
Morphew, Mrs. Raymond, 921 Anderson
Morris, Mrs. William E., 517 DeForrest
Nast, Mrs. Jerome, 807 Craig
Nast, Mrs. Maurice, 317 Rosebud
O'Brien, Mrs. Thomas R., 646 DeForrest
O'Byrne, Mrs. George T., 1227 Third
Oshman, Mrs. Joseph, 1205 Brentwood
Pasternack, Mrs. Joseph G., 253 Oleander
Perkins, Mrs. Maury J., 221 Rosebud
Pilcher, Mrs. John F., 2901 Churchill
Posner, Mrs. Sidney, Robstown
Powell, Mrs. Sam M., 538 Indiana
Pruessner, Mrs. Harold, 703 Dabney
Riley, Mrs. James R., 4787 Ocean Dr.
Riley, Mrs. Winston E., 308 Louise
Rinehart, Mrs. A. B., 3226 Topeka
Rodholm, Mrs. A. K., 621 Indiana
Rogers, Mrs. F. Fungston, 642 Chamberlain
Rosenheim, Mrs. Philipp, 522 Harrison
Russo, Mrs. G. M., 1520 Sulaine Pl.
Schuster, Mrs. George, III, 502 Vaky
Sharp, Mrs. James C., 3702 N. Saxet
Sigler, Mrs. Robert, 201 Indiana
Slabaugh, Mrs. Carl B., 3620 Austin
Sloan, Mrs. Joe, 1349 Logan
Sloan, Mrs. John J., 330 Laurel
Smith, Mrs. Youel C., 338 Catalina
Sory, Mrs. Crysup, 1019 Ponder
Spann, Mrs. R. G., 1226 Seventh
St. John, Mrs. Ralph, 225 Indiana
Stewart, Mrs. Charles D., 114 E. Vanderbilt
Tabler, Mrs. J. Walton, 438 Delaine
Talley, Mrs. O. H., 3701 S. Saxet
Thomas, Mrs. James H., 625 Louisiana
Thomas, Mrs. John R., 702 Morgan
Thomas, Mrs. Rex E., 1517 Devon
Triplett, Mrs. William C., 236 Circle Dr.

AUXILIARY MEMBERS, 1954—*continued*

Tyree, Mrs. James Imes, 3343 San Antonio St.
White, Mrs. H. A., 412 King
Wilkins, Mrs. Robert, 4213 Ramsey
Williamson, Mrs. C. M., 427 Del Mar
Williford, Mrs. E. A., 453 Santa Monica
Woods, Mrs. H. B., 1335 Third
Wright, Mrs. L. David, 6033 Edgewater
Yates, Mrs June, 709 Indiana
Yeager, Mrs. Franklin, 3650 N. Saxet
York, Mrs. Thomas L., 1437 Daytona

SAN PATRICIO-ARANSAS-REFUGIO COUNTIES AUXILIARY

Baen, Mrs. Dan, Mathis
Deitch, Mrs. Ernest, Sinton
Elliott, Mrs. Boyce, P. O. Box 1196, Aransas Pass
Ewing, Mrs. Ferdinand S., Sinton
Glover, Mrs. G. E., Tivoli
Guynes, Mrs. W. Allison, Mathis
Horine, Mrs. Maurice, Ingleside
Jenkins, Mrs. Young S., Taft
Love, Mrs. A. J., Mathis
McConchie, Mrs. R. D., P. O. Box 333, Aransas Pass
Meitzen, Mrs. Travis C., Refugio
Miller, Mrs. H. A., P. O. Box 503, Refugio
Pierce, Mrs. J L., Jr., Sinton
Rittiman. Mrs. M. C., Sinton
Selby, Mrs. Claude A., P. O. Box 876, Sinton
>Simpson, Mrs. Charles, Sinton
Tasch, Mrs. A. F., Taft
Voss, Mrs. Alpheus H., P. O. Box 208, Odem
Woods, Mrs. Lloyd G., Refugio

WEBB-ZAPATA-JIM HOGG COUNTIES AUXILIARY*

Canales, Mrs. Gregorio M., 1819 Washington St.
Canseco, Mrs. Francisco M., 1101 Mier St.
Cigarroa, Mrs. J. Gonzalez, 708 Matamoros St.
Cigarroa, Dr. Margaret J., 2419 Corpus Christi St.
Crawford, Mrs. J. L., 1701 Rosario St.
Fuller, Mrs. M. L., 1804 Musser St.
Graham, Mrs. Steve H., Jr., 1515 Lane
King, Mrs. Albert C., 2004 Galveston
>Longoria, Mrs. Enrique M., 2105 Lane
Lowry, Mrs. John T., 1320 McClelland Ave.
Malakoff, Mrs. Murray E., 2019 Musser
McGee, Mrs. Aubry S., 2301 Freemont
Montalvo, Mrs. Lauro, 1020 Davis Ave.
Powell, Mrs. Paul H., Jr., 1902 Musser
Powell, Mrs. William R., Hamilton Hotel
Puig, Mrs. Valentine L., Jr., 1401 Market
Reitman, Mrs. James S., 1820 Guerrero
Rottenstein, Mrs. Max, 1401 Lane
Trevino, Mrs. Gonzalez, 806 Matamoros
Valls, Mrs. Miguel, 1820 Chihuahua

SEVENTH DISTRICT

Mrs. Abner A. Ross
Lockhart
Council Woman

BASTROP-LEE COUNTIES AUXILIARY

>Burns, Mrs. Robert B., Giddings
Flemming, Mrs. J. V., Elgin
Goddard, Mrs. Chauncey G., Bastrop
Hardt, Mrs. Sterling M., Bastrop
Hazzard, Mrs. Alford R., Giddings
Loveless, Mrs. Robert W., Bastrop
Mantzel, Mrs. Sherwood W., Giddings
Morris, Mrs. Roy H., Jr., Elgin
Stephens, Mrs. J. D., Smithville
Vickers, Mrs. Albert F., Giddings
Wood, Mrs. W. E., Elgin

CALDWELL COUNTY AUXILIARY

Du Boise, Mrs. Otho K., Lockhart
Fielder, Mrs. Darwin, Lockhart
Gambrell, Mrs. William, Jr., Luling
O'Bannion, Mrs. John Turner, Luling
>Ross, Mrs. Abner Alverly, Lockhart
Wales, Mrs. Philip, Lockhart

HAYS-BLANCO COUNTIES AUXILIARY†

deSteiguer, Mrs. John R., 722 Viola
Eastwood, Mrs. Herbert K., 1024 W. San Antonio
Elliott, Mrs. Benge, 115 Hillcrest
Heatly, Mrs. Maurice Dean, 1000 Burleson
McCormick, Mrs. T. Charles, Box 582, Buda

*Address is Laredo unless otherwise stated.
†Address is San Marcos unless otherwise stated.

Moore, Mrs. William Lockhart, Jr., 215 Johnson
Roberts, Mrs. Joseph Thomas, Sr., 802 Belvin
>Scheib, Mrs. C. W., 141 Blanco
Sowell, Mrs. Rugel Frierson, 1209 Belvin
White, Mrs. David L., 807 Highland Terrace
Williams, Mrs. Milton Coke, 810 W. San Antonio

LAMPASAS-BURNET-LLANO COUNTIES AUXILIARY

Allen, Mrs. George Scott, Burnet
Brook, Mrs. W. M., Lampasas
Duffy, Mrs. Jack G., Bertram
Gray, Mrs. George L., Llano
Hoerster, Mrs. Dan J., Llano
Hoerster, Mrs. Henry J., Llano
Kern, Mrs. John C., Burnet
McMillin, Mrs. Rush, Lampasas
>Patteson, Mrs. Morris K., Lampasas
Shepperd, Mrs. Joe A., Burnet
Shepperd, Mrs. Ray L., Burnet
Vaughn, Mrs. T. D., Bertram

TRAVIS COUNTY AUXILIARY*

Adamson, Mrs. William C., 1515 W. 29th
Archer, Mrs. Thomas J., 3203 Meredith
Baggett, Mrs. Seldon O., 1519 Mohle Dr.
Bailey, Mrs. Charles W., 2208 Enfield Rd.
Bailey, Mrs. Joe W., 2504 Galewood
Barkley, Mrs. Douglas F., 1302 Crestwood Rd.
Bates, Mrs. B. Clary, 4600 Laurel Canyon Dr.
Black, Mrs. Walter B., 401 W. 32nd
Blaustone, Mrs. Henry H., 1606 Pearl
Blewett, Mrs. Emerson K., 105 W. 33rd
>Bohls, Mrs. Sidney W., 803 E. 32nd
Brandt, Mrs. Otto, Jr., 2415 Dormarion Lane
Bratton, Mrs. Robert E., 1606 Poquonock
Brownlee, Mrs. C. Hanford, 1901 W. 35th
Carter, Mrs. Carl E., 603 Carolyn
Carter, Mrs. Rexford G., 2610 St. Anthony
Castner, Mrs. Charles W., Box 318, Rusk
Chauvin, Mrs. E. V., 1104 Meriden Lane
Clark, Mrs. George E., Jr., 2410 Matthews Dr.
Cleveland, Mrs. Glevis W., 2902 Bowman Rd.
Coleman, Mrs. James M., 3208 Clearview
Colwell, Mrs. Leslie C., 3318 Perry Lane
Cooper, Mrs. R. Allwyn, 1411 Newfield Lane
Covert, Mrs. Frank M., III, 2202 Meadowbrook
Crockett, Mrs. John A., 2519 Exposition
Cromer, Mrs. Horace E., 3410 Windsor Rd.
Darnall, Mrs. Charles M., 2805 Wooldridge Dr.
Davidson, Mrs. Harry T., 2610 Jefferson
Decherd, Mrs. George M., 1415 Preston
Dildy, Mrs. Charles Bethea, 611 W. Lynn
Doles, Mrs. Emmett A., 2400 Hancock Dr.
Douglas, Mrs. John E., 3202 Cherry Lane
Dryden, Mrs. Sam H., 4201 Lullwood Rd.
DuBilier, Mrs. Ben, 5408 Shoalcreek Blvd.
Eckhardt, Mrs. James W., 810 Avondale Rd.
Eckhardt, Mrs. Joe C., 2300 Rio Grande
Edens, Mrs. Lee E., 2814 San Pedro
Eppright, Mrs. Ben R., 2500 Kenmore Cts.
Esquivel, Mrs. Sandi, 2306 Townes Lane
Exline, Mrs. A. L., Jr., 2405 Sonora Ct.
Fatter, Mrs. Mervin E., 1304 Crestwood Rd.
Faubion, Mrs. Darrell B., 3311 Oakmont
Forbes, Mrs. M. Allen, Jr., 1804 Stamford Lane
Fox, Mrs. Kermit W., 2008 Raleigh
Gibson, Mrs. James W., 3406 Duval
Gilbert, Mrs. G. Horace, 2705 Cherry Lane
Gilbert, Mrs. Joe, 2409 Red River
Gilbert, Mrs. Joe Thorne, 1513 Forest Trail
Glynn, Mrs. James D., 2404 Tower Dr.
Goddard, Mrs. Walter C., 1108 W. 9th
Granberry, Mrs. Howard B., 912 W. 6th
Granberry, Mrs. Howard B., Jr., Rt. 5, Box 59
Gregg, Mrs. Banner, 2100 Parkway
Griffen, Mrs. Lawrence L., 2300 McCullough
Hahn, Mrs. William Burford, 3503 Windsor Rd.
Hamer, Mrs. James, 113 W. 33rd
Hanna, Mrs. Ralph, 2400 Pemberton Pl.
Hardwicke, Mrs. Charles P., 1409 Wathen
Harris, Mrs. Woodson Weldon, 1410 Nickerson
Hayes, Mrs. Sigman W., 4603 Sinclair
Helm, Mrs. Fred P., 1900 Bremen
Herrod, Mrs. James H., 2109 Bridle Path
Hilgartner, Mrs. Henry L., 2808 Bowman Rd.
Hoerster, Mrs. Sam A., Jr., 2104 Woodmont
Holland, Mrs. Lang F., 505 W. 13th
Holtz, Mrs. Harvey E., Red Bud Trail
Hunter, Mrs. R. O., 3221 Clearview

*Address is Austin unless otherwise stated.

Jackson, Mrs. J. Warren, 5312 Shoal Creek Blvd.
Johnson, Mrs. Billy Frank, 1904 Travis Heights Blvd.
Johnson, Mrs. David O., 1204 Woodland
Johnson, Mrs. J. Edward, 2203 Robinhood Trail
Kelton, Mrs. William W., Jr., 3302 James Borough
Key, Mrs. Sam N., 2314 Woodlawn
Key, Mrs. Sam N. Jr., 2007 Robinhood Trail
King, Mrs. William C., 1611 Palma Plaza
Klint, Mrs. Hugo, 311 W. 13th
Klotz, Mrs. Harry L., 2200 Griswold Lane
Kreisle, Mrs. James E., 2009 Hopi Trail
Kreisle, Mrs. Matthew F., 811 W. 31st
Kreisle, Mrs. Matthew F., Jr., 3108 Glenview
Krueger, Mrs. E., 310 E. 9th
LaLonde, Mrs. Albert, Rt. 2, Buda
Lassiter, Mrs. James W., 4708 Highland Terrace
Legett, Dr. Georgia Felter, 1707 Colorado
Legett, Mrs. Martin, 3907 Maplewood
Lippmann, Mrs. Otto, 3104 Perry Lane
Long, Mrs. Walter K., 1804 Pearl
Lowry, Mrs. Frederick C., 4712 Highland Terrace
Martin, Mrs. Claude A., 2901 Windsor Rd.
McCauley, Mrs. Morris Dewitt, 3309 Gilbert
McCrummen, Mrs. Thomas D., 2300 Windsor Rd.
McCuistion, Mrs. C. Hal, Canyon Circle
McElhenney, Mrs. Thomas J., 1511 Rainbow Bend
McLean, Mrs. William F., 5511 Shoal Creek Blvd.
Miears, Mrs. C. H., 4801 Shoalwood
Milligan, Mrs. Barth, 4616 Red River
Morgan, Mrs. William P., 2401 Pemberton Pl.
Morris, Mrs. Truman N., 2 Niles Rd.
Morrison, Mrs. Robert B., 2710 Stratford Dr.
Murray, Mrs. Robert Vincent, 408 W. 32nd
Murray, Mrs. Robert Vincent, Jr., 1012 W. 22nd
Nanney, Mrs. Audie L., 3005 Bridle Path
Neighbors, Mrs. Allen H., Jr., 3716 Gilbert
Neighbors, Mrs. Allen H., Sr., 1803 West Ave.
Nichols, Mrs. James R., 800 Rio Grande
Pattillo, Mrs. Albert, 1406 W. 29th
Perkins, Mrs. Clay, 807 Leonard
Pelphrey, Mrs. Charles F., 5410 Shoal Creek Blvd.
Pohl, Mrs. Donald E., 3506 Clearview
Price, Mrs. P. Clift, 3203 Sunny Lane
Primer, Mrs. Ben M., 2709 Rio Grande
Rabb, Mrs. Virgil S., Star Rt. A
Rainey, Mrs. John, 3010 Perry Lane
Ravel, Mrs. Jerome C., 2605 Thomas Dr.
Roberts, Mrs. Walter Donald, 2207 Hopi Trail
Robinson, Mrs. Harold L., 2307 McCullough
Robison, Mrs. James T. Paul, 1109 Gaston
Ross, Mrs. Raleigh R., 1511 W. 24th
Rothen, Mrs. Robert M., 5002 W. Park Dr.
Rousos, Mrs. Anthony P., 2105 Bowman
Rude, Mrs. Joe C., 4005 Balcones Dr.
Runge, Dr. Gretchen, 2412 W. 12th
Scarbrough, Mrs. Lee F., 5401 Shoal Creek Blvd.
Schiller, Mrs. Nelson L., 1606 Preston
Schoch, Mrs. Eugene P., 2403 Indian Trail
Scott, Mrs. Zachary T., 3700 Windsor Rd.
Senter, Mrs. Jerald R., 6306 Nasco Dr.
Shepard, Mrs. Herbert L., 5006 Shoal Creek Blvd.
Shipp, Mrs. R. W., 306 W. 8th
Simms, Mrs. Benjamin F., 4210 Wilshire Parkway
Smith, Mrs. Howard E., 1509 Preston
Standifer, Mrs. C. H., 1601 Preston
Suehs, Mrs. Oliver W., 2805 Robbs Run
Suehs, Mrs. P. E., 600 Bellvue Pl.
Swearingen, Mrs. Richard O., 1411 Ethridge
Terry, Mrs. Albert A., 2411 Pemberton Pl.
Thomas, Mrs. John C., 3 Niles Rd.
Thomas, Mrs. John F., 1900 Forest Trail
Thorne, Mrs. Clifford, 3802 Balcones Dr.
Thorne, Mrs. Lansing S., Jr., 1501 Rockmoor
Thorne, Mrs. Milner S., 2816 San Pedro
Tipton, Mrs. George W., 3419 Windsor Rd.
Tisdale, Mrs. Albert A., 4205 Caswell Ave.
Todaro, Mrs. Samuel P., 604 Carolyn
Turner, Mrs. Milton, 2101 Newfield Lane
Wade, Mrs. David, 2103 Schulle Ave.
Walter, Mrs. Luther P., 3212 Meredith
Watt, Mrs. Terrance, 1013 Gaston
Watt, Mrs. Will, 1502 Marshall Lane
White, Mrs. Benny O., 1706 W. 31st
Wilborn, Mrs. Sam W., 2512 Hillview
Williams, Mrs. Harold L., 1204 Crestwood
Williams, Mrs. Harold M., 3221 Gilbert

AUXILIARY MEMBERS, 1954—*continued*

Williams, Mrs. Harris, 2505 McCallum
Wilson, Mrs. Rabun T., 2911 Harris Blvd.
Woodson, Mrs. Palmer, 2415 Pemberton Pl.
Woolsey, Mrs. Sam A., 509 W. 12th
Yeakel, Mrs. Earl L., Jr., 2208 Mountainview
Zedler, Mrs. Garland G., 2904 Kerbey Lane
Zidd, Mrs. Edward, 1412 Preston

WILLIAMSON COUNTY AUXILIARY

Gaddy, Mrs. Hal R., Jr., Georgetown
Gregg, Mrs. Dick B., Round Rock
Hermann, Mrs. Robert C., Georgetown Rd., Taylor
>Houghton, Mrs. James F., 1817 Lexington, Taylor
Johns, Mrs. Jay J., 717 Huff, Taylor
Martin, Mrs. John R., Georgetown
Rice, Mrs. Albert J., Georgetown

EIGHTH DISTRICT

Mrs. Andrew J. Magliolo
Galveston
Council Woman

BRAZORIA COUNTY AUXILIARY

Brown, Mrs. G. Bedford, Jr., 1008 Robinhood, Angleton
Caldwell, Mrs. John S., 827 Magnolia, Lake Jackson
Carlton, Mrs. B. Hardy, Box 1136, Freeport
Carroll, Mrs. J. A., 1110 Sidmore, Alvin
Fuste, Mrs. Carlos E., Jr., 907 Garden, Alvin
Gray, Mrs. Ralph E., 410 Circle Way, Lake Jackson
Greenwood, Mrs. William M., West Columbia
Hale, Mrs. Robert A., Box 735, Angleton
>Hardwick, Mrs. M. Warren, Box 847, Angleton
Heimbigner, Mrs. Elmer, 429 Huisache, Lake Jackson
Holt, Mrs. William C., 212 Magnolia, Angleton
Johnson, Mrs. Oscar L., Box 327, Lake Jackson
Kirkpatrick, Mrs. Robert, 1615 W. Broad, Freeport
McCary, Mrs. A. O'Brian, 1303 W. Broad, Freeport
McCary, Mrs. R. Marden, Box 1135, Freeport
Merz, Mrs. H. E., Alvin
Miller, Mrs. Robert C. Box F, Lake Jackson
Montgomery, Mrs. Joseph S., Box 837 Angleton
Nicholson, Mrs. William D., 1111 W. 6th, Freeport
O'Leary, Mrs. John C., 1747 W. 8th, Freeport
Perryman, Mrs. Gerald F., 818 W. 7th, Freeport
Steele, Mrs. Wayne K., 1005 Morningside, Angleton
Stevens, Mrs. George M., Drawer A, Lake Jackson
Stewart, Mrs. James A., 38 Lake Rd., Lake Jackson
Turner, Mrs. F. C., 425 Huisache, Lake Jackson
Woolf, Mrs. Martin P., 1713 W. 7th, Freeport

COLORADO-FAYETTE COUNTIES AUXILIARY

Boelshe, Mrs. Leslie, La Grange
Daniel, Mrs. Joyce, La Grange
Guenther, Mrs. John G., La Grange
Ihle, Mrs. L. E., Schulenburg
Laughlin, Mrs. J. C., Eagle Lake
Laughlin, Mrs. J. R., Eagle Lake
Paine, Mrs. Henry C., La Grange
Ryan, Mrs. James E., Weimar
Shult, Mrs. C. I., Columbus
>Watzlavick, Mrs. A. J., Schulenburg
Williams, Mrs. Edward, Schulenburg
Wooten, Mrs. James H., Columbus
Youens, Mrs. Thomas, Columbus
Youens, Mrs. Willis G., Weimar
Zatopek, Mrs. Leland, La Grange

DE WITT-LAVACA COUNTIES AUXILIARY

Brown, Mrs. Marian, Yoakum
Burns, Mrs. J. G., Cuero
Burns, Mrs. J. W., Cuero
Buttery, Mrs. James M., Hallettsville
Connally, Mrs. J. V., Shiner
Dobbs, Mrs. W. G., Cuero
Douthit, Mrs. W. G., Cuero
Duckworth, Mrs. M. A., Cuero
Dufner, Mrs. C. T., Cuero
Gastring, Mrs. J. B., Yoakum
Gremmel, Mrs. G. E., Yoakum
>Hall, Mrs. O. E., Cuero
Marek, Mrs. Emil H., Yoakum
Milner, Mrs. R. J., Yoakum
Norwierski, Mrs. Leon, Yorktown
Prather, Mrs. T. A., Cuero
Pridgen, Mrs. J. H., Cuero
Renger, Mrs. Harvey, Hallettsville
Renger, Mrs. Paul, Jr., Hallettsville
Renger, Mrs. Paul, Sr., Hallettsville
Richter, Mrs. L. B. S., Yoakum
Spikes, Mrs. George A., Hallettsville
Trott, Mrs. J. C., Yoakum
Wagner, Mrs. Frank, Shiner
Wagner, Mrs. Robert, Shiner
Welles, Mrs. Edward H., Hallettsville

GALVESTON COUNTY AUXILIARY*

Adriance, Mrs. Carroll T., 5328 Avenue O
Ainsworth, Mrs. William H., 3828 Avenue P½
Allen, Mrs. Charles Robert, 20 Cedar Lawn, S.
Anderson, Mrs. William T., 201 E. Oak, La Marque
Aves, Mrs. Fred W., Bayou Bend, Dickinson
Baird, Mrs. Elwood E., 1114 Postoffice
Baxter, Mrs. Virgil C., 807 N. Boulevard
Beeler, Mrs. George W., 2427 Westward Ave., La Marque
Binney, Mrs. Charles, 306 8th
Blacklock, Mrs. David, 922 Tallow Square, Texas City
Blocker, Mrs. Truman G., Jr., 2410 Avenue L
Brindley, Mrs. Paul, 4306 Sherman
Bruce, Mrs. E. Ivan, Jr., 1406 Lamar Dr., La Marque
Caravageli, Mrs. Menelous A., 2314 Avenue N½
Casey, Mrs. Robert S., 111 8th Ave., N., Texas City
Childers, Mrs. John H., 115 Whiting Ave.
Cone, Mrs. Robert E., 2602 Avenue O
Cooke, Mrs. Willard R., 4510 Caduceus
Danforth, Mrs. D. R., 113 20th Ave., N., Texas City
Danforth, Mrs. F. N., 18 9th Ave., N., Texas City
Davis, Mrs. Harry K., 1114 1st St., League City
Delany, Mrs. John J., 4608 Avenue O
deMesquita, Mrs. Paul B., 2402 Sealy
Duflot, Mrs. Leo S. M., 112 Dolphin Ave.
Eames, Mrs. Dan H., 2106 Evergreen, La Marque
Eggers, Mrs. George W. N., 4625 Caduceus
Fisher, Mrs. W. C., Jr., 3214 Avenue P
Flautt, Mrs. J. A., 1805 18th
Ford, Mrs. G. David, 5508 Menard
Ford, Mrs. Hamilton, 2500 Fairwood Rd., La Marque
Fowler, Mrs. Frederick, 3509 Avenue P
Fowler, Mrs. M. Lake, 2210 39th
Fuchs, Mrs. Carl J., 1125 Hunter Dr., Texas City
Futch, Mrs. Edward D., III, 5215 Avenue O
Garbade, Mrs. Francis A., 4509 Ursuline
Garber, Mrs. E. Peter, 4311 Sherman
Gibbs, Mrs. Reagan H., 5812 Borden
Gingrich, Mrs. Wendell, 1212 Winnie
Graves, Mrs. Marvin L. (Hon.), 11 Shadow Lawn, Houston
Green, Mrs. Robert B., 1905 3rd Ave., N., Texas City
Hander, Mrs. William W., 1410 Colorado, La Marque
Hansen, Mrs. Arild E., 4319 Caduceus
Harris, Mrs. Titus H., 1428 Broadway
Hejtmancik, Mrs. Milton R., 118 Marlin
Herrmann, Mrs. George R., 1409 Market
Jackson, Mrs. Ira J., 105 Marlin
Jarrell, Mrs. Norman D., 304 9th Ave., N., Texas City
Jarvis, Mrs. Garth L., 1112 Postoffice
Jinkins, Mrs. A. J., 5101 Avenue S½
Jinkins, Mrs. Julius L., 3121 Avenue P
Jinkins, Mrs. Julius L., Jr., 5225 Denver Dr.
Jinkins, Mrs. W. J., 4802 Denver Dr.
Johnson, Mrs. Jesse B., 4627 Sherman
Johnson, Mrs. Jesse B., Jr., 1404 Rhodora, La Marque
Johnson, Mrs. J. K., Capri Apts. # D
>Jones, Mrs. Edgar F., Jr., 4728 Crockett
Kamin, Mrs. Peter B., 5703 Fraser
Kealey, Mrs. E. T., 1964 1st Ave., N., Texas City
Kirksey, Mrs. O. T., Jr., 121 Bonita
Kleiman, Mrs. Harold, 108 Albacore
Kolb, Mrs. Weldon G., 1318 Rhodora, La Marque
Lancaster, Mrs. Lifford R., 2800 Avenue N½
Lee, Mrs. George T., 4600 Caduceus
Lefeber, Mrs. Edward J., 1723 27th
Levin, Mrs. William C., 4814 Denver
Lewis, Mrs. Stephen R., 2605 Avenue O½
Longfield, Mrs. Aaron N., 113 Trout
Magliolo, Mrs. Albert, 405 Wakefield Dr., League City
Magliolo, Mrs. Amedeo, Box 788, Dickinson
Magliolo, Mrs. Andrew J., Rt. 1, Box 13-R, Dickinson
Magliolo, Mrs. Joseph C., Box 875, Dickinson
Manske, Mrs. Gerhard, Box 400, Texas City
Marr, Mrs. William L., 11 Cedar Lawn Circle
Matlage, Mrs. W. T., 1301 Bay St., Texas City
McDonald, Mrs. Eugene C., 2721 Magnolia, La Marque
McDonald, Mrs. Richard, 1805 Austin Ave., La Marque
McGivney, Mrs. John Q., 5005 Crockett
McLarty, Mrs. E. Sinks, Buccaneer Hotel
McReynolds, Mrs. George S., 20 Cedar Lawn Circle
Meadows, Mrs. John C., Jr., 138 San Marino
Middleton, Mrs. John W., 5018 Sherman
Moore, Mrs. Robert M., 1711 Rosenberg
Mullen, Mrs. Brooks W., 2114 36th
Otto, Mrs. John L., 4802 Sherman
Panos, Mrs. Theadore, 101 Trout
Parrish, Mrs. B. R., 4401 Avenue O
Perlman, Mrs. Bernard, 2301 39th
Potter, Mrs. William B., 4519 Woodrow
Quinn, Mrs. C. F., 218 12th Ave., N., Texas City
Randall, Mrs. Edward, 2004 Broadway
Randall, Mrs. Edward, Jr., 3502 Avenue P
Rigdon, Mrs. R. Harrison, 1402 Market
Ritchie, Mrs. Earl B., 4804 Sherman
Robinson, Mrs. H. Reid, 3420 Avenue O
Ross, Mrs. M. Lamar, Jr., 4915 Crockett
Ruskin, Mrs. Arthur, 2615 Avenue O½
Schmidt, Mrs. H. A., 303 13th Ave., N., Texas City
Schwab, Mrs. Edward H., 4827 Austin
Simpson, Mrs. Robert R., 233 20th Ave., N., Texas City
Singleton, Mrs. Albert O., 1602 Broadway
Singleton, Mrs. Albert O., Jr., 913 16th
Snodgrass, Mrs. Sam R., 1217 Market
Snyder, Mrs. Clifford C., 109 Bonita
Spiller, Mrs. William F., 3823 Avenue P½
Stembridge, Mrs. Vernie A., 2215 Avenue L
Stephen, Mrs. Weldon W., 5321 Perry
Stiernberg, Mrs. Cam, 113 17th Ave., N., Texas City
Stirling, Mrs. E. Hopkins, 5719 Stewart
Stone, Mrs. Charles T., 11 Cedar Lawn, N.
Stone, Mrs. Charles T., Jr., 4514 Avenue N½
Stubbs, Mrs. James B., 1302 Avenue H
Sykes, Mrs. Clarence S., 4628 Sherman
Thiel, Mrs. John M., 2110 Oaklawn Dr., La Marque
Thompson, Mrs. Edward R., 1516 Broadway
Towler, Mrs. Martin L., 5115 Avenue T
Tree, Mrs. Herschel Glen, 122 8th Ave., N., Texas City
Twidwell, Mrs. Leonard, 715 10th Ave., N., Texas City
Wall, Mrs. Dick P., 1202 Broadway
Weinert, Mrs. Herman, Jr., 5001 Crockett
Wellman, Mrs. G. O., 827 22nd Ave., N., Texas City
Williams, Mrs. G. D., Box 487, La Marque
Wilson, Mrs. William A., III, 157 San Fernando
Wolma, Mrs. Fred J., Jr., 120 Barracuda

*Address is Galveston unless otherwise stated.

VICTORIA-CALHOUN-GOLIAD COUNTIES AUXILIARY*

Alcorn, Mrs. Robert S., 1504 E. Park
Allen, Mrs. Richard C., 802 Anaqua
Bade, Mrs. Craig, 710 W. Nueces
Braman, Mrs. Myrtle, 206 W. Stayton
Bush, Mrs. L. E., Port Lavaca
Coleman, Mrs. W. L., 1705 Meadowlane
Constant, Mrs. George, 307 W. Commercial
>Ehlert, Mrs. Edward, Jr., 2207 N. Liberty
Ferguson, Mrs. R. H., 404 E. Goodwin
Glover, Mrs. George E., 1311 E. Park
Hilderbrand, Mrs. H. E., Goliad
Hopkins, Mrs. Joseph V., 202 W. Power
Lander, Mrs. Roy S., 2402 N. DeLeon
Lester, Mrs. S. W., Port Lavaca
Lancaster, Mrs. York, Port Lavaca
Logsdon, Mrs. F. M., Port Lavaca

*Address is Victoria unless otherwise stated.

AUXILIARY MEMBERS, 1954—*continued*

McCollum, Mrs. C. J., 1201 Poplar
McGlothlin, Mrs. G. E., 2205 E. Sabine
Mooney, Mrs. Ern C., 402 N. Avenue E
Paul, Mrs. Jesse W., 1905 E. Virginia
Pillsbury, Mrs. C. B., 1506 E. Guadalupe
Reed, Mrs. Roy G., 610 Rosebud
Sale, Mrs. W. W., 705 N. Craig
Seger, Dr. Eva, 1704 E. Virginia
Shields, Mrs. Allan, 404 W. Commercial
Shields, Mrs. F. B., 402 W. Commercial
Smith, Mrs. Heaton, 505 N. Washington
Story, Mrs. Joseph R., 208 W. Guadalupe
Tomb, Mrs Andrew S., 2307 Ben Jordan
Tomme, Mrs. J. W., Port Lavaca
Ward, Mrs. Rawley W., 505 N. West

WHARTON-JACKSON-MATAGORDA-FORT BEND COUNTIES AUXILIARY

Ammann, Mrs. F. E., Rosenberg
Bader, Mrs. Joseph, Edna
Bauknight, Mrs. James M., Ganado
Black, Mrs. Vernon A., Wharton
Blair, Mrs. William M., Wharton
Blasingame, Mrs. F. J. L., Wharton
Boswell, Mrs. Sam, Rosenberg
Brewer, Mrs. Paul, Bay City
Emmett, Mrs. W. B., Wharton
Halamicek, Mrs. John F., El Campo
Johnson, Mrs. Leonard B., El Campo
Johnson, Mrs. R. G., Newgulf
Knolle, Mrs. B. E., Rosenberg
Kolle, Mrs. F. W., Wharton
Kuykendall, Mrs. H. D., Sugarland
Leslie, Mrs. Robert E., El Campo
Little, Mrs. R. D., Wharton
Matthes, Mrs. J. C., Bay City
Mortland, Mrs. S. R., Ganado
>Much, Mrs. J. C., Richmond
Nichols, Mrs. C. V., Richmond
Northington, Mrs. Harold M., Wharton
Presley, Mrs. Walter D., El Campo
Sanford, Mrs. E. B., Palacios
Schuhmann, Mrs. J. D., East Bernard
Scott, Mrs. W. E., Rosenberg
Sherrill, Mrs. Douglas B., El Campo
Shoultz, Mrs. Charles A., Bay City
Simons, Mrs. J. W., New Gulf
Stepan, Mrs. John D., Rosenberg
Thiltgen, Mrs. Winston S., El Campo
Thompson, Mrs. Stanley E., Richmond
Voulgaris, Mrs. Dennis M., Wharton
Wilcox, Mrs. L. A., Palacios
Yelderman, Mrs. J. C., Needville
Zipp, Mrs. R. D., Edna

NINTH DISTRICT

Mrs. Carl M. Hansen
Navasota
Council Woman

AUSTIN-WALLER COUNTIES AUXILIARY

Bolton, Mrs. Graham, Hempstead
Gordon, Mrs. V. L., Sealy
Hopkins, Mrs. J. J., Brookshire
Neely, Mrs. J. A., Bellville
Neely, Mrs. R. A., Bellville
Neely, Mrs. W. B., Bellville
Roensch, Mrs. H. E., Bellville
Smith, Mrs. F. T., Jr., Bellville
>Walker, Mrs. S. C., Hempstead

GRIMES COUNTY AUXILIARY

Coleman, Mrs. Solon D., 1302 E. Washington, Navasota
Hansen, Mrs. Marius, Jr., 316 Brosig, Navasota
Ketchum, Mrs. Everard T., 319 Ketchum, Navasota
Parker, Mrs. M. E., Anderson
Sanders, Mrs. G. C., Richards
>Stewart, Mrs. Homer L., 1306 E. Washington, Navasota
Thompson, Mrs. Hardy E., 1311 Neal, Navasota

HARRIS COUNTY AUXILIARY*

Abbett, Mrs. Jack P., 4130 Underwood
Able, Mrs. Luke W., 5319 Pine, Bellaire
Adam, Mrs. George F., 4510 Caroline
Adams, Mrs. Granville Q., 2003 Swift
Ainsworth, Mrs. Joseph T., 6726 Fairfield
Alexander, Mrs. George, 705 Robin Circle, Pasadena
Alexander, Mrs. H. L., 3210 Parkwood
Alexander, Mrs. J. C., 4627 Banning

*Address is Houston unless otherwise stated.

Ameen, Mrs. Ray C., 15269 Central Ave., San Lorenzo, Calif.
Ames, Mrs. Frederick D., 853 Rocky River Rd.
Anderson, Mrs. A. Burton, 4048 Overbrook
Anderson, Mrs. Thomas A., Jr., 4513 Sunburst, Bellaire
Armbrust, Mrs. Charles A., Jr., 3818 Seminole
Armstrong, Mrs. J. T., 2506 Dorrington
Armstrong, Mrs. John W., 4927 Winnetka
Arnold, Mrs. Enga M., 706 Chelsea, Apt. 4
Arnold, Mrs. Hiram P., 3306 Merrick
Arnold, Mrs. Hugh F., 2005 Wroxton
Arnold, Mrs. Jap H., 6930 Burgess
Arnold, Mrs. William T., 2617 Pemberton
Ashkenazy, Mrs. Moses, 5839 South Seas
Ashmore, Mrs. C. Marshall, 5405 Longmont
Aves, Mrs Fred H., 4711 Sunburst Ct., Bellaire
Aydam, Mrs. Charles W., 5102 Westheimer
Baird, Mrs. R. W., Jr., 2513 MacGregor Way
Baird, Mrs Val C., 3701 Del Monte
Baker, Mrs. Lowell B., 4922 Bellaire Blvd., Bellaire
Ballantyne, Mrs. A. J., 3207 Oakmont
Barclay. Mrs. Sam D., 2403 Inwood
Barkley, Mrs. Howard T., 4207 Yoakum
Barnes, Mrs. J. Peyton, 3651 Olympia
Barrett, Mrs. John, 3115 Reba
Bashour, Mrs. Sam, 5701 Jackson
Behr, Mrs. Thomas S., 3127 Wentworth
Behrens, Mrs. Charles A., 4001 Huey
Bell, Mrs. Justin E., 1821 River Oaks Blvd.
Belleggie, Mrs. Philip A., 6027 Floyd
Bennett, Mrs. William H., Box 193, Humble
Bernard, Mrs. Lynn A., 2415 San Felipe Rd.
Best, Mrs. Paul W., 3665 Wickersham
Bettis, Mrs. Moody C., 103 Cherrywood, Bellaire
Beyer, Mrs. Alvin, Jr., 2234 Glenhaven
Billups, Mrs. J. T., 3860 Olympia
Blackburn, Mrs. E. A., 5669 Bordley
Blair, Mrs. Lyman C., 3406 Georgetown
Blair, Mrs. Robert K., 3929 Del Monte
Blattner, Mrs. Russell J., 2227 Bellfontaine
Bloom, Mrs. Fred, 3457 Locke Lane
Bloom, Mrs. Manuel G., 2712 Arbor
Bloxsom, Mrs. Allan Penny, 2240 Chilton
Blundell, Mrs. J. Reese, 2187 Troon
Bonham, Mrs. Russell F., Rt. 4, Box 209-B
Bonin, Mrs. W. P., 3202 Aberdeen
Bourdon, Mrs. Lynn L., 5591 Longmont
Bowen, Mrs. Ralph, 3509 Montrose
Boyd, Mrs. A. N., 1829 August
Boylston, Mrs. B. F., 3218 Cloverdale
Braastad, Mrs. W. H., 1006 Post Oak Lane
Braden, Mrs. Albert H., 2351 Kelving
Braden, Mrs. Albert H., Jr., 3853 Palm
Brady, Mrs. Randle J., 3317 Binz
Brandau, Mrs. George H., 3703 Olympia
Brandes, Mrs. E. B., 3310 Calumet
Brannon, Mrs. Jack G., 3415 Graustark
Brauer, Mrs. Raymond O., 4600 Edith, Bellaire
Brodsky, Mrs. Alex E., 1615 Bonnie Brae
Brown, Mrs. James Albert, 4109 Fernwood
Brown, Mrs. R. Alec, 3804 Mt. Vernon
Brown, Mrs. T. C., 2702 Albans
Broyles, Mrs. George D., Jr., 3907 Childress
Bruder, Mrs. Wood H., 8360 Leafy Lane, Spring Branch
Bruhl, Mrs. Charles E., 1706 North Blvd.
Bruhl, Mrs. Charles Kennedy, 6039 Glen Cove
Bryan, Mrs. W. G., 4820 San Jacinto
Bukowski, Mrs. Lucian M., 4 Westlane
Bunting, Mrs. John J., 5401 Lynbrook
Burdeaux, Mrs. B. D., Jr., 4709 Linden, Bellaire
Burge, Mrs. Curtis Hunter, 8828 Sandringham
Burke, Mrs. Thomas W., 3402 Wickersham
Burnett, Mrs. Mathew D., Jr., 3705 Drummond
Burr, Mrs. Harry B., 3016 Reba
Burrows, Mrs. J. B., 3008 University Blvd.
Butler, Mrs. Donald B., 3226 Milburn
Cady, Mrs. Lee, 2002 Holcombe Blvd.
Caffery, Mrs. Eldon Lee, 3207 Maroneal, Apt. 3
Calhoun, Mrs. C. Alsworth, 3809 Piping Rock
Cameron, Mrs. Bruce M., 2411 Wordsworth
Cantrell, Mrs. W. A., 3617 Yoakum
Caplovitz, Mrs. Harry, 4507 Caroline
Carnes, Mrs. Harry E., 6109 Cypress, Bellaire
Carrico, Mrs. Carl C., 1909 Austin
Carrington, Mrs. D. C., 10502 Memorial Dr.
Carroll, Mrs. Roland B., 530 Piney Point
Cecala, Mrs. Philip J., 2319 S. Shepherd
Chalmers, Mrs. P. H., 6407 Peerless
Chamberlain, Mrs. J. Allen, 5315 Doliver
Chapin, Mrs. Elisha H., 3828 Del Monte
Chapman, Mrs. Don W., 3707 Maroneal
Chunn, Mrs. Edward Keith, 2433 Glenhaven
Clapp, Mrs. J. Alston, Jr., 2143 Chilton
Clark, Mrs. P. LeMon, 3815 Seminole
Clarke, Mrs. Edward T., 4007 Markham
Clarke, Mrs. Herndon H., 2015 Dryden
Clarke, Mrs. Jared E., 2124 Inwood
Clarkson, Mrs. Ira S., 2708 Westlane
Cockrell, Mrs. J. A., 3316 Rosedale
Cody, Mrs. Claude C., III, 301 W. Cowan
Cody, Mrs. Melville L., 2610 Gramercy
Cohen, Mrs. Raymond, 2204 Bellfontaine
Cole, Mrs. William Frank, 2222 Inwood
Collette, Mrs. Alan, 3438 Overbrook
Collins, Mrs. Vincent P., 105 Shasta
Compere, Mrs. T. H., 2631 Fenwood
Connor, Mrs. Edwin E., 410 S. Walter, Pasadena
Connor, Mrs. W. Harris, 2910 Sunset
Coogle, Mrs. C. P., 2220 Maroneal
Coole, Mrs. Walter A., 102 Portland
Cooley, Mrs. Denton A., 1813 South Blvd.
Cope, Mrs. R. Louis, 6605 Meadowlawn
Coulter, Mrs. W. W., 5701 Jackson
Cowart, Mrs. O. H., 320 W. Calvin
Cox, Mrs. DeWitt W., Jr., 1527 Cheshire Lane
Cox, Mrs. Joseph H., 2006 Lamar Dr.
Crain, Mrs. Lovell B., 2801 Jarrard
Crank, Mrs. H. Harlan, 5217 Green Tree
Crapitto, Mrs. Louis A., 108 Oak Pl.
Crigler, Mrs. Cecil M., 3617 Olympia
Crocker, Mrs. Ed., 2044 Timber Lane
Cromwell, Mrs. Henry A., 3650 Locke Lane
Cronin, Mrs. Thomas D., 2232 Stanmore
Cruce, Mrs. W. V., 151 Ingram, Fort Sam Houston Village, #2, San Antonio
Cruse, Mrs. Ray, 14th Field Hosp., APO 59, San Francisco, Calif.
Cummings, Mrs. Hatch W., Jr., 2137 Chilton
Cunningham, Mrs. G. Norman, 2106 Colquitt
Curb, Mrs. Dolph, 3755 Merrick Dr.
Dailey, Mrs. James E., 3214 Reba
Daily, Mrs. Herchel, 4119 Fernwood
Daniel, Mrs. Joe E., 4500 Rossmoyne
Dargan, Mrs. J. L., 2008 Milford
Dashiell, Mrs. Albert N., 5639 Meadow Lake
Davis, Mrs. C. Q., 2535 Sunset
Deaton, Mrs. Grady, 1908 Second, Galena Park
DeBakey, Mrs. Michael, 5323 Cherokee
Denman, Mrs. Frank R., 2235 Mimosa Lane
Denman, Mrs. Peyton R., 1220 Southmore
DeVore, Mrs. Neal M., 502 Pinehaven
DeYoung, Mrs. Richard B., 4707 Linden, Bellaire
Dickson, Mrs. J. Charles, 5310 Mandell
Dippel, Mrs. A. Louis, 2521 Stanmore
Doak, Mrs. Edmond K., 3741 Del Monte
Doak, Mrs. N. P., 2230 Branard
Dodd, Mrs. G. E., 5554 Little Lake, Bellaire
Donohue, Mrs. W. M., 2722 Pemberton
Donovan, Mrs. Michael M., 2411 Ella Lee
Donovan, Mrs. Thomas J., 3506 Sunset
Dornak, Mrs. Franklin K., 402 Sul Ross
Dorsey, Mrs. Frederick G., 1716 Wroxton Ct.
Duff, Mrs. Kenneth R., 2140 Del Monte
Duggan, Mrs. LeRoy B., 2725 Pemb rton Dr.
Durham, Mrs. Charles A., 810 W. 31st
Durham, Mrs. Mylie E., 730 W. 43rd
Durrance, Mrs. Fred Y., 2124 Albans
Duson, Mrs. Craddock K., 2322 Suffolk
Dustin, Mrs. Herman E., 1118 Wheeler
Duty, Mrs. Winthrop S., 1138 Fair Oaks
Earl, Mrs. David M., 4029 Ella Lee
Eden, Mrs. George F., 2336 Wordsworth
Edwards, Mrs. Robert A., 2331 North Blvd.
Ehlers, Mrs. H. J., 2112 Brentwood
Ehni, Mrs. George, 3635 Underwood
Eichhorn, Mrs. Ralph, 4431 N. Roseneath
Eidman, Mrs. F. G., 4427 N. Roseneath
Elliott, Mrs. J. Joseph, 403 Little John Lane
Elliott, Mrs. Robert B., 5701 Jackson, Apt. 1405
Embree, Mrs. Elisha D., 1915 Branard
Emmert, Mrs. Max, 4102 Bluebonnet
Engelhardt, Mrs. H. Tristram, 5415 Austin
Entzminger, Mrs. Lindell B., 3738 Dumbarton
Epstein, Mrs. I. V., 8419 Greenbush Dr.
Ernst, Mrs. Frank, 67 Huntley Dr.
Estess, Mrs. B. H., 3746 Darcus
Etter, Mrs. Richard L., 2740 Pemberton
Evans, Mrs. Howard L., 6428 Belmont
Farfel, Mrs. Bernard, 3342 Wichita
Faris, Mrs. Arthur M., 49 Briar Hollow Lane
Farish, Mrs. G. C., 3435 W. Holcombe Blvd.
Fatherree, Mrs. Thomas J., 3745 Drummond
Feagin, Mrs. Horace C., 3201 Ferndale
Feamster, Mrs. Robert C., 3631 Underwood
Feinstein, Mrs. Dan, Military Service
Filippone, Mrs. John M., 4701 Pine, Bellaire
Finney, Mrs. R. Milton, 1936 Rice Blvd.

AUXILIARY MEMBERS, 1954—*continued*

Fishbein, Mrs. Harry, 3418 Oakdale
Fisher, Mrs. William C., III, 2220 Salisbury
Fitch, Mrs. Edward O., 1832 Kirby
Flanary, Mrs. L. M., 1402 Gardenia Dr.
Flanz, Mrs. Bernard, 5219 Balkin
Flynt, Mrs. Otis P., 3207 Shenandoah
Foote, Mrs. Stephen A., Jr., 20 West Oaks Dr.
Ford, Mrs. Walter A., 2238 Richmond
Foster, Mrs. Joseph B., 2020 W. Main
Fountain, Mrs. Edmund M., 4033 Piping Rock
Frachtman, Mrs. H. Julian, 2547 N. MacGregor Way
Frawley, Mrs. J. T., 8233 Glenview Dr.
Freedman, Mrs. Tracy B., Shamrock Hotel, 1253
Freeman, Mrs. Bromley S., 3752 Seminole
Freundlich, Mrs. Charles, 2715 Centenary
Frierson, Mrs. James N., 2210 Kipling
Fuller, Mrs. Rex G., Box 31, Waller
Gamble, Mrs. J. F., 4050 Nenana
Gandy, Mrs. D. Truett, 2925 Ella Lee
Gandy, Mrs. Joe R., 2104 Pine Valley
Gardner, Mrs. Herman L., 2245 Maroneal
Gardner, Mrs. Robert A., 4041 Ella Lee
Garrett, Mrs. Edwin E., 1614 16th, Galveston
Gates, Mrs. Charles S., 3119 Avalon Pl.
Gatoura, Mrs. George J., 2402 Dorrington
Glassman, Mrs. Arthur L., 3521 Tartan Lane
Glen, Mrs. John King, 4412 Montrose
Glover, Mrs. F. Scott, 3619 Bellfontaine
Goar, Mrs. E. L., 3203 Huntingdon
Goodall, Mrs. Robert J., 3602 Dumbarton
Goodloe, Mrs. N. Maxwell, 3652 Ella Lee
Goodwin, Mrs. Roy T., 5065 Fieldwood
Gordon, Mrs. William Boyd, 5906 Malmedy
Gottlieb, Mrs. M. F., 1333 Thornton
Graves, Mrs. Ghent, 3416 Garrott
Graves, Mrs. M. L. (Hon.), 11 Shadowlawn
Gready, Mrs. Donald M., 1606 Rosedale
Gready, Mrs. T. G., Jr., 3024 Bellaire Blvd.
Green, Mrs. Charles C., 2231 Southgate
Green, Mrs. Louis, 8316 Fairhope Pl.
Greene, Mrs. James A., 2512 Southmore
Greenwood, Mrs. James, 3624 Overbrook
Greenwood, Mrs. James, Jr., 3394 Chevy Chase
Greer, Mrs. Alvis E., 1715 North Blvd.
Greer, Mrs. Cecil, 3214 Prospect
Greer, Mrs. David, 24 Crestwood
Griffey, Mrs. E. W., 2218 Troon
Griswold, Mrs. C. M., 2121 Brentwood
Grunbaum, Mrs. F. V., 2335 Maroneal
Guilford, Mrs. Fred R., 1211 Barkdull
Guthrie, Mrs. Thomas, Jr., 2514 Dryden
Haden, Mrs. Henry C., 3622 Wickersham
Haggard, Mrs. Carl M., 5938 Glen Hurst
Haley, Mrs. Melvin D., 109 Daytonia, Bellaire
Haley, Mrs. S. Willard, 1915 Temple Dr.
Hallson, Mrs. D. C. McKenzie, Rt. 4, Box 590
Hamilton, Mrs. Carlos R., 3615 Del Monte
Hamrick, Mrs. Wendell H., 2815 Rice Blvd.
Handly, Mrs. L. L., 716 W. Alabama
Haney, Mrs. Fred, 3724 Broadway
Hanson, Mrs. Hugh H., 3717 Plumb
Hardie, Mrs. Robert H., 3817 Aberdeen Way
Hardy, Mrs. S. Baron, 4001 Piping Rock
Harrington, Mrs. Paul R., 4602 Ivanhoe
Harris, Mrs. C. P., 2129 Brentwood
Harris, Mrs. Fred, 2404 Inwood
Harris, Mrs. Herbert H., 3457 Meadow Lake
Harris, Mrs. J. Wade, 2437 Brentwood
Harris, Mrs. John H., 1729 Banks
Harrison, Mrs. Malcom W., 5411 Pine, Bellaire
Harrison, Mrs. W. T., 5555 Little Lake Dr.
Harwood, Mrs. Nathan, 3722 Sunset Blvd.
Haus, Mrs. Loren W., 3634 Bluebonnet
Hauser, Mrs. Abe, 3704 S. MacGregor Way
Hayes, Mrs. Herbert T., Lamar Hotel, Apt. 6E
Heard, Mrs. J. Griffin, 3059 Reba
Helman, Mrs. Rowland, 3631 Newcastle
Henry, Mrs. Marshall G., 1710 S. Post Oak Lane
Hill, Mrs. Austin, 8310 Buffalo Speedway
Hinds, Mrs. Gordon F., 2207 Bolsover
Hines, Mrs. Norman D., 2322 Southgate
Hoagland, Mrs. Lester L., 3510 Childress
Hodell, Mrs. George R., 5312 Bayou Glen
Hodges, Mrs. J. Edward, 2801 Main
Hoeflich, Mrs. C. W., 2224 Salisbury Lane
Hofer, Mrs. Jesse W., 1656 Colquitt
Holland, Mrs. T. L., 4315 San Felipe
Hollimon, Mrs. James H., 3115 Bluebonnet
Holloman, Mrs. Walter, 3131 Prescott
Hollub, Mrs. Charles J., 417 W. Friar Tuck
Hooker, Mrs. Lyle, 5138 Longmont
Hooper, Mrs. C. C., Jr., 617 Tartar St., Pasadena
Hotchkiss, Mrs. D. H., Jr., 314 W. Cowan
Howard, Mrs. A. Philo, 3608 Audubon
Howard, Mrs. J. M., 1817 Wroxton
Hubbard, Mrs. Oscar E., Military Service
Hucherson, Mrs. Denman C., 2310 Braeswood Blvd.
Hughes, Mrs. Fred M., 3604 University
Hull, Mrs. John G., 3209 Locke Lane
Hutchins, Mrs. Selwyn P. R., 5815 Charlotte
Iiams, Mrs. Frank J., 2204 Troon
Jackson, Mrs. Daniel, 4723 Arvilla Lane
Jackson, Mrs. Richard H., 3226 Purdue
Jacobi, Mrs. R. E., 5922 Bois D'Arc
James, Mrs. Powhatan W., Jr., 3746 Plumb
Jaubert, Mrs. Francis L., Jr., Military Service
Jenkins, Mrs. Daniel E., 3615 Bluebonnet
Jenkins, Mrs. Edward E., 4822 Linden, Bellaire
Johnson, Mrs. C. B., 4647 Engersoll
Johnson, Mrs. Lawrence W., 106 Dillon
Johnson, Mrs. R. Marion, 2152 Del Monte
Johnson, Mrs. Seale, 3111 University
Johnston, Mrs. Robert A., 7 Shadow Lawn
Jones, Mrs. J. Randolph, 1422 Marshall
Jones, Mrs. W. P., 1005 E. Park Lane, Pasadena
Jorns, Mrs. C. Forrest, 4306 S. MacGregor Way
Kahle, Mrs. Warren, 4150 Lanark Lane
Kaiser, Mrs. Clarence H., 1114 Timber Grove
Karbach, Mrs. Nelson W., Jr., 6131 Lake
Karnaky, Mrs. Karl John, 2412 Oakdale
Kelsey, Mrs. Mavis P., 2136 Brentwood
Kelsey, Mrs. John R., 3638 Underwood
Kemp, Mrs. Hardy A., 7332 Staffordshire
Kennedy, Mrs. John C., 2356 Bolsover
Kennerly, Mrs. Thomas P., 8919 Limerick Lane
Kerr, Mrs. Denton, 1924 Braeswood
Kilgore, Mrs. F. Hartman, 4012 Meadow Lake
Kilgore, Mrs. Morris W., 1206 Lovett
Kilgore, Mrs. N. A., 2405 Maconda
Kimbell, Mrs. Isham, Jr., 1317 Overhill Dr.
Kincaid, Mrs. Harvey L., Rr. 1, Box 336-K
King, Mrs. Joe W., 4042 Bluebonnet
Kirkham, Mrs. H. L. D., 3603 Audubon Pl.
Kirkland, Mrs. Arthur A., 3618 Sweetbriar
Kitchen, Mrs. Benjamin, 803 Hawthorne
Klanke, Mrs. Charles W., 127 N. Haywood
Klein, Mrs. Perry B., 3219 Rosedale
Knittel, Mrs. Schubert, 4644 Bellaire Blvd., Bellaire
Knoll, Mrs. Alfred F., 5210 Pine Forest Rd.
Knolle, Mrs. Guy E., 2028 Timber Lane
Kolodny, Mrs. George Robert, 3703 Westerman
Kyle, Mrs. J. Allen, 1702 Main
Lambert, Mrs. Y. A., Jr., 2102 6th St., Galena Park
Lancaster, Mrs. Frank H., 32 Crestwood
Latimer, Mrs. Mark H., 55 Huntley Dr.
Lattimore, Mrs. Joseph S., 4713 Fleetwood, Bellaire
Lawrence, Mrs. B. A., 2732 Merrick
Leader, Mrs. Abel J., 3101 Bluebonnet
Leaton, Mrs. R. E., 3737 Griggs Rd.
Lechenger, Mrs. G. C., 4819 Caroline
Ledbetter, Mrs. A. A., 3262 Reba
Ledbetter, Mrs. Paul, 3508 Inwood
Leggett, Mrs. M. K., 2350 Bluebonnet
Leigh, Mrs. R. E., Jr., 3910 Childress
Leong, Mrs. Richard W., 5410 Braeburn, Bellaire
Leonard, Mrs. Robert B., 601 W. Clay
Levin, Mrs. Louis, 5410 Mr. Houston Rd.
Levy, Mrs. M. D., 5302 Institute Lane
Levy, Mrs. Moise D., Jr., 2410 Gramercy
Levy, Mrs. S. A., 2121 McClendon
Lewis, Mrs. Arthur N., 4017 Overbrook
Lieppman, Mrs. Jack E., 5410 Blythewood
Liles, Mrs. Ralph, 4921 Crawford
Lindsey, Mrs. Bert G., Jr., 5109 Patrick Henry, Bellaire
Littell, Mrs. Milton, 4002 Roseneath
Little, Mrs. Harry M., 3306 Bluebonner
Livesay, Mrs. W. R., 3851 Durness
Loeffler, Mrs. R. Kenneth, 551 Three Corners Dr.
Logue, Mrs. Lyle J., 3340 Del Monte
Lomas, Mrs. R. D., 4047 Aberdeen
Lowe, Mrs. Percy E., 4374 Blodgett
Lowe, Mrs. Thomas E., 4385 Blodgett
Lummis, Mrs. Frederick R., 2127 Troon Rd.
Lunin, Mrs. Arthur B., 2312 Bluebonnet
Mabry, Mrs. J. B., 1932 Dryden
MacComb, Mrs. W. S., 402 Pinehaven Dr.
MacIntyre, Mrs. Robert S., 2312 Suffolk
Madsen, Mrs. A. C., 5328 Calhoun
Malewitz, Mrs. Edward C., 6532 Belmont
Marcuse, Mrs. P. M., 4405 Charleston
Maresh, Mrs. Henry R., 2416 Riverside
Margraves, Mrs. R. D., 2428 Reba
Marshall, Mrs. Reagan M., 4601 Caroline
Martin, Mrs. Richard G., Military Service
Mathis, Mrs. Robert L., 3719 Turnberry Circle
Mayfield, Mrs. Jack H., 4419 N. Roseneath
McCallum, Mrs. Marion J., 1346 Curtin
McCulley, Mrs. J. Duncan, 2334 Tangley
McDeed, Mrs. W. G., 3809 Ella Lee
McGehee, Mrs. F. O., 949 Kirby
McGraw, Mrs. John P., 3763 Odin Ct.
McHenry, Mrs. R. K., 3660 Chevy Chase
McIndoe, Mrs. Frank W., 2607 Barbara Lane
McKay, Mrs. H. E., Jr., Box 625, Humble
McKeever, Mrs. Duncan C., 2529 Reba
McMurrey, Mrs. Allen, 22 Briar Hollow Lane
McNamara, Mrs. D. G., 3831 Seminole
McNeill, Mrs. A. S., 1502 Hyde Park
McPeak, Mrs. Edgar M., 8363 Park Pl.
McReynolds, Mrs. I. S., 3744 Inwood
McReynolds, Mrs. R. J., 4132 Broadway
McRoberts, Mrs. W. A., Jr., 4013 Coleridge
McSpadden, Mrs. Floyd F., 1349 Cheshire Lane
Melton, Mrs. W. Truett, 2224 Dryden
Meltzer, Mrs. Leonard, 3110 Ferndale
Mendell, Mrs. David, 3023 Convoy
Merrill, Mrs. S. J., 4928 Spruce, Bellaire
Messer, Mrs. J. N., 2612 S. Calumet
Meynier, Mrs. M. J., Jr., 47 Briar Hollow Lane
Miller, Mrs. George V., 2418 Southgate
Miller, Mrs. Sam I., Jr., 410 N. Avenue A, Bellaire
Milligan, Mrs. John J., 3764 Gramercy
Mitchell, Mrs. A. Lane, 327 E. Cowan
Moers, Mrs. Robert O., 3739 Drake
Molloy, Mrs. James P., 2624 Prospect
Montgomery, Mrs. C. F., 2225 Quenby
Moody, Mrs. I. W., 5489 Fieldwood
Moore, Mrs. D. Lewis, 1307 Sul Ross
Moore, Mrs. George L., 1660 Kipling
Moore, Mrs. Jack, 4703 Mayfair, Bellaire
Moore, Mrs. T. O., 2014 Suffolk
Moorhead, Mrs. William H., 1915 Albans Rd.
Morgan, Mrs. Ray M., Jr., 1710 Sky Lark Lane
Morris, Mrs. G. C., Jr., Military Service
Morrison, Mrs. J. Winston, 4922 Winfree
Morrow, Mrs. Edwin J., 2722 Werlein
Morse, Mrs. Walter S., 5650 Cedar Creek
Moursund, Mrs. W. H., 5625 Jackson
Myers, Mrs. Claude D., 2104 Pelham
Newton, Mrs. B. L., 2141 Dryden
Nicosia, Mrs. R. V., 4021 Piping Rock
Norris, Mrs. Ronald F., 4603 Bryn Mawr Lane
O'Heeron, Mrs. Michael K., 3029 Underwood
Ohlhausen, Mrs. S. G., 4450 S. MacGregor Way
Oldham, Mrs. Dudley Y., 3618 Locke Lane
Oliver, Mrs. J. Stanley, 4311 Laurel Dr.
Oliver, Mrs. J. T., 4135 Fernwood
Olson, Mrs. Stanley W., 3639 Drummond
O'Neal, Mrs. Kermit C., 5701 Jackson, Apt. 1010
Orman, Mrs. McDonald, 2335 Glenhaven
Ory, Mrs. Edwin M., 3766 Nottingham
Overstreet, Mrs. John W., 3464 Wickersham
Overton, Mrs. Robert C., 2212 Troon Rd.
Owen, Mrs. A. George, 1805 Banks
Owens, Mrs. J. B., 613 Harold
Owsley, Mrs. W. C., Jr., 5326 Lampasas
Page, Mrs. J. Herbert, 5517 Crawford
Palm, Mrs. William M., 612 E. Friar Tuck
Pannill, Mrs. Fitzhugh C., Jr., 3770 Portsmouth
Park, Mrs. David R., 2026 Suffolk
Park, Mrs. James H., Jr., 3238 Reba
Parrish, Mrs. Frank F., 5308 Woodway
Paton, Mrs. Donald M., 309 Saddlewood
Patrick, Mrs. Ralph C., 5055 Calhoun
Patteson, Mrs. J. L., 418 W. Friar Tuck
Pawelek, Mrs. I. L., 3009 Avalon
Pawelek, Mrs. Louis G., 3424 Prospect
Peek, Mrs. John Sealy, 10405 Palestine
Perdue, Mrs. George W., 2523 Stanmore
Perry, Mrs. John L., Jr., 2307 Branard
Peters, Mrs. I. D., 4330 S. MacGregor Way
Peterson, Mrs. Henry A., 20 Courtlandt Pl.
Peterson, Mrs. Marion G., Military Service
Phelps, Mrs. Kenton R., 2440 Nottingham
Phillips, Mrs. John Roberts, 5806 Bayou Bend
Phillips, Mrs. Leon, 3703 Rosedale
Pittman, Mrs. James E., 3220 Binz
Potts, Mrs. Charles R., 3 Briar Hollow Lane
Powell, Mrs. Norborne B., 3002 San Felipe
Poyner, Mrs. Herbert, 2248 Chilton
Price, Mrs. William P., 108 Calvi Ct., Bellaire
Prince, Mrs. Homer E., 2440 Del Monte
Pugsley, Mrs. Cornelius, 218 Piney Point Rd.
Pulliam, Mrs. L. T., 75 Piney Point Rd.
Purdie, Mrs. Robert M., 3244 Locke Lane
Purnell, Mrs. Guy W., 3712 Darcus
Qualtrough, Mrs. Walter F., 28 Briar Hollow Lane
Queen, Mrs. Don, 5402 Fayette
Rader, Mrs. John F., 3751 Carleston
Radding, Mrs. Robert S., 5214 Newkirk

AUXILIARY MEMBERS, 1954—*continued*

Ramsey, Mrs. W. E., 3616 Meadow Lake
Raney, Mrs. Lovel W., 315 W. Alabama
Red, Mrs. W. S., Jr., 1936 Larchmont
Reece, Mrs. Charles D., 2031 Banks
Renfrow, Mrs. W. Frank, 2510 Del Monte
Richardson, Mrs. J. B., 2423 Brazoria
Richeson, Mrs. R. A., 4011 Merrick
Ried, Mrs. Hubert L., 2638 Oakdale
Rivers, Mrs. Franklin M., 9021 Wickford
Robbins, Mrs. E. Freeman, 2410 Rosamond, Apt. 111
Robertson, Mrs. R. C. L., 5472 Lynbrook
Robinett, Mrs. James B., Jr., 3434 Norris
Robins, Mrs. Bill, 4406 Roseneath
Robinson, Mrs. Fred W., 4533 Merrie Dr.
Robinson, Mrs. H. C., 4012 Inverness
Robinson, Mrs. Tryon, 4709 Maple, Bellaire
Rodgers, Mrs. Lawrence R., 3723 S. Braeswood Blvd.
Rogers, Mrs. Stanley, 2925 Darnell, Bellaire
Rohrer, Mrs. George E., Jr., 3758 Drummond
Rose, Mrs. J. M., 3014 Tilden
Royce, Mrs. Thomas L., 3834 Del Monte
Rumph, Mrs. Quah, 2444 Sheridan
Russell, Mrs. Thomas G., 2204 Looscan Lane
Rutledge, Mrs. Felix, 2229 San Felipe
Ryan, Mrs. Bert M., 2508 Dryden
Sacco, Mrs. Allan C., 10607 Memorial Dr.
Salerno, Mrs. Joseph P., 2901 Avalon
Salinger, Mrs. Alfons, 2214 Calumet
Salmon, Mrs. George W., 2122 McClendon
Sanders, Mrs. Charles B., 6 Courtlandt Pl.
Sanders, Mrs. Zal H., 3302 Southmore
Sanderson, Mrs. T. A., 2320 Southgate
Schaffer, Mrs. Randolph, 1514 Milford
Scher, Mrs. David, 5607 H. M. C., Apt. 3
Schilling, Mrs. John G., 3511 N. Braeswood Blvd.
Schnur, Mrs. Sidney, 1211 S. Shepherd
Schrum, Mrs. David, 3306 Sackett
Schuhmacher, Mrs. L. F., Jr., 7024 Staffordshire
Schultz, Mrs. Jacob F., 3444 Locke Lane
Selke, Mrs. Oscar O., Jr., 3646 Olympia
Seybold, Mrs. W. D., 3729 Wickersham
Shearer, Mrs. Thomas P., 2703 Tangley
Shelton, Mrs. Elvin L., Jr., 3522 Bluebonnet
Sher, Mrs. Malcolm F., 3819 Purdue
Sherrill, Mrs. Lloyd H., 2905 Plumb
Sherrill, Mrs. William M., 7434 Briefway
Shindler, Mrs. Thomas O., 5701 Jackson
Shirley, Mrs. Carl W., 9019 Chatsworth
Shoemaker, Mrs. Roger, 1232 Overhill Dr.
Shrader, Mrs. Harold E., 617 Tartar, Pasadena
Shullenberger, Mrs. C. C., 4403 Acacia, Bellaire
Sinclair, Mrs. T. A., 2157 Troon
Sinclair, Mrs. Thomas A., Jr., 321 Lindenwood Dr.
Singleton, Mrs. E. B., 3421 Overbrook
Silverman, Mrs. Robert, 3011 M. A. S. St.
Skaggs, Mrs. Ray H., 4247 Sunset Blvd.
Skelton, Mrs. James M., 4712 Fleetwood, Bellaire
Skogland, Mrs. J. E., 8820 Memorial Dr.
Slataper, Mrs. E. L., 3702 Turberry Circle
Slataper, Mrs. F. J., 2001 Wentworth
Smith, Mrs. B. F., 8 Chelsea
Smith, Mrs. Burt B., 2001 Sunset
Smith, Mrs. Clifford, 3461 Piping Rock
Smith, Mrs. Edward T., 2120 Brentwood
Smith, Mrs. J. Murry, 1911 Carroll
Smith, Mrs. Jackson A., 3827 Norfolk
Snyder, Mrs. Hal, 3930 Charleston
Sonenthal, Mrs. Ronald J., 502 Timber Terrace
Speck, Mrs. Carlos D., Jr., 3709 Montrose Blvd.
Spencer, Mrs. Walter C., 2812 Westgrove Lane
Spencer, Mrs. William A., 5306 Stuyvesant Lane
Spezia, Mrs. J. L., 2626 Newman
Spiller, Mrs. J. B., 11 Tiel Way
Spurr, Mrs. Charles L., 5553 Little Lake, Bellaire
Stackhouse, Mrs. Howard, 2506 Bluebonnet
Stalnaker, Mrs. Paul R., 5401 San Jacinto
Staub, Mrs. John D., 1925 Kipling
Stevenson, Mrs. Murphy D., 2418 Nottingham
Stool, Mrs. Joseph A., 2417 Glenhaven
Stork, Mrs. W. J., 1117 Alabama
Stough, Mrs. John T., 3415 Wickersham
Strashun, Mrs. Mat. F., 3302 Cloverdale
Strassman, Mrs. E. O., 2310 Binz
Synnott, Mrs. J. D., 748 W. 43rd
Synnott, Mrs. Tom, 2727 Revere
Tackaberry, Mrs. A. L. W., 2703 Grant
Talley, Mrs. A. T., 2128 Southmore
Talley, Mrs. A. T., Jr., 1354 Suebarnett
Talty, Mrs. Matthew H., Jr., 3758 Grennoch
Tausend, Mrs. H. J., 6035 Rose
Taylor, Mrs. Fred M., 4805 Bellview Dr., Bellaire
Taylor, Mrs. Holman, 2026 North Blvd., Apt. 7
Taylor, Mrs. Homer A., Jr., 4127 Lanark Lane
Tharp, Mrs. Warren B., 304 Crestwood
Thomas, Mrs. Albert M., 2412 Charleston
Thomas, Mrs. Charles, 4314 Rossmoyne
Thomas, Mrs. Fred P., 4625 Pine, Bellaire
Thomas, Mrs. J. Sellers, Jr., 4605 Huisache
Thomas, Mrs. Stephen, 761 Kuhlman
Thomason, Mrs. Edgar M., 2314 Peckham
Thompson, Mrs. Walker, 4610 Cedar Oaks Lane
Thorn, Mrs. S. W., 1714 South Blvd.
Thorning, Mrs. W. B., 1702 W. Main
Toland, Mrs. William A., 3471 Wickersham
Trible, Mrs. John B., 2402 Calumet
Truitt, Mrs. J. J., 2203 Brentwood
Tucker, Mrs. E. J., 3766 Grennoch
Tucker, Mrs. J. Norris, 3609 Piping Rock
Turboff, Mrs. Sidney, 3138 S. MacGregor Way
Turner, Mrs. B. Weems, 2947 Inwood
Turner, Mrs. C. Gary, 2435 Del Monte
Tusa, Mrs. Theo S., 3713 Del Monte
Tusa, Mrs. Theo S., Jr., 2802 Westheimer
Tuttle, Mrs. L. L. D., 2223 Inwood
Ulert, Mrs. I. A., 1619 Kipling
Usher, Mrs. Frank C., 2219 Richmond
Vander Bosshe, Mrs. Leo J., 2011 Hewett
>Vanzant, Mrs. Thomas J., 3828 Inwood
Vaughan, Mrs. Luther N., 3707 Inwood
Viehweg, Mrs. W. R., 1105 Dismuke
Vincent, Mrs. Terry S., 3511 Broadmead
von Pohle, Mrs. Kenneth C., 252 S. Post Oak Lane
Wachsman, Mrs. David V., 2514 Glenhaven
Wagner, Mrs. E. L., 2414 Gramercy
Wagner, Mrs. Robert G., 2039 Dryden
Waldron, Mrs. George W., 3659 Inwood
Walker, Mrs. Joseph D., 3439 Piping Rock
Wall, Mrs. John A., 2217 Maconda
Wallis, Mrs. W. M., 1012 Rosedale
Walter, Mrs. Paul J., 3205 Glenhaven
Warner, Mrs. Clyde M., 3256 Reba
Warner, Mrs. Lucien M., 2912 Ella Lee
Watson, Mrs. James E., Jr., 2208 Swift
Watson, Mrs. Thomas D., 2071 Brentwood
Weil, Mrs. Sol D., Jr., 2246 Dryden
Welsh, Mrs. Hugh C., 3465 Inwood
Weisiger, Mrs. Ross, 3715 Drummond
West, Mrs. Joseph E., Jr., 116 Santa Fe
Wexler, Mrs. Alvin S., 7272 Woodridge
White, Mrs. A. W., Jr., 6530 Sivley
White, Mrs. E. C., 5315 Pine, Bellaire
White, Mrs. Roland L., Claire Lane Apts., Page Plaza, Corpus Christi
Whitehurst, Mrs. James R., 2414 Hazard
Whitsitt, Mrs. J. J., 5312 Cherokee
Wigby, Mrs. Palmer E., 300 Little John Lane
Wilkerson, Mrs. Edward, 12 Chelsea
Williams, Mrs. Bryan V., 4402 Roseneath
Williams, Mrs. E. Carson, 2115 Dickey Pl.
Williford, Mrs. L. E., 1135 W. Gray
Wills, Mrs. Seward H., 5327 Mandell
Wilson, Mrs. Carl, 1512 W. Alabama
Windrow, Mrs. Nuel C., Jr., 3628 Westchester
Winograd, Mrs. Eugene, 1903 N. Nina Lee
Wise, Mrs. Robert A., 3448 Locke Lane
Wise, Mrs. Robert J., 819 W. Main
Withers, Mrs. Ben T., 3010 Virginia
Withers, Mrs. Henry W., 2908 Ella Lee
Wolf, Mrs. Edward T., 4411 Fannin
Wolters, Mrs. Carlton E., 2612 Oakdale
Wootters, Mrs. John H., 2119 Pine Valley
Wright, Mrs. William K., 3649 Overbrook
Yates, Mrs. C. W., 2611 Ave. G, Rosenberg
York, Mrs. Bryon P., 2501 N. MacGregor Way
Young, Mrs. Carl B., 3325 Del Monte
Youngblood, Mrs. J. C., 3011 Ella Lee
Younkin, Mrs. Charles R., 4604 Locust, Bellaire
Zanek, Mrs. Otto L., 2129 Sunset
Zarr, Mrs. Lynn, 3330 Del Monte
Zeis, Mrs. L. B., 4501 N. Roseneath
Zeluff, Mrs. George W., 3819 Linklea Dr.
Zionts, Mrs. Martin A., 3507 Louisiana

EAST HARRIS COUNTY CHAPTER*

Atkins, Mrs. Richard Dan, 3221 Wisconsin
Bridges, Mrs. William Hillary, 917 Leavins
Bruce, Mrs. George D., 122 W. Bayshore Dr.
Crossman, Mrs. Lyman Weeks, 1506 Woodlawn Dr.
>Davis, Mrs. Hamlet I., Jr., 1316 E. James
Duke, Mrs. Herbert H., E. Texas Ave.
Dyer, Mrs. Robert D., 3129 Ohio
Fayle, Mrs. Percy R., 2000 Wright Blvd.
Felknor, Mrs. George Eckel, Jr., 1501 Woodlawn Dr.
Hankins, Mrs. Lawson A., 522 W. Gulf
Hinton, Mrs. Leslie, Crosby
Howell, Mrs. Theodore S., 1601 California
Humphrey, Mrs. Stanley G., 2315 Missouri
Jaubert, Mrs. Frank L., Jr., 209 Lafayette Dr.
Jones, Mrs. Malcolm A., 206 Bayshore Dr.
Jones, Mrs. William Thoreau, 911 Leavins
Kilpatrick, Mrs. Hamilton W., III, 1307 Monroe
Liggett, Mrs. Charles Lee, 1600 Mississippi
Lillie, Mrs. Gordon A., 310 W. Sterling
Marshall, Mrs. William E., 207 Harvey
Mayes, Mrs. Lee P., 211 Hackberry Lane
Peck, Mrs. Temple T., 1606 Mississippi
Pipkin, Mrs. Robert W., 513 Finley
Porter, Mrs. John T., Burnet Bay
Sammons, Mrs. James H., Highlands
Sammons, Mrs. Karl T., Highlands
Sappington, Mrs. Harry O., 112 N. Burnet
Sharp, Mrs. William E., 3212 Wisconsin
Smolens, Mrs. Nathan M., 402 W. James
Whitson, Mrs. Robert Oliver, 800 W. Lobit

*Address is Baytown unless otherwise stated.

POLK-SAN JACINTO COUNTIES AUXILIARY

Corso, Mrs. John, Livingston
>Dabney, Mrs. J. T., Livingston
Dameron, Mrs. J. H., Livingston
Gardner, Mrs. T. L., Livingston
Grimes, Mrs. Ivison, Camden
Hale, Mrs. D. M., Cold Springs
Olive, Mrs. Roy, Livingston

WALKER-MADISON-TRINITY COUNTIES AUXILIARY

Addison, Mrs. Eugene M., 1415 20th, Huntsville
Autrey, Mrs. S. L., Trinity
Barnes, Mrs. Sam R., Trinity
Blalock, Mrs. Raymond B., Highway 45, E., Huntsville
Cole, Mrs. Tom C., 1903 Avenue P, Huntsville
Veazey, Mrs. William B., 1516 Avenue O, Huntsville
>Woodward, Mrs. Walter M., 2011 Avenue O, Huntsville

WASHINGTON-BURLESON COUNTIES AUXILIARY*

>Giddings, Mrs. Thomas, 1320 S. Austin
Hasskarl, Mrs. Robert A., 1400 S. Day
Hasskarl, Mrs. W. F., Jr., Biggs AFB, EL Paso
Hasskarl, Mrs. Walter F., Sr., Washington Hgts.
Knolle, Mrs. Olga, 1008 S. Day
Knolle, Mrs. Roger E., 801 S. Clinton
Knolle, Mrs. Waldo A., 511 Sycamore
Pazdral, Mrs. George V., Sommerville
Schoenvogel, Mrs. C. W., 830 Indiana, Corpus Christi
Schoenvogel, Mrs. Otto F., 112 Mulberry
Southern, Mrs. Charles E., Walnut Hill Dr.
Tottenham, Mrs. Edwin P., 603 E. Academy

MEMBERS-AT-LARGE, NINTH DISTRICT

Bell, Mrs. Henry G., Conroe
Carroll, Mrs. Emil, Conroe

TENTH DISTRICT

Mrs. L. C. Heare
Port Arthur
Council Woman

ANGELINA COUNTY AUXILIARY†

Arnett, Mrs. R. K., 707 Lazy Lane
Clement, Mrs. J. C., 1101 Persimmon
Clements, Mrs. P. C., 903 Southwood
Denman, Mrs. L. H., 601 S. First
Estep, Mrs. M. A., 715 Mantooth Ave.
Evans, Mrs. C. W., 1010 Southwood Dr.
Hyman, Mrs. Bernard, 210 Paul Ave.
Klein, Mrs. J. C., 1015 W. Grove Ave.
Martin, Mrs. J. E., 1016 Morningside Dr.
Mitchell, Mrs. W. A., 320 Mantooth
Orman, Mrs. Forrest C., 911-D Pinedell Manor
Shepard, Mrs. Groom S., 909 Moore Ave.
Spivey, Mrs. Dan, 804 Martha
Sweatland, Mrs. A. E., 804 Frank Ave.
Taylor, Mrs. R. W., 501 Jefferson Ave.
Taylor, Mrs. T. A., 402 E. Shepard
>Wade, Mrs. J. H., 718 Frank Ave.

HARDIN-TYLER COUNTIES AUXILIARY

Aston, Mrs. William, P. O. Box 385, Sour Lake
Barclay, Mrs. Watt, Woodville

*Address is Brenham unless otherwise stated.
†Address is Lufkin unless otherwise stated.

AUXILIARY MEMBERS, 1954—*continued*

Burton, Mrs. Gayle, P. O. Box 788, Woodville
Gilchrist, Mrs. John Q., P. O. Box 546, Woodville
Parker, Mrs. Wade M., 735 N. 5th, Silsbee
Poshataske, Mrs. W. J., Silsbee
>Tate, Mrs. John, P. O. Box 636, Kountze
Tennison, Mrs. George, Silsbee

JASPER-NEWTON COUNTIES AUXILIARY

Bird, Mrs. Noel, Jasper
Dickerson, Mrs. Joe, Jasper
Jones, Mrs. Tom R., Pineland
McCall, Mrs. J. W., Jasper
McCall, Mrs. J. W., Jr., Jasper
McCall, Mrs. Lois, Jasper
McCreight, Mrs. W. F., Kirbyville
>McGrath, Mrs. J. J., 964 Ave. A, Jasper
Moore, Mrs. John T., Kirbyville
Richardson, Mrs. A. J., Jr., Jasper
Richardson, Mrs. A. J., Sr., Jasper
Sonders, Mrs. William, Sr., Jasper
Stockdale, Mrs. Rider, Jasper

JEFFERSON COUNTY AUXILIARY*

Adams, Mrs. Rohert M., 3867 Main Ave., Groves
Adkins, Mrs. Charles F., 2150 Ashley
Alexander, Mrs. Hugh E., 2370 Harrison
Allamon, Mrs. E. L., 2200 East Dr.
Allison, Mrs. F. Peel, 3155 Rohinhood Lane
Anderson, Mrs. Roland B., 2927 Thirty-First, Port Arthur
Barr, Mrs. H. Buford, 2490 Ashley
Barr, Mrs. Richard E., 2524 Long
Beheau, Mrs. Eugene R., 1195 East Dr.
Bevil, Mrs. H. Grady, 2515 Long
Bevil, Mrs. Harold H., 3230 N. Willowood Dr.
Bevil, Mrs. Lamar C., 2570 Louisiana
Beyt, Mrs. F. J., 3812 Lakeshore Dr., Port Arthur
Blackwood, Mrs. James Quincy, 3240 Redwood Dr.
Blum, Mrs. Sigmund L., 2260 Hazel
Brown, Mrs. Walter D., 2274 North
Browne, Mrs. Rohert Sloman, 4545 Sunken Ct., Port Arthur
Brownrigg, Mrs. T. H., 2550 Long
Byhee, Mrs. J. A., 2425 Pecos Blvd.
Byram, Mrs. Dan Heard, 4231 Lakeshore Dr., Port Arthur
Byrd, Mrs. Houston F., 1102 Montrose, Port Arthur
Byrd, Mrs. Lee Roy, Jr., 1901 Stanley Blvd., Port Arthur
Caldwell, Mrs. Pierson C., 3235 Redwood Dr.
Carahelle, Mrs. R. William, 430 Orange, Port Arthur
Carter, Mrs. John H., 2475 Evalon
Carter, Mrs. Louian C., 3848 Lakeshore Dr., Port Arthur
Catalano, Mrs. Russell J., 990 Twenty-Third
Christie, Mrs. Alonzo B., 6525 Madison, Groves
Chunn, Mrs. B. D., 269 Ridgeland
Cochran, Mrs. Ernest Winston, 2415 Beech
Colhy, Mrs. Fred, 2380 Hazel
Colletti, Mrs. Ben M., 2401 Thomas Blvd., Port Arthur
Couch, Mrs. Ray E., 4130 Philmont, Port Arthur
Crager, Mrs. Jay C., 2490 North
Crawford, Mrs. George F., 517 Fourteenth
>Curry, Mrs. Dwight Edward, 4037 Procter, Port Arthur
Darnell, Mrs. B. C., 2405 Ashley
Dart, Mrs. Raymond O., 3150 French Dr.
Duplan, Mrs. Don C., Jr., 4637 Alamosa, Port Arthur
Duren, Mrs. Norman, 3180 Rohinhood Lane
Eisenstadt, Mrs. H. B., 210 Fourth Ave., Port Arthur
Elster, Mrs. Benjamin B., 3601 Fifth, Port Arthur
English, Mrs. Dudley M., 690 Nineteenth
Erhard, Mrs. Peter S., 3010 Blackmon Lane
Esslinger, Mrs. Josh J., 125 East Dr.
Fama, Mrs. Joseph R., 3280 Redwood Dr.
Ferguson, Mrs. Edward C., 2965 French Dr.
Fertitta, Mrs. Julian J., 1485 Thomas Rd.
Fett, Mrs. Bennie J., 3100 Sixth, Port Arthur
Fortney, Mrs. Paul N., 2627 Hazel
Fuselier, Mrs. J. D., 4400 Twin City, Port Arthur
Gardner, Mrs. John N., 2534 Long
Gill, Mrs. George Glenwood, 2665 Long
Glass, Mrs. Walter W., Jr., 3449 Platt Ave., Port Arthur
Goldblum, Mrs. Harvey H., 2525 Glenwood Dr., Port Arthur
Goodwin, Mrs. C. R., 623 Fourteenth, Nederland
Graher, Mrs. W. J., 695 Twentieth
Granata, Mrs. Sam V., 3226 North
Gray, Mrs. Willis J., 2365 McFaddin
Greenherg, Mrs. Philip B., 2398 Laurel
Hager, Mrs. Dale Carroll, 695 Twenty-Second
Hammill, Mrs. James E., 5200 Sixth, Port Arthur
Harlan, Mrs. H. D., 2460 Long
Harper, Mrs. J. Y., 4800 Lakeshore Dr., Port Arthur
Hart, Mrs. John A., 1050 Thomas Rd.
Hartman, Mrs. Lee E., 525 Yount
Hartman, Mrs. Sam F., 545 Twenty-Third
Healey, Mrs. Gordon, 1917 Woodrow, Port Arthur
Heare, Mrs. L. C., 2600 Las Palmas, Port Arthur
Hearn, Mrs. J. William, 5550 Hehert
Hendry, Mrs. C. H., 2494 Hazel
Hennington, Mrs. Herhert M., 595 Twenty-Third
Hill, Mrs. Isaac H., 845 Fifth, Port Arthur
Hines, Mrs. J. C., 1903 Gary, Nederland
Hinshaw, Mrs. Arvil J., 3110 Willowood Dr.
Holmes, Mrs. Glen Iden, 940 Fifteenth
Hosen, Mrs. Harris, 3008 Fifth, Port Arthur
Huhner, Mrs. Alan E., 750 Yount
Hyman, Mrs. B. M., 5610 Duff
Jacohson, Mrs. Harry, 2330 Long
Kaplan, Mrs. Hyman J., 2330 Harrison
Keith, Mrs. Frank R., Jr., 2632 Thirty-Third, Port Arthur
Killingsworth, Mrs. W. Price, 1919 Wignall, Port Arthur
Koshkin, Mrs. Bernard D., 740 Fifteenth
Kuhlman, Mrs. Frederick Y., 860 Nall, Port Neches
Ledhetter, Mrs. L. H., 820 Twenty-First
Lewis, Mrs. Seah J., 258 N. Circuit Dr.
Lindsey, Mrs. Eugene H., 2510 Calder Ave.
Lombardo, Mrs. Roy T., 810 Nineteenth
Lowenstein, Mrs. Joseph M., 218 Avant Lane, Port Arthur
Lowry, Mrs. Harvey M., 3275 North
Lyons, Mrs. Sam B., 273 W. Circuit Dr.
Makins, Mrs. James, 3000 Bernhardt Dr., Port Arthur
Mann, Mrs. David Aden, 2135 Victoria
Martin, Mrs. J. D., 1897 Rivercrest
Martin, Mrs. T. W., 4609 Alamosa, Port Arthur
Matlock, Mrs. Thomas B., 2935 Sixth, Port Arthur
McNemer, Mrs. Philip H., 2940 Avenue D
McRee, Mrs. Edgar C., 4610 Hollywood Dr., Port Arthur
McRee, Mrs. W. E., Jr., 3844 Delaware Dr., Port Arthur
Meyer, Mrs. Paul R., 3801 Lakeshore Dr., Port Arthur
Miller, Mrs. Kenneth T., 2225 Harrison
Mitchell, Mrs. Theo C., 701 Nineteenth
Mixson, Mrs. H. J., 3290 Dogwood Lane
Montagnet, Mrs. Joseph M., Jr., 1945 Thomas Rd.
Moore, Mrs. Darwin D., 5770 Hehert
Moore, Mrs. R. E., 1604 Gary, Nederland
Neidhardt, Mrs. Heinrich W., 2193 South
Newton, Mrs. William A., 2340 Harrison
Norris, Mrs. Thomas A., 3820 Delaware Dr., Port Arthur
Orrill, Mrs. R. Ray, 4639 Forest, Port Arthur
Painton, Mrs. Clifford E., 3849 Platt Ave., Port Arthur
Pecora, Mrs. Tony Lawrence, 2351 Angelina
Pentecost, Mrs. Charles LaThadwin, 540 Twenty-Third
Petit, Mrs. Paul Thurlow, Calder Rd.
Petry, Mrs. James L., 3401 Central, Port Arthur
Phillippi, Mrs. George McCown, 2170 Ashley
Pitre, Mrs. Roy Paul, 3720 Seventh, Port Arthur
Powell, Mrs. Leslie Charles, 650 Washington Blvd.
Prudhomme, Mrs. Eck G., General Delivery, Winnie
Pruit, Mrs. Lee T., 1415 Calder Ave.
Quick, Mrs. David W., Jr., 805 Central Dr.
Rafes, Mrs. Earl H., 2175 Evalon
Reeves, Mrs. Thomas Joseph, 670 Wade
Reid, Mrs. William Loomer, 3130 Willowood Dr.
Reimers, Mrs. Arthur Francis, 565 Twenty-Second
Richman, Mrs. Irving M., 3125 N. Willowood Dr.
Rohert, Mrs. W. Pierre, 3050 Rohinhood Lane
Ross, Mrs. Oliver Harold, 3409 Tenth, Port Arthur
Semons, Mrs. Robert J., 207 Twenty-Fourth, Nederland
Serafino, Mrs. L. C., Lucas Dr.
Shaddix, Mrs. Arthur C., 1186 Broadway
Shorkey, Mrs. Richard L., 3340 Redwood Dr.
Simpson, Mrs. Rufus King, 2450 Louisiana
Skarke, Mrs. E. A., 2363 Calder Ave.
Sloan, Mrs. John Walter, 3425 Central Ave., Port Arthur
Smith, Mrs. Denton W., 3065 Minglewood Dr.
Smith, Mrs. John Terry, 2090 South
Smith, Mrs. William A., Caldwood
Solis, Mrs. G. R., 2310 Rosedale, Port Arthur
Starr, Mrs. Harry, 805 Fifth
Stephenson, Mrs. George Bruce, 1355 Thomas Rd.
Stevens, Mrs. Robert Bruce, Calder Pl.
Stoeltje, Mrs. Joe, 2700 Forrest
Suehs, Mrs. M. E., Jr., 2245 Hazel
Sutton, Mrs. Fred W., 2634 North
Sykes, Mrs. Walter P., 2104 Pecos Blvd.
Tew, Mrs. Alton H., 3275 Redwood Lane
Thompson, Mrs. James D., 3007 Fortieth, Port Arthur
Thornton, Mrs. William Rosser, 909 MacArthur, Port Neches
Todd, Mrs. Charles Hugh, Jr., 2495 Louisiana
Toomin, Mrs. Leonard A., 2565 Harrison
Torhett, Mrs. John Walter, 1450 Lucas Dr.
Tritico, Mrs. Joseph J., 4510 Evergreen, Port Arthur
Tyndall, Mrs. Thomas Matthews, 2380 Long
Vaughan, Mrs. B. H., 2121 Lakeshore Dr., Port Arthur
Walker, Mrs. Taylor C., 1010 Twenty-Third
Wallace, Mrs. Lorings Scott, 1105 Twenty-Second
Wallace, Mrs. William G., 2572 McFaddin
Walters, Mrs. Felix A., 1405 Nederland Ave., Nederland
Weisbach, Mrs. Philip T., 2361 Louisiana
Weiss, Mrs. Morris, 2875 Lakeview Circle
White, Mrs. Clarence M., 1865 Thomas Rd.
White, Mrs. J. Milton, Sr., 4525 Sunken Ct., Port Arthur
White, Mrs. John M., Jr., 3010 Las Palmas, Port Arthur
Wier, Mrs. Stuart T., 2235 Ashley
Williams, Mrs. Charles Laval, 1776 East Dr.
Williams, Mrs. Ford G., 2006 Hazel
Williams, Mrs. Lewis McLaurine, 3155 S. Willowood Lane
Williams, Mrs. Stewart McGehee, 3740 Holland Dr.
Williford, Mrs. H. B., 2565 Hazel
Willoughby, Mrs. Russell C., 4611 Springdale, Port Arthur
Wilson, Mrs. I. Gordon, 2369 Central Dr.
Woodward, Mrs. John Franklin, Jr., 1450 Thomas Rd.
Young, Mrs. I. T., 3748 Procter, Port Arthur

*Address is Beaumont unless otherwise stated.

LIBERTY-CHAMBERS COUNTIES AUXILIARY

Anchel, Mrs. Melvin, Cleveland
Bellamy, Mrs. Richard Claude, Box 287, Liberty
Bevil, Mrs. Jack, Hull
Castle, Mrs. Charles William, Box 309, Liberty
>Clements, Mrs. Richard Owen, 715 Main, Liberty
Delaney, Mrs. Alhert Lindsey, Box 309, Liberty
Fahring, Mrs. George H., Anahuac
Fahring, Mrs. Thomas Lloyd, Anahuac
Griffin, Mrs. Frank Samuel, 2314 Cos, Liberty
Harris, Mrs. Orion Wendell, 2309 Centennial, Liberty
Richter, Mrs. Earnest Roland, Dayton
Schulz, Mrs. Donald Paul, Box 309, Liberty
Shearer, Mrs. A. R., Mt. Belvieu
Wilson, Mrs. Reginald, Dayton

NACOGDOCHES COUNTY AUXILIARY*

Allen, Mrs. James I., 7405 Castle Dr., Biggs AFB, Texas
Allen, Mrs. Walter B., 1004 Jack Lock
Beall, Mrs. J. Frank, 2709 Raguet
Blackwell, Mrs. T. J., 317 N. Fredonia
Buckele, Mrs. Mathew J., San Augustine
Coussons, Mrs. Charles W., Box 482
Haley, Mrs. C. R., Box 175, San Augustine
McKinney, Mrs. Edgar P., 402 Hospital
Nelson, Mrs. Alhert L., 1115 North
Neuville, Mrs. Carroll F., Box 907

*Address is Nacogdoches unless otherwise stated.

AUXILIARY MEMBERS, 1954—*continued*

Pennington, Mrs. T. Jack, Jr., 820 Mound
Pennington, Mrs. T. Jack, Sr., 1422 North
Rogers, Mrs. Eugene S., 129 Pine
Taylor, Mrs. James G., Jr., 105 Blount
Tucker, Mrs. Henry, 310 Zeno
>Tucker, Mrs. Stephen B., 1401 Mound

ORANGE COUNTY AUXILIARY*

Bennett, Mrs. David, 2008 Knotty Pine
Covington, Mrs. Charles M., 1711 Hart
Eastman, Mrs. George L., Jr., 11 Circle Q
Gaspar, Mrs. Geza, 304 Seventh
Ingram, Mrs. Robert A., 1004 Clairmont Dr.
Kent, Mrs. Edward H., 1209 Orange Ave.
Minkus, Mrs. Robert F., No. 5 Circle Q Roselawn
Moffitt, Mrs. O. Peyton, 1507 Chapman
Pearce, Mrs. H. Wynne, 812 Cypress
Peters, Mrs. Leo J., Jr., 1212 Seventeenth
Pretz, Mrs. E. C., 229 E. Farragut
Schofield, Mrs. Elmer C., 2010 Knotty Pine
Seastrunk, Mrs. Oliver C., 1029 Clairmont Dr.
Shaddock, Mrs. Carroll B., 702 Cherry
>Siddon, Mrs. William H., 6 Sunset Circle B
Swickard, Mrs. George Y., 712 Park Ave.
Walsh, Mrs. John K., 711 Pine
Watson, Mrs. Victor D., 3 Circle S
Williams, Mrs. Howard C., 2109 Third
Woolley, Mrs. Talmadge O., 511 Seventh

SHELBY-SAN AUGUSTINE COUNTIES AUXILIARY

Hurst, Mrs. T. L., Center
Oates, Mrs. L. S., Center
>Warren, Mrs. Spencer, Center
Warren, Mrs. Walter M., Center
Windham, Mrs. Jack H., Shelbyville
Windham, Mrs. W. C., Center

ELEVENTH DISTRICT

Mrs. C. H. Stripling
Jacksonville
Council Woman

ANDERSON-HOUSTON-LEON COUNTIES AUXILIARY

Bell, Mrs. R. H., 408 E. Neches, Palestine
Bentley, Mrs. Bascom W., 404 S. Royal, Palestine
Brown, Mrs. A. B., Jr., Crockett
Darsey, Mrs. Edward, Crockett
Dean, Mrs. John L., Jr., Crockett
Felder, Mrs. Fred E., 810 E. Neches, Palestine
Goolsby, Mrs. C. B., 201 Gordon, Crockett
>Hunter, Mrs. R. H., 203 Redbud, Palestine
Hunter, Mrs. R. Q., 909 Hunter, Palestine
Joyce, Mrs. C. D., Jr., 1012 Highland Dr., Palestine
Kay, Mrs. R. H., 1001 Swanson, Palestine
Murphy, Mrs. Joseph G., Elkhart Hwy., Palestine
Murray, Mrs. C. O., Crockett Clinic, Crockett
Powell, Mrs. E. P., Centerville
Stokes, Mrs. Paul B., 922 Houston, Crockett

CHEROKEE COUNTY AUXILIARY†

Berhns, Mrs. C. L., Box 318, Rusk
Bilbro, Mrs. G. W., 711 El Paso
Boyd, Mrs. J. T., Edgewood Dr.
Bregham, Mrs. Floyd H., 606 N. Main, Rusk
Cobble, Mrs. T. H., Rusk
Crawford, Mrs. Joe S., Jacksonville
Davenport, Mrs. Harbert, Odom St.
Etta, Mrs. Roscoe, Alto
Gabbert, Mrs. W. E., Rusk
Gray, Mrs. M. L., Fort Worth St.
Hilliard, Mrs. George, 622 John
Kuykendall, Mrs. M. J., Rusk
Rives, Mrs. Hugh F., 1016 Fort Worth
Rucker, Mrs. Collier, 1117 Avalon Dr.
Stolzar, Mrs. Irwin, Avalon Dr.
Stripling, Mrs. C. H., 402 El Paso
Townsend, Mrs. Walter, Rusk
Travis, Mrs. J. M., 531 S. Ragsdale
Travis, Mrs. Lewie, 616 El Paso
>Travis, Mrs. R. T., 637 San Antonio
Verheyden, Mrs. Floyd, 813 John

FREESTONE COUNTY AUXILIARY

Bonner, Mrs. L. L., Fairfield
>Cox, Mrs. Jack R., Teague
Gage, Mrs. Maurice, Teague

*Address is Orange unless otherwise stated.
†Address is Jacksonville unless otherwise stated.

HENDERSON COUNTY AUXILIARY*

Buie, Mrs. Ralph R., 117 Parsons Parkway
Cockerell, Mrs. Lonnie, 309 W. Corsicana
Easterling, Mrs. A. H., 611 E. Tyler
Geddie, Mrs. Nolan D., Jr., Rodriquez Army Hospital, APO 851, New York, N.Y.
Geddie, Mrs. Nolan D., Sr., 708 S. Palestine
Gibson, Mrs. John W., Thunderbird Dr.
Henderson, Mrs. Roy E., 506 E. College
>Hodge, Mrs. Robert H., 710 E. Tyler
Price, Mrs. Don, 615 E. Corsicana
Wilcox, Mrs. Melvin R., Jr., Mill Run Rd.

RUSK-PANOLA COUNTIES AUXILIARY†

Baker, Mrs. C. D., Carthage
Boswell, Mrs. W. E., Colonial Dr.
Braswell, Mrs. M. T., 410 S. High
Deason, Mrs. Loyd, 1010 Ruby
Gerardy, Mrs. Carl W., Carthage
Hilbun, Mrs. Lynn, 105 Oak Lawn
Hooker, Mrs. Lynn, Carthage
Johnson, Mrs. Glenn, Carthage
Kennamer, Mrs. Harold G., Overton
Perlman, Mrs. Samuel, Carthage
>Prince, Mrs. K. C., Carthage
Ross, Mrs. J. E., 307 N. Marshall
Shipp, Mrs. L. M., 116 S. Marshall
Smith, Mrs. W. C., Carthage
Suehs, Mrs. H. A., 309 College
Suehs, Mrs. Paul, 412 E. Main
Wolfe, Mrs. Alfred S., 210 Evenside

SMITH COUNTY AUXILIARY‡

Alexander, Mrs. Ernest, 313 W. Fourth
Allen, Mrs. George, 919 E. Dulse
Anderson, Mrs. Carter, 519 Victory Dr.
Bailes, Mrs. Porter, 2809 Bain Pl.
Bailey, Mrs. William, 405 Mockingbird Lane
Baldwin, Mrs. R. E. G., 1100 Camellia Dr.
Bankhead, Mrs. A. J., 1208 S. Sneed
Baskin, Mrs. Grady, 2611 Henson
Betts, Mrs. Floyd, 1414 Belmont Dr.
Birdwell, Mrs. J. Weldon, 2519 New Copeland Rd.
Bradford, Mrs. S. W., 2015 S. College
Brelsford, Mrs. Gates H., 1012 W. Eighth
Brown, Mrs. George, 2711 Old Bullard Rd.
Brown, Mrs. Glynne, 223 E. Second
Brown, Mrs. Irving, 1221 S. Chilton
Bryant, Mrs. Howard, 2212 S. Chilton
Burch, Mrs. William, 1018 Watkins
>Caldwell, Mrs. Elbert H., Highland Park Acres
Calley, Mrs. C. R., 102 E. Fourth
Cameron, Mrs. Harold, 2818 Pounds
Clawater, Mrs. Earl, Jr., 1901 Henderson Dr.
Clawater, Mrs. Earl, Sr., 1517 S. Chilton
Daniels, Mrs. Hubert B., Jr., 122 Rowland Pl.
DeCharles, Mrs. P. M., 1126 E. Watkins
Faber, Mrs. Edwin, 421 Rose Circle
Faust, Mrs. J. J., 205 E. Second
Ferrel, Mrs. B., Bullard
Freiberg, Mrs. Milton, 705 Hudson
Goldfeder, Mrs. Jesse, 1805 S. Chilton
Jarmon, Mrs. Thomas, 2520 Old Bullard Rd.
Jones, Mrs. Joe C., 1315 W. Sixth
Lamberth, Mrs. Ivey, 1015 W. Eighth
Lauck, Mrs. Robert, 805 Wilma
Lee, Mrs. Madison, 2005 Overhill Dr.
Marshall, Mrs. Robert L., 2224 Old Bullard Rd.
McCulloh, Mrs. Albert, 728 Barbara
McDonald, Mrs. C. C., Highland Park Acres
Moore, Mrs. Masters H., 1307 S. Chilton
Mullowney, Mrs. J. P., 2745 Curtis Dr.
Neill, Mrs. Lawrence, 1904 Sunnybrook
Neill, Mrs. Lex, 1112 S. Broadway
Page, Mrs. Roy L., 1900 S. Chilton
Pope, Mrs. Irvin, 423 Vine
Rhine, Mrs. Leland, 2112 Jarrel
Rice, Mrs. E. D., 925 S. Chilton
Roosth, Mrs. Harold, 2014 Hilltop Dr.
Roosth, Mrs. Wiley, 2739 S. Chilton
Ross, Mrs. William R., 409 Lindsey Lane
Rowe, Mrs. W. E., 401 Victory Dr.
Selman, Mrs. Joseph, 1114 S. Wall
Shirley, Mrs. Clayton, 2418 Old Bullard Rd.
Taylor, Mrs. Phillip W., 2738 New Copeland Rd.
Thompson, Mrs. Cone, Jr., 907 S. Bois d'Arc
Vaughn, Mrs. Jim, 508 S. Vine
Wilcox, Mrs. Leland, 223 Ford
Willingham, Mrs. C. E., 319 W. Second
Wilson, Mrs. Ben H., 810 Vine Hgts.
Windham, Mrs. L. B., Ridge Rd.
Woldert, Mrs. Albert, 608 W. Woldert
Young, Mrs. C. B., 1104 E. Dulse

*Address is Athens unless otherwise stated.
†Address is Henderson unless otherwise stated.
‡Address is Tyler unless otherwise stated.

MEMBERS-AT-LARGE, ELEVENTH DISTRICT

Moore, Mrs. Roscoe, Mineola

TWELFTH DISTRICT

Mrs. G. V. Brindley, Jr.
Temple
Council Woman

BELL COUNTY AUXILIARY*

Alsup, Mrs. A. H., 1216 N. 3rd
Althaus, Mrs. John W., Veterans Hospital
Anderson, Mrs. H. B., 1810 N. 15th
Arnold, Mrs. W. O., 309 W. Nugent
Bartels, Mrs. R. N., 617 N. 5th
Bassel, Mrs. Paul M., Hwy. 36
Bradfield, Mrs. E. O., 408 W. Shell
Brindley, Mrs. G. V., 600 W. Garfield
Brindley, Mrs. G. V., Jr., 720 W. Nugent
Brindley, Mrs. Hanes H., 1312 N. 7th
Broders, Mrs. A. C., Jr., 1206 N. 4th
Broders, Mrs. A. C., Sr., 1105 N. 6th
Brown, Mrs. J. B., 504 W. Park
Burow, Mrs. F. Paul, Killeen
Carabasi, Mrs. Robert J., 709 W. Houston
Chernosky, Mrs. W. A., 517 N. 9th
Chisolm, Mrs. J. T., 1503 S. 9th
Christian, Mrs. J. J., 410 King Circle
Cochran, Mrs. L. M., Veterans Hospital
Coleman, Mrs. J. A., Jr., 1502 S. 5th
Cox, Mrs. C. H., Jr., 1504 N. 5th
Curtis, Mrs. Raleigh R., 1919 N. 7th
DeBord, Mrs. Bert, Jr., 1116 N. 9th
Dysart, Mrs. D. N., 1512 E. Avenue B
Eanes, Mrs. David F., 602 W. Nugent
Fowler, Mrs. Joe A., Killeen
Galindo, Mrs. D. L., 302 S. 22nd
Gillespie, Mrs. C. H., 304 King Circle
Gober, Mrs. Olin B., 630 W. Nugent
Greenlee, Mrs. Ralph G., Old Pendleton Rd.
Greenwood, Mrs. J. H., 517 W. Shell
Haines, Mrs. Richard D., 612 N. 7th
Hammond, Mrs. Fred M., 509 W. Thompson
Harlan, Mrs. R. K., 1207 N. 3rd
Hightower, Mrs. N. C., 2011 N. 15th
Howell, Mrs. F. W., 1307 N. 5th
Ibarra, Mrs. J. D., Jr., 1319 N. 1st
Johnson, Mrs. Joel H., 720 N. 11th
Keil, Mrs. Ernest W., 107 E. King
Kilman Mrs. J. R., 1405 N. 5th
Long, Mrs. W. B., Belton
Longmire, Mrs. V. M., 1309 N. 9th
McCelvey, Mrs. J. S., 804 N. 11th
McKenney, Mrs. John F., 411 E. Lamar
McMillan, Mrs. C. D., 1815 S. 15th
Moon, Mrs. A. E., 716 N. 13th
Moore, Mrs. J. C., 1111 N. 1st
Murray, Mrs. Robert A., 1110 N. 8th
Phillips, Mrs. Charles, 1304 N. 3rd
Pittman, Mrs. J. W., Belton
Pollock, Mrs. L. W., 618 N. 13th
Powell, Mrs. W. N., 1219 N. 9th
Rodarte, Mrs. J. G., 1011 N. 13th
Schubert, Mrs. H. A., Veterans Hospital
Scott, Mrs. A. C., Jr., 618 N. 9th
Seedorf, Mrs. E. E., 57th Street Rd.
Sewell, Mrs. J. G., Belton
Sherwood, Mrs. M. W., 605 N. 9th
Shibler, Mrs. S. W., 711 N. 11th
Simmon, Mrs. Wincent J., 400 King Circle
Sommer, Mrs. Arno W., 410 Lamar Dr.
Speed, Mrs. Terrell, 702 W. Thompson
Stevenson, Mrs. C. A., 1107 N. 4th
Stevenson, Mrs. R. A., 1315 N. 7th
Stinson, Mrs. J. C., 805 N. 8th
Talley, Mrs. J. Bartow, 1320 N. 9th
Talley, Mrs. L. R., 1203 N. 3rd
Veirs, Mrs. E. R., 601 W. King
Walker Mrs. J. C., 1509 N. 13th
Ward, Mrs. W. P., 1117 N. 8th
Weinblatt, Mrs. Jack S., 1620 N. 11th
>White, Mrs. Raleigh R., 619 N. 9th
Wilson, Mrs. James D., 1215 N. 3rd
Winston, Mrs. John R., 304 W. French
Wolf, Mrs. A. Ford, 318 N. Main
Woodson, Mrs. W. B., RFD #1

BOSQUE COUNTY AUXILIARY

Archer, Mrs. J. T., Jr., Meridian
Blankenship, Mrs. W. W., Mosheim
Dudney, Mrs. N. E., Clifton
Goodall, Mrs. C. L., Clifton
Goodall, Mrs. V. D., Clifton
Holder, Mrs. W. T., Clifton
Holt, Mrs. R. D., Meridian
Long, Mrs. A. M., Valley Mills
Pike, Mrs. A. N., Iredell
>Witcher, Mrs. S. L., Clifton

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AUXILIARY MEMBERS, 1954—*continued*

BRAZOS-ROBERTSON COUNTIES AUXILIARY*

Andres, Mrs. Dwight W., Woodlawn Estates, College Station
Benbow, Mrs. Robert H., 1126 E. 24th
Cole, Mrs. Charles M., 507 E. 24th
Fleming, Mrs. Joseph P., Hearne
Grant, Mrs. Richard B., 509 E. 30th
Guynes, Mrs. H. C., Hearne
Hughes, Mrs. Louis B., Hearne
Marsh, Mrs. John Emory, 150 Jones, College Station
Marsh, Mrs. John Emory, Jr., 705 E. 31st
Martin, Mrs. Jay W., Bryan
McGill, Mrs. A. G., 610 E. 32nd
Richardson, Mrs. S. C., 811 E. 29th
Sanders, Mrs. J. G., Bremond
Searcy, Mrs. Thomas A., Hearne
Sharp, Mrs. John E., Hearne
>Walton, Mrs. Thomas O., Jr., Munson Dr., College Station
Walton, Mrs. Thomas Turner, 1711 S. Highway 6
Wilkerson, Mrs. Lonnie Otto, 302 E. 27th

CORYELL COUNTY AUXILIARY

Brown, Mrs. John Thomas, Gatesville
Goodall Mrs. Edwin, Memphis, Tenn.
Jones, Mrs. Kermit, Gatesville
Lowrey, Mrs. Elworth, Gatesville
>Lowrey, Mrs. Wendell, Gatesville

ERATH-HOOD-SOMERVELL COUNTIES AUXILIARY

>Bryan, Mrs. Tom F., Dublin
Cedars, Mrs. Wacil, Stephenville
Hearne, Mrs. C. R., Stephenville
Jordan, Mrs. Carl, Dublin
Lancaster, Mrs. Gus, Granbury
Morron, Mrs. C. R., Stephenville
Pate, Mrs. Joe, Dublin
Redwine, Mrs. H. P., Dublin
Terrell, Mrs J. C., Stephenville
Terrell, Mrs. Vance, Stephenville

FALLS COUNTY AUXILIARY†

Barnett, Mrs. J. H., 406 Agnes
Barnett, Mrs. John B., 403 Agnes
Bennett, Mrs. Alfred C., 828 Southland
Brown, Mrs. J. Mitchell, 208 Oakland Pl.
Buie, Mrs. Neil D., Jr., 118 Maryland
Buie, Mrs. Neil D., Sr., 407 Capps
Bussell, Mrs. James S., 437 Collier Lane
Cornwell, Mrs. Charles H., 204 Lake
Davison, Mrs. Milton A., 432 Agnes
Gallagher, Mrs. Joseph C., 204 Shenandoah
Giles, Mrs. Roy G., 417 Houghton
Glass, Mrs. Tom G., 727 Watson
Hampshire, Mrs. G. H., 215 Winter
Hohf, Mrs. Jerome C., 113 E. Southland
Hutchings, Mrs. E. P., 800 Southland
Hutchins, Mrs. Albert M., 437 Capps
McKinley, Mrs. Frank, Jr., 417 Norwood
>Miller, Mrs. C. R., Ward St.
Reese, Mrs. W L., E. Live Oak
Smith, Mrs. Howard O., 904 Southland
Smith, Mrs. Walter S., 416 Agnes
Swetland, Mrs. D R., 829 Southland
Torbett, Mrs. J. W., Sr., 402 Houghton
Torbett, Mrs. Oscar, 609 Foster

HAMILTON COUNTY AUXILIARY

>Hafer, Mrs. W. F., Hico
Kooken, Mrs. Robert A., Hamilton

HILL COUNTY AUXILIARY

Buie, Mrs. J. Morgan, Whitney
>Cason, Mrs. Dick, Hillsboro
Garrett, Mrs. Charles A., Hillsboro
Shirey, Mrs. Robert, Hillsboro
Smith, Mrs. Nellins C., Hillsboro

JOHNSON COUNTY AUXILIARY‡

Barker, Mrs. Gates R., 102 Bellevue
Clark, Mrs. Elmo L., 104 Adams
Dennis, Mrs. Mills, 105 Sunset
English, Mrs. Robert O., Glen Rose
Hamilton, Mrs. Con D., 304 Bellevue
Honea, Mrs. T. C., 206 Bellevue
>Jowell, Mrs. Charles C., Box 36
Kimbro, Mrs. Robert W., 909 Prairie
Knox, Mrs. Marshall T., 201 Bellevue
Little, Mrs. John G., 606 W. Chambers
Peters, Mrs. Joe F., 109 Scurlock
Pickens, Mrs. J. Wendell, 302 Forest
Rice, Mrs. John S., Loma Alto Pl.
Shiflett, Mrs. R. Mason, Hilltop Dr.
Smyth, Mrs. Olin T., 11 Hill Terrace Pl.
Turner, Mrs. Ben H., 201 Featherston
Whitehouse, Mrs. William R., 903 Forest
Wright, Mrs. Glenn R., 1005 Forest
Yater, Mrs. Tolbert F., 308 Sunset

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†Address is Marlin unless otherwise stated.
‡Address is Cleburne unless otherwise stated.

McLENNAN COUNTY AUXILIARY*

Aide, Miss Mathilda, 802 LaClede Ave., Bellmead
Anderson, Mrs. Gilbert I., 1509 Alexander
Anspach, Mrs. Harold M., Rt. 10, Box 76
Atkins, Mrs. Neal M., 3232 N. 29th
Avent, Mrs. Woodrow M., 2609 Old Oaks Dr.
Aynesworth, Mrs. Horace T., 3000 Cumberland
Aynesworth, Mrs. M. Brian, 2816 Lindsey Hollow Rd.
Barnes, Mrs. Maurice C., Robin Rd.
Baskin, Mrs. Roy H., 3925 Cobbs Dr.
Bellegie, Mrs Nicholas J., 702 Professional Bldg.
Berry, Mrs. George W., 905 N. 44th
Bradford, Mrs. J. C., Mart
Brooks, Mrs. Cleveland H., 2300 Bosque
Brown, Mrs. William W., Arroyo Rd.
Bryant, Mrs. George C., 2924 Trice
Cannon, Mrs. 1. F., Mart
Colgin, Mrs. James H., 3808 Morrow
Colgin, Mrs. Merchant W., 2621 Austin
Collins, Mrs. Lawrence D., 120 N. 17th
Connally, Mrs. H. Frank, 2401 Cedar Ridge Rd.
Dudgeon, Mrs. Howard R., Jr., 600 Fitzpatrick
>Dunlap, Mrs. John C., 3925 Maple
Even, Mrs. Martin M., 3917 Morrow
Fine, Mrs. Eldon B., 3200 Cumberland
Ford, Mrs. Walter L., Veterans Hospital
Forsythe, Mrs. John R., Brookview Apts.
Gandy, Mrs. William M., 3000 Mitchell
Garrett, Mrs. James M., 1408 Austin
Gassler, Mrs. Robert K., 2901 Trice
Germany, Mrs. H. J., 2324 Bosque
Gidney, Mrs. William H., West
Goodman, Mrs. Aubrey L., 3305 Castle
Granger, Mrs. Wayne H., 409 N. 41st
Hanks, Mrs. Robert J., 3222 Cumberland
Hipps, Mrs. Herbert E., 1604 Columbus
Hoehn, Mrs. F. William, 3722 Chateau
Husbands, Mrs. Tom L., 2607 Lake Air Dr.
Jaworski, Mrs. Hannibal, Roosevelt Hotel
Kee, Mrs. John L., 1819 Morrow
King, Mrs. Walter B., Jr., 2509 N. 31st
Kirby, Mrs. F. F., 2801 Sanger
Kleiman, Mrs. R. B., Brookview Apts.
Magid, Mrs. Moreton A., 39th and Penn
Manske, Mrs. Arnold O., 121 Castle
McMahan, Mrs. George T., Veterans Hospital
Mitchell, Mrs. Holland C., 3501 Brookview Dr.
Murphy, Mrs. Paul C., 3100 Maple
Oliver, Mrs. Tom M., 1825 Colonial
Reese, Mrs. W. L., 1616 N. 5th
Richey, Mrs. Harvey M., 2425 Cedar Ridge Rd.
Roche, Mrs. Buell F., 3024 Live Oak
Roddy, Mrs. Louis H., Brookview Apts.
Ross, Mrs. Philip H., 3321 N. 32nd
Schwartze, Mrs. Erich W., 737 Grice
Scruggs, Mrs. James H., Jr., 4112 Grim
Shellenberger, Mrs. Charles G., 2501 Cedar Ridge Rd.
Shipp, Mrs. John R., 3120 Trice
Siler, Mrs. Ivy Wood, 2004 Columbus
Smith, Mrs. Ed, 1226 Herring
Spark, Mrs. Milton, 3805 Herwol
Talley, Mrs. John E., 2700 Homan
Traylor, Mrs. Clayton J., 2123 Colcord
Trice, Mrs. W. G., 414 N. 23rd
Trippet, Mrs. Horace H., 3723 Chateau
Warren, Mrs. Daniel D., 1322 Washington
Weekly, Mrs. F. Clay, 2624 Old Oaks Dr.
Wells, Mrs. Howard W., 3329 Stewart Dr.
Wilson, Mrs. Loyal K., 1303 Colcord
Woodward, Mrs. Joseph W., 805 N. 44th
Woolsey, Mrs. H. U., 400 Rice
Woolsey, Mrs. William J., Lake Waco

*Address is Waco unless otherwise stated.

MILAM COUNTY AUXILIARY

Barkley, Mrs. Thomas Sessions, 309 E. Cameron, Rockdale
Crump, Mrs. Thomas Eugene, 402 N. Jefferson, Cameron
Denson, Mrs. Thomas Leland, 306 E. 11th, Cameron
Green, Mrs. Travis Cochran, 730 W. Cameron, Rockdale
Hamilton, Mrs. Lawrence E., Box 326, Rogers
Howard, Mrs. Charles Harris, Jr., 104 W. 3rd, Cameron
Newton, Mrs. William Roland, Jr., 1006 E. 15th, Cameron
Read, Mrs. Edwin Preston, 104 W. 3rd, Cameron
>Richards, Mrs. John Terrence, 345 W. Bell, Rockdale
Shapiro, Mrs. David, 1005 E. 15th, Cameron
Slaughter, Mrs. Manuel Owen, Hunter St., Rockdale
Swift, Mrs. Clifford Gibson, 1402 N. Davis, Cameron
Woods, Mrs. Herbert Spencer, Jr., 724 W. Bell, Rockdale
Yeary, Mrs. Robert Allen, 1402 Highland Dr., Rockdale

NAVARRO COUNTY AUXILIARY*

Barnebee, Mrs. James H., 510 N. 25th
Barron, Mrs. Stanley Jake, 1221 W. 2nd Ave.
Bone, Mrs. Robert D., 1225 Bowie Dr.
Bowmer, Mrs. Otho C., 715 W. 1st Ave.
>Burnett, Mrs. Samuel H., 2919 W. 2nd Ave., Rt. 1
Carter, Mrs. W. W., 328 S. 31st
David, Mrs. J. Wilson, 1619 W. Park Ave.
Gary, Mrs. Charles L., 405 N. 38th
Gibson Mrs. Louis E., 2009 W. Collin
Griffin, Mrs. Ben H., Frost
Grizzaffi, Mrs. Anthony I., Frost
Hamill, Mrs. Daniel B., 1700 Elmwood
Kelton, Mrs. Leslie E., Jr., Cowhead Rd.
Logsdon, Mrs. William K., 608 Mills Pl.
Mertz, Mrs. Robert D., 1912 W. Collin
Miller, Mrs. Dubart, 2311 W. 9th Ave.
Miller, Mrs. Will, 613 Mills Pl.
Mitchell, Mrs. Paul H., 2921 W. 2nd Ave., Rt. 1
Newton, Mrs. Earl H., 1723 W. 3rd Ave.
Rosen, Mrs. Bernard, 1205 Columbia Circle
Sanders, Mrs. Gurley H., Kerens
Shell, Mrs. William T., Jr., 2411 Park Row
Sneed, Mrs. William R., 619 N. 25th
White, Mrs. Robert N., Blooming Grove
Wills, Mrs. T. Opie, 602 Mills Pl.

MEMBERS-AT-LARGE, TWELFTH DISTRICT

Carrington, Mrs. W. L., Box 108, Mexia

THIRTEENTH DISTRICT

Mrs. W. Frank Armstrong
Fort Worth
Council Woman

BAYLOR-KNOX-HASKELL COUNTIES AUXILIARY

Balch, Mrs. E. H., Seymour
Edwards, Mrs. T. S., Knox City
Eiland, Mrs. D. C., Munday
Foy, Mrs. J. W., Seymour
Frizzell, Mrs. T. P., Knox City
Randal, Mrs. C. M., Jr., Seymour
Taylor, Mrs. W. M., Goree
Williams, Mrs. Temple W., Haskell
Wilson, Mrs. Roy E., Seymour

CLAY-MONTAGUE-WISE COUNTIES AUXILIARY

Bryant, Mrs. David, Bridgeport
Crumpler, Mrs. Hulen, Bowie
Crumpler, Mrs. Prentice, Bowie
Harris, Mrs. E. P., Bowie
Inabnitt, Mrs. W. T., Decatur
Major, Mrs. David, Nacona
Major, Mrs. John, Nacona
Rogers, Mrs. T. J., Decatur
Shilling, Mrs. Harold, Bridgeport
Valcik, Mrs. John, Decatur
Wright, Mrs. E. W., Bowie

EASTLAND-CALLAHAN-STEPHENS-SHACKELFORD-THROCKMORTON COUNTIES AUXILIARY

Addy, Mrs. E. E., Jr., Cisco
Barrow, Mrs. W. B., Eastland
Brazda, Mrs. A. W., Ranger
Brogdon, Mrs. Bill, Gorman
Cartwright, Mrs. Hubert H., 1109 E. Walker, Breckenridge
>Ford, Mrs. T. Carroll, 1410 S. Wheeler, Breckenridge
Graham, Mrs. E. L., Graham Bldg., Cisco
Harris, Mrs. Calvin W., 211 N. Austin, Ranger

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AUXILIARY MEMBERS, 1954—*continued*

Holmes, Mrs. Robert Leslie, Jr., 1202 W. Walker, Breckenridge
Jackson, Mrs. T. G., Blockwell Sanitarium, Gorman
Kuykendall, Mrs. P. M., West Texas Clinic, Ranger
Malouf, Mrs. G. M., Ranger
Payne, Mrs. Frank C., 120 E. Williams, Breckenridge
Stuhblefield, Mrs. M. L., Box 1046, Baird
Stuhhlefield, Mrs. R. L., Military Service
Townsend, Mrs. E. R., Exchange Bldg., Eastland
Treadwell, Mrs. M. A., Jr., Eastland
Watkins, Mrs. W. P., Ranger Clinic, Ranger
White, Mrs. J. C., Military Service
Whittington, Mrs. James C., Military Service

PALO PINTO-PARKER-YOUNG-JACK-ARCHER COUNTIES AUXILIARY

Ahney, Mrs. Thomas B., Weatherford
Allen, Mrs. Platt L., Weatherford
Allensworth, Mrs. John C., Mineral Wells
Conner, Mrs. Paul K., Jacksboro
Divine, Mrs. Blaine, Graham
Eidson, Mrs. Jack L., Weatherford
Gowan, Mrs. R. E. L., Graham
Jordan, Mrs. Robbie C., Mineral Wells
McCall, Mrs. James D., Mineral Wells
McCloud, Mrs. Ben L., Jr., Mineral Wells
McCloud, Mrs. Ben L., Sr., Mineral Wells
Merrick, Mrs. John B., Weatherford
Nelson, Mrs. Joe T., Weatherford
>O'Quinn, Mrs. William A., Mineral Wells
Railshack, Mrs. G. D., Jr., Mineral Wells
Roan, Mrs. John L., Weatherford
Rosser, Mrs. V. O., Jr., Graham
Russell, Mrs. Earl M., Weatherford
Smith, Mrs. John E., Weatherford
Spears, Mrs. Jean Wiley, Graham
Whalen, Mrs. Carl H., Weatherford
Williams, Mrs. Charles R., Mineral Wells
Yeager, Mrs. Edward F., Mineral Wells

TARRANT COUNTY AUXILIARY*

Allison, Mrs. Wilmer L., 4503 Norma
Alliston. Mrs. Wiley S., Jr., 3559 Dorothy Lane, S.
Anderson, Mrs. Herman W., Jr., 3601 Norfolk
Anderson, Mrs. James V., 3606 Shelhy Dr.
Andujar, Mrs. John J., 2951 Benhrook Blvd.
Anthony, Mrs. Ernest E., Jr., Rt. 7, Box 156
Anthony, Mrs. Walter P., Jr., 321 N. Bailey
Antweil, Mrs. Abraham, 1919 Forest Park Blvd.
Archer, Mrs. Maurice C., 3721 W. Biddison
Armstrong, Mrs. William Frank, 2432 Medford Ct., E.
Ashworth, Mrs. Charles T., 2409 Colonial Parkway
Aurin, Mrs. Fred B., 4160 Anita
Auringer, Mrs. Arthur J., Fidder Rd., Arlington
Austin, Mrs. Carl M., 2601 Highview Terrace
Avery, Mrs. Jack W., 516 Cluh Oaks Dr.
Bailey, Mrs. Noel R., 345 N. Roaring Springs Rd
Baker, Mrs. Rohert G., 5824 El Campo Terrace
Ball, Mrs. Bert C., 6128 Curzon
Ball, Mts. Charles E., 4208 Lone Oak Dr.
Barher, Mrs. Morest C., 2426 Race
Barcus, Mrs. James R., 2020 Hillcrest
Barcus, Mrs. William S., 2306 Park Pl.
Barker, Mrs. Rohert C., 1414 Mistletoe Dr.
Barnes, Mrs. C. Keith, 2917 Benbrook Blvd.
Barrier, Mrs. Charles W., 6467 Hilldale Dr.
Beall, Mrs. Frank C., 4801 Bryce, Apt. A
Beard, Mrs. Bruce H., 2140 Warner Rd.
Beasley, Mrs. C. Harold (Dr. Grace), 3226 Odessa
Beaton, Mrs. Hugh, 2319 Colonial Parkway
Beavers. Mrs. George Herhert, 46 Valley Ridge Rd.
Begley, Mrs. Grant F., 2016 Jenson Rd.
Bennett, Mrs. Jerrell, 3501 Bellaire Dr., S.
Benton, Mrs. James H., 2224 W. Hawthorne
Bihhy, Mrs. Douglas E., 3812 Haywood Dr.
Bickel, Mrs. Rohert D., 6321 Kenwick Dr.
Black, Mrs. Thomas W., 2600 Ryan Place Dr.
Blaha, Mrs. Frank, 3905 Trail Lake Dr.
Bond, Mrs. Tom B., 554 Summit Ave.
Bontley, Mrs. Paul T., 112 Oriole Dr., Arlington
Boone, Mrs. James B., 1912 Tremont
Booth, Mrs. Jack H., 6463 Greenway Rd.
Bowden, Mrs. Andy, Jr., 4408 Norwich Dr.
Boyd, Mrs. Frank D., 104 Penn
Bradshaw, Mrs. Wilher V., Jr., 6490 Camp Bowie Blvd.
Braselton, Mrs. Charles W., Jr., 3642 S. Hills
Brasher, Mrs. Ray V., 112 Williamshurg Lane
Brentlinger, Mrs. Rohert, 415 S. West, Arlington
Brewster, Mrs. Clarence Burke, 3844 S. Hills Circle
Brooks, Mrs. James W., 4600 Nolan
Brown, Mrs. Charles H., 6317 Greenway Rd.
Brown, Mrs. William Porter, Rt. 6, Box 157
Brownfield, Mrs. Jack, 3212 Odessa
Burcey, Mrs. Leroy, 6051 Valley View Dr.
Bussey, Mrs. Thomas B., 1600 Oakhurst Scenic Dr.
Butler, Mrs. Allan W., Jr., 3845 Shelby Dr.
Bynum, Mrs. Frank L., 3512 Rashti Ct.
Campbell, Mrs. James Franklin, 2017 Windsor Pl.
Carpenter, Mrs. Nathan C., 3612 Potomac
Chambers, Mrs. James O., 400 Hazelwood Dr.
Childs, Mrs. Tilden L., Jr , 2205 Windsor Pl.
Chorn, Mrs. Etheredge H., 2435 Stadium Dr.
Church, Mrs. John M., 2531 Boyd
Clayton, Mrs. Charles F., Rt. 8, Box 119
Cochran, Mrs. John R., 3824 Winslow Dr.
Coffey, Mrs. Alden, Weatherford Hwy.
Cohen, Mrs Frank, 3644 Norfolk Dr.
Coleman, Mrs. Thomas J., 4108 Trail Lake Dr.
Collier, Mrs. Julius W., 2536½ Luhbock
Compere, Mrs. Dolphus E., 3719 Winslow Dr.
Cook, Mrs. Percy Lee, Mansfield
Covert, Mrs. J. D., 3808 Hilltop Rd.
Crabh, Mrs. McKinley H., 3613 Park Hill Dr.
Cross, Mrs. Thomas J., 2424 Lofton Terrace
Cunningham, Mrs. Ernest, 3620 Biddison
Cyrus, Mrs. Elbert M., Jr., 6209 Kenwick
Daly, Mrs. Jack E., 2200 Huntington Lane
Daly, Mrs. T. J., 4024 Dexter
Daugherty, Mrs. Frank J., 6236 Kenwick
Davenport, Mrs. Emory, 4416 Calmont
Davis, Mrs. Edwin, 1320 Washington
Day, Mrs. Giles W., 1900 Marigold
Deaton, Mrs. Hohart O., 1221 Clara
DeBusk, Mrs. Jack S., 3434 Townsend Dr.
Diamond, Mrs. William D., 6559 Locke
Ditto, Mrs. H. Howard, 2904 Alton Rd.
Doss, Mrs. Alexander K., 2701 Benhrook Blvd.
Doss, Mrs. Doyle J., 3701 S. Washington
Douglass, Mrs. Hal C., 3708 Bellaire Dr., N.
Edwards, Mrs. Walter T., 5101 Malinda Lane
Ellis, Mrs. Joe B., 922 E. Broadus
Enloe, Mrs. George A., 607 Rivercrest Dr.
Eschenhrenner, Mrs. John W., 3605 Shelhy Dr.
Etier, Mrs. Edgar L., 3257 Cockrell
Ezell, Mrs. Edgar, 2114 Warner Rd.
Farley, Mrs. James A., US Naval Air Station, Corpus Christi
Fershtand, Mrs. John B., 2323 Mistletoe Dr.
Fitzwilliam, Mrs. C. Dennis, 6200 Kenwick
Flood, Mrs. William E., 3929 Weyhurn Dr.
Francis, Mrs. Fred W., 2614 Kensington Dr.
Funk, Mrs. Theron H., 2724 Willing
Garnett, Mrs. John W., 3700 Wyndale Ct.
Gilliland, Mrs. Lloyd N., Jr., 3913 Westcliff Rd., S.
Givens, Mrs. J. M., Rt. 3, Box 217-C
Godley, Mrs. Lowie O., 2129 Park Pl.
Goggans, Mrs. Alhert M. (Dr. Diane), 3237 Rogers Rd.
Goldberg, Mrs. Ahraham I., 1937 Forest Park Blvd.
Gooch, Mrs. Frank B., 2541 Waits
Goodman, Mrs. T L., 1933 Forest Park Blvd.
Grammer, Mrs. James H., 408 N. Bailey
Grammer, Mrs. Richard B., 3628 Potomac
Gray, Mrs. Billy N., 2615 Forest Park Blvd.
Griffin, Mrs. Otho P., 3604 Norfolk
Griffith, Mrs. M. A., 2110 Roosevelt
Grogan, Mrs. Oscar R., 3200 Avondale
Grogan, Mrs. Roy L., 3639 Encanto Dr.
Grunow, Mrs. Otto H., 3958 Mt. Vernon
Guerra, Mrs. R. Lopez, 1509 Ellis
Haffke, Mrs. Oscar W., 3632 Biddison
Hall, Mrs. Ewin P., 2233 Hemphill
Hallmark, Mrs. James A., 3843 Winslow Dr.
Halpin, Mrs. Frank W., 3460 Indale Rd.
Hardwick, Mrs. B. Randol, 4800 Winthrop, E.
Hargis, Mrs. Charles P., 3817 W. 4th
Harris, Mrs. Charles H., II, 2208 Mistletoe Ave.
Harris, Mrs. J. Rohert, 3625 Suffolk
Hawker, Mrs. Laverne J., 3709 Windale Ct.
Hawkins, Mrs. Charles P., 853 Northwood
Helhing, Mrs. Hugh V., Rt. 10, Box 663
Hendricks, Mrs. William C., Jr., 3321 Avenue G
Hewatt, Mrs. John W., 2006 Provine
Hicks, Mrs. Charles E., 6109 Milhurn
Hiett, Mrs. Carey, 505 Alta Dr.
Higgins, Mrs. William P., Jr., 3710 Winslow Dr.
Hightower, Mrs. Lovick P., 4001 W. 7th
Holmgren, Mrs. Rohert B., 3600 Country Cluh Circle
Holsapple, Mrs. Cortell K., Jr., 2555 Waits
Hook, Mrs. James H., 2215 Wilshire Blvd.
Horn, Mrs. Will S., 2217 Winton Terrace, W.
Horn, Mrs. Will S., Jr., 5313 Bryce, Apt. B
Howard, Mrs. Rex J., 4208 Pershing
Howard, Mrs. Rex Z., 3125 Wahash
Huffman, Mrs. A. M., 3029 Lipscomb
Hulsey, Mrs. Sim H., 2214 Ward Parkway
Hyde, Mrs. X. R., 232 Pumphrey Dr.
Ingham, Mrs. Mahlon, 4529 Stadium Dr.
Innis, Mrs. E. Renshaw, 3503 Bellaire Dr., N.
Isaacks, Mrs. Hub E., 5815 Merrymount Rd.
Ishell, Mrs. Marney C., 3908 Earl
Jackson, Mrs. Atras E., 3204 University Dr., S.
Jackson, Mrs. Holland T., 211 Crestwood Dr.
Jagoda, Mrs. Samuel, 2512 Fifth Ave.
Jenkins, Mrs. Wesley N., 2609 Greene
Jernigan, Mrs. John M., 3812 Trail Lake Dr.
Jernigan, Mrs. Lane M., 3632 Manderly Pl.
Jewell, Mrs. George W., Jr., 4919 Black Oak Lane
Johnson, Mrs. Clive R., 2516 Oakland Blvd.
Johnson, Mrs. F. Melvin, 2801 W. Biddison
Jordan, Mrs. Carl F., 1711 Thomas Pl.
Jorns, Mrs. K. L., 3117 Jane Lane
Kauffmann, Mrs. Adolph F., III, 6363 Waverly Way
Keith, Mrs. Joseph M., 1825 Lynnhaven Rd.
Kihhie, Mrs. Horace K., 2417 Medford Ct., E.
Kihhie, Mrs. Kent V., 715 W. Leuda
King, Mrs. Gerald A., 4409 Morris Ct.
Kirkpatrick, Mrs. Joe S., 2100 Stratford Park Dr.
Kleuser, Mrs. Lawrence P., 2324 Medford Ct. W.
Knox, Mrs. Warren G., 2101 Glencrest Dr.
Kramer, Mrs. John T., Jr., 1905 N. Riverside Dr.
Kerr, Mrs. Walter, 3625 Westcliff Rd., S.
Lace, Mrs. William Ted, 3701 Country Club Circle
Lacy, Mrs. George W., 3200 Mount Vernon
Ladd, Mrs. Arnett D., 2224 Ward Parkway
Lauderdale, Mrs. Thomas L., Jr., 2212 Hawthorne
Leaffer. Mrs. Harry, 4208 Ranier Ct.
Lees, Mrs. Charles R., 150 Pumphrey Dr.
Lemmon, Mrs. Rohert G., 3806 Mattison
Lennox, Mrs. Walter R., 1901 W. Lotus
Leon, Mrs. William R., 2200 Ward Parkway
Leverett, Mrs. Jack K., 4817 Waldron
Levy, Mrs. Louis J., 2530 Highview Terrace
Lindsay, Mrs. John F., Jr., 3708 Winthrop
Lipscomb, Mrs. Cuvier P., 3200 Ridglea Ave.
Littlepage, Mrs. Henry B., 3101 Avondale Ave
Looney, Mrs. Rohert H., 2801 Spruce Park Dr.
Lorimer, Mrs. Wishard S., Jr., 2606 Greene
Lorimer, Mrs. Wishard S., Sr., 3851 Winslow Dr.
Luke, Mrs. Edward A., 2904 Oakland
Lyle, Mrs. Hudge M., 3901 Westcliff Rd., S.
Mallard, Mrs. Robert S., Westchester House, Apt. 627
Marietta, Mrs. John S., 6391 Hilldale Ct.
Marrs, Mrs. Wolford D., 2411 Fifth Ave.
Matheson, Mrs. Dan N., 2500 Cockrell
Mayo, Mrs. Talmadge D., Jr., 3116 Mary's Lane
McBride, Mrs. James, 4017 W. 6th
McCarroll, Mrs. Molloy C., 3724 Linden
McCollum, Mrs. Charles H., Jr., 3137 Stadium Dr.
McDonald, Mrs. Henry C., Jr., 6479 Kirkwood Rd.
McDonald, Mrs. Rohert P., 4100 Ranier Ct.
McKee, Mrs. Frank, Rt. 1, Box 464, Arlington
McKee, Mrs. Frank S., 4329 Meadowhrook Dr.
McKenzie, Mrs. Walten H., 3877 Bellaire Circle
McKinney, Mrs. William W., 3208 Avondale
McVeigh, Mrs. Joseph F., 4800 Crestline Rd.
Mitchell, Mrs. Gatlin, 1221 Thomas Pl.
Mitchell, Mrs. Rohert H., 6332 Curzon
Moorman, Mrs. Warren W., 3720 Bunting
Moreton, Mrs. Robert D., 3848 Linslow Dr.
Morgan, Mrs. William H., 6313 Malvey
Morphis, Mrs. Oscar L., 1942 Fairmount
Morris, Mrs. Ahner J., 3661 Monticello Dr.
Mulkey, Mrs. Young J., 2309 Harrison
Murchison, Mrs. St. Julian R., 3205 Stadium Dr.
Murphy, Mrs. James D., 6101 Kenwick
Myers, Mrs. Theodore B., 2236 Hawthorne
Myers, Mrs. William T., 4245 Ranier Ct.
Mycoskie, Mrs. B. J., 103 Varsity Circle, Arlington

*Address is Fort Worth unless otherwise stated.

AUXILIARY MEMBERS, 1954—*continued*

Neal, Mrs. Durwood E., 3545 Suffolk
Neighbors, Mrs. DeWitt, 2221 Edwin
Norman, Mrs. J. K., 4900 Trail Lake Dr.
Nyman, Mrs. Randall D., 2365 Park Pl.
O'Bannon, Mrs. Roscoe P., 2135 Warner Rd.
Ott, Mrs. William O., 1017 W. Terrell
Owen, Dr. May, Texas Hotel
Patterson, Mrs. John B., 2317 Mistletoe Dr.
Petta, Mrs. Walter B., 3717 Carolyn Rd.
Phillips, Mrs. William G., 3005 Springdale Rd.
Ponton, Mrs. Arvel R., 6355 Waverly Way
Price, Mrs. Earl P., 2208 Edwin
Price, Mrs. Richard V., 4320 Standish Rd.
Pumphrey, Mrs. Andrew B., Rt. 8, Box 107
Rapfogel, Mrs. Irving, 4325 Norwich Dr.
Rathgaber, Mrs. Van D., 2320 Mistletoe Blvd.
>Readinger, Mrs. Ivan H., 6213 Kenwick
Reeves, Mrs. Ernest E., 3240 Rogers Rd.
Rehfeldt, Mrs. Fred C., 5912 El Campo Terrace
Renshaw, Mrs. Horace S., 2913 Alton Rd.
Richards, Mrs. John H., 4222 Birchman
Richardson, Mrs. James J., 2404 Medford Ct., E.
Riddell, Mrs. Joseph M., 3817 Spurgeon
Riddle, Mrs. Charles H., 7305 Briley
Riley, Mrs. Jack C., 3819 W. 4th
Risley, Mrs. Thomas W., 3900 White Settlement, Apt. 26
Roan, Mrs. Leo N., 1535 Cooper
Roberts, Mrs. Aaron L., 1818 Eighth Ave.
Robertson, Mrs. J. A., 3004 Ryan Ave.
Robinson, Mrs. Charles, 1942 Marigold
Rogers, Mrs. Ernest D., 3232 Bellaire Dr., W.
Rohrer, Mrs. Vern, 4805 Staples
Ross, Mrs. Nealie, 1407 S. Adams
Rumph, Mrs. Demetrius M., 1521 Grand
Rumph, Mrs. Mal, 2301 Winton Terrace, W.
Sager, Mrs. E. M., 1712 Carleton
Savage, Mrs. Hugh W., 2605 Colonial Parkway
Schenck, Mrs. Charles P., 3117 Stadium Dr.
Schoolfield, Mrs. Emmett, 1501 W. Myrtle
Schoonover, Mrs. Frank S., 600 Eighth Ave.
Schwartz, Mrs. Edwin G., 2420 Shirley
Scroggie, Mrs. Val D.,*3801 Arundel
Sealy, Mrs. William Burgess, 6325 Locke
Sehested, Mrs. Herman C., 3223 Westcliff Rd., W.
Sewell, Mrs. John H., 6429 Locke
Sewell, Mrs. Robert L., 5101 Bryce
Shelley, Mrs. Harold J., 4071 Modlin
Shields, Mrs. Thomas L., 3800 Wildwood
Shoemaker, Mrs. Thomas J. W., 1919 Grand Ave.
Short, Mrs. James W., 4408 Inwood Rd.
Siddons, Mrs. George Y., 1920 Berkley Pl.
Skokan, Mrs. William, 3704 Westcliff Rd., S.
Small, Mrs. David E., 4013 Trail Lake Dr.
Smith, Mrs. James Ronald, 3612 Fuller
Smith, Mrs. Stanley C., 4224 Curzon
Smith, Mrs. Wallace B., 4701 Winthrop Ave., W.
Snyder, Mrs. Frank L., 304 Virginia Pl.
Snyder, Mrs. Roy E., 6729 Hanover Rd.
Sokolsky, Mrs. Irving, 4821 Staples
Spackman, Mrs. Edgar W., 3648 W. Biddison
Steger, Mrs. Joseph H., 3426 Westcliff Rd., S.
Steinberger, Mrs. Eugene, 3528 Rashti Ct.
Stewart, Mrs. George A., Jr., 3600 Hamilton Dr.
Stouffer, Mrs. James G., 5057 Penrose.
Stow, Mrs. Robert C., Jr., 3705 Country Club Circle
Sumner, Mrs. Wendell W., 2804 Harlanwood
Swift, Mrs. William B., 2817 Alton Rd.
Swords, Mrs. H. Logan, 509 Conner
Tadlock, Mrs. Marvin E., 4512 E. Lancaster
Tatum, Mrs. William C., 1828 Hillcrest
Taylor, Mrs. Elbert D., 1504 Smilax Circle
Teague, Mrs. William H., 2017 Maple Leaf
Terrell, Dr. Blanche, 2621 Waits
Terrell, Mrs. C. E., 2618 Waits
Terrell, Mrs. Caleb O., Jr., 2205 Winton Terrace, W.
Terrell, Mrs. Charles J., 2436 Medford Ct., W.
Terrell, Mrs. Truman C., 2401 Stadium Dr.
Thomas, Mrs. Hiram C., 2917 Simondale Dr.
Thomas, Mrs. Henry W., Jr., 1700 Glenwick Dr.
Thomason, Mrs. Thomas H., 4451 Crestline Rd.
Thompson, Mrs. Burl V., 3840 Shelby Dr.
Thompson, Mrs. W. R., 5211 Bryce
Tipps, Mrs. Derrell Conway, 2554 Greene
Tom, Mrs. John C., Jr., 500 Eastwood
Toppin, Mrs. Bruce E., 3608 Purington
Touzel, Mrs. Cecil S. E., 921 Hillcrest
Trimble, Mrs. Terrill M., Jr., 3109 University Dr., S.
Tucker, Mrs. John T., Jr., 4225 Ranier Ct.
Van Zandt, Mrs. I. L., 3815 Lenox Dr.
Viard, Mrs. W. S., Sr., 1008 Lydick Lane
Walker, Mrs. James N., 6324 Curzon
Walker, Mrs. Webb, 3600 Encanto Dr.
Wallace, Mrs. John, 3821 Westcliff Rd., S.
Walsh, Mrs. Edmund, 4416 Norwich
Waltrip, Mrs. P. M., Jr., 3600 Manderly Pl.
Ware, Mrs. Drue O. D., 3204 Ridglea Ave.
Watson, Mrs. Asa C., Jr., 4312 Norwich Dr.
Webb, Mrs. William S., 1209 Thomas Pl.
West, Mrs. Walter B., 2919 Alton Rd.
Westbrook, Mrs. B. B., Jr., 618 Colvin
Whayne, Mrs. Harry U., Jr., 3813 Bunting
White, Mrs. Richard Joseph, 1433 Cooper
Whittenburg, Mrs. Ross, 4805 Winthrop Dr., E.
Whorton, Mrs. Carl M., 3221 Meadowbrook Dr.
Wier, Mrs. Edward M., 1208 Mistletoe Dr.
Wiggins, Mrs. John A., Jr., 2529 Highview Terrace
Wiggins, Mrs. Kenneth, 4413 Harwen Terrace
Willess, Mrs. Hersel F., 4109 Ben Mar Ave.
Williams, Mrs. Claude, 3544 Kent
Wilson, Mrs. Edwin B., Jr., 3016 Haynie
Wilson, Mrs. Stephen W., 6483 Kirkwood
Wise, Mrs. Joe R., 3756 Country Club Circle
Wollenman, Mrs. Oscar J., Jr., 1724 Martel
Womack, Mrs. Harry H., 4811 Winthrop Dr., E.
Wood, Mrs. William W., 3409 Worth Hills Dr.
Woodward, Mrs. Cicero S., Masonic Home, Arlington
Worrall, Mrs. Cyrus L., 6400 Greenway Rd.
Wyss, Mrs. Herbert E., 2225 Marigold

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Ailts, Mrs. Bernard H., 1110 Leggett
Andrus, Mrs. Allan, Anson
Arrant, Mrs. Arthur Gray, 868 Hickory
Bass, Mrs. Thomas B., 1717 Holbron
Bessire, Mrs. Milton C., 2309 Lincoln Dr.
Bowyer, Mrs. Mack Fisher, 2034 Palm
Bridge, Mrs. Harry R., 1834 Sandefer
Bridges, Mrs. James P., 1350 Meander
Burditt, Mrs. Jesse Newton, 2145 Idlewild
Burns, Mrs. Coleman C., 4125 Monticello
Buzbee, Mrs. Herman Ray, 1109 Albany
Cockerell, Mrs. Earl R., 1225 Sylvan Dr.
Colbert, Mrs. R. E., Rule
Crow, Mrs. Jack A., 1365 Sylvan Dr.
Duff, Mrs. Julius Caesar, Anson
Estes, Mrs. Sol Beauford, Old Anson Rd.
Estes, Mrs. Jack M., 818 Elmwood
Fox, Mrs. William Irby, 1234 Shelton
Gardner, Mrs. C. B., Merkel
Gibson, Mrs. John Paul, 1626 N. 8th
Gilmore, Mrs. John F., 4109 Benbrook
Griggs, Mrs. Harry A., Albany
Harper, Mrs. Earl, 334 Jeanette
Hawkins, Mrs. Elmer J., Hamlin
Haynes, Mrs. Jack S., 4013 Lynnwood Lane
Hedrick, Mrs. T. Wade, 1310 Sylvan Dr.
Hodges, Mrs. Frank Carlton, 102 Oldham Lane
Hollis, Mrs. Lawrence William, 1865 N. 7th
Hooks, Mrs. J. M., Jr., 3902 Monticello
Jackson, Mrs. Leland, 934 Albany
Johns, Mrs. Richard B., 534 EN Twenty-Second
Johnson, Mrs. Dale F., 1138 Leggett
Johnson, Mrs. L. Frank, 1399 Austin
Kimbrough, Mrs. Ernest M., Haskell
Kirkpatrick, Mrs. Ronal B., 918 Palm
Leggett, Mrs. Claude B., 502 College Dr.
Lester, Mrs. Roy T., 4034 Benbrook
Little, Mrs. Otis W., 885 Orange
Magee, Mrs. Jefferson D., 1173 Glenwood
McDonald, Mrs. Donald H., 1342 Elmwood
McFadden, Mrs. Candour Alfred, 942 Santos
Merrick, Mrs. James Estes, 1350 Cedar
Metz, Mrs. Lowie F., Stamford
Middleton, Mrs Edwin E., 942 Elmwood
Murtha, Mrs. Carroll E., 2926 S. 11th
Nail, Mrs. Benjamin M., Jr., Haskell
>Pate, Mrs. Virgil A., Jr., 1318 Glenwood
Pattillo, Mrs. Guy Lowell, 1018 Sayles
Perrin, Mrs. Eugene Douglas, Hamlin
Petty, Mrs. Preston, 1349 Victoria
Pickard, Mrs. Luther J., 1622 Cedar Crest
Porter, Mrs. Bruce, 1218 Westridge
Prichard, Mrs. Clarence L., 2042 S. 8th
Pruet, Mrs. Royce W., 418 Riverside
Pugh, Mrs. David, 4110 Waldemar
Ramsey, Mrs. Wayne V., 1682 Hickory
Rode, Mrs. R. Lee, 1018 Ballinger
Sadler, Mrs. William T., 602 Oak, Merkel
Seale, Mrs. William Herbert, 735 Sayles
Sellers, Mrs. Erle D., 1301 Elmwood
Shoultz, Mrs. Vardeman Hudson, 1602 Cedar Crest
Sibley, Mrs. William Ruck, 1118 Leggett
Smith, Mrs. Marshall LeRoy, Hamlin
Smith, Mrs. Travis, 849 Elmwood
Snow, Mrs. Joseph Cagle, 335 Sayles
Snow, Mrs. William Riley, San Angelo Hwy.
Strole, Mrs. Donald G., N. Abilene
Taylor, Mrs. Floyd D., 818 Leggett
Thigpen, Mrs. J. E., Haskell
Thurman, Mrs. George Donald, 1141 N. 18th
Turnbull, Mrs. Marshall Darwin, 1902 N. 10th
Webster, Mrs. LaVerne John, 4090 Benbrook
Williams, Mrs. Jarrett E., 909 Leggett
Williamson, Mrs. Lee, 1210 Blair

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Adams, Mrs. Walter B., Jr., 1669 Ardath
Allen, Mrs. David H., 2107 Hiawatha
Arrington, Mrs. John, 1600 Grant
Atkinson, Mrs. Curtis, 1302 Polk
Bebb, Mrs. Edwin C., 508 Fillmore
Bebb, Mrs. Kenneth, 2308 Farington
Berg, Mrs. Owen C., 3202 Hollywood
Brown, Mrs. Charles H., 1902 Wilson
Browne, Mrs. Frank, Military Service
Carpenter, Mrs. Philip, Burkburnett
Caskey, Mrs. Marion W., 2401 Speedway
Clark, Mrs. Gordon, Iowa Park
Collard, Mrs. Felix R., 2414 Ninth
Collins, Mrs. Bailey R., 2017 Berkley
Collins, Mrs. Paul, 1815 McGregor
Cox, Mrs. E. Aubrey, 1668 Victory
Crump, Mrs. W. Edward, 1816 Ardath
Daily, Mrs. Robert Lee, 2305 Ellingham
Dorbandt, Mrs. B. W., 2201 Avondale
Egdorf, Mrs. O. C., 2013 Wenonah
Fletcher, Mrs. Donald E., 3602 Lake Park Dr.
Glover, Mrs. Milton H., 1315 Grant
Hall, Mrs. J. D., 1723 Elizabeth
Hartsook, Mrs. Charles R., 2715 Ninth
Hathorn, Mrs. Jerry B., Jr., 1559 Carol Lane
Heymann, Mrs. Julius A., 3113 Milby
Hilburn, Mrs. R. E., 1510 Polk
Holland, Mrs. L. B., 1655 Pearl
Holt, Mrs. J. Gordon, Jr., 3202 Birch
Huff, Mrs. Mark E., 1100 Polk
Humphrey, Mrs. Irving L., 2215 Cooke
Humphrey, Mrs. T. Roger, 3313 Barrett Pl.
Jackson, Mrs. J. L., III, 2016 Keeler
Johnson, Mrs. J. A., 2408 Clarinda
Kanatser, Mrs. J. E., 2103 Miramar
Kiel, Mrs. Oliver Birdell, 2104 Miramar
Kimbrough, Mrs. Orman Trimble, 1809½ Ardath
Knox, Mrs. Roland F., 2102 Berkley
Ledbetter, Mrs. Harry, 2111 Indian Heights
Ledford, Mrs. Henry P., 3212 Beech
Lee, Mrs. James T., 2306 Ellingham
Little, Mrs. J. A., 2107 Berkley
Lovett, Mrs. James P., Olney
Lowry, Mrs. W. P., 300 Morningside
Maltry, Mrs. Emile, 1602 St. John
Manar, Mrs. Roger, 1820 Wilson
Mangum, Mrs. Carl E., 2901 Taft
Mansur, Mrs. Harl D., 1652 Pearl
Maxfield, Mrs. Jack, 2011 Berkley
>McFatridge, Mrs. Keith W., 1805 Victory
Meredith, Mrs. Elisha, Olney
Nail, Mrs. James B., 2023 Berkley
Nelson, Mrs. Richard L., 2204 Avondale
Nunnelley, Mrs. Emmett C., 1654 Victory
Parker, Mrs. W. L., 2107 Avondale
Parnell, Mrs. L. D., 1508 Tilden
Parsons, Mrs. C. W., 1670 Dayton
Perry, Mrs. John H., 1822 Ardath
Pierce, Mrs. A. W., 2310 Clarinda
Powers, Mrs. Stephen A., 2414 Martin
Prichard, Mrs. Horace D., 3715 Kessler
Reagan, Mrs. John R., 117 Pembroke
Rector, Mrs. William L., 1673 Victory
Reser, Mrs. Wayne A., 2212 Harrell
Rosenblatt, Mrs. William, 126 Pembroke
Rundell, Mrs. W. Kennard, 1808 McGregor
Russell, Mrs. I. D., 1701 Elizabeth
Seibold, Mrs. George, 2109 Berkley
Shaw, Mrs. Clint M., 1518 Tenth
Simmons, Mrs. Nolan L., 2407 Clarinda
Singleton, Mrs. George T., 2207 Avondale
Slaughter, Mrs. George W., 2412 Cambridge
Smith, Mrs. Percy King, 2110 Wenonah
Steed, Mrs. Joe, 1642 Keeler
Sullivan, Mrs. Larlev C., 2010 Arthur
Taylor, Mrs. Fred W., 2220 Hampstead Lane
Theimer, Mrs. Louis M., 3315 Sherwood Lane
Thompson, Mrs. John G., Electra
Trimble, Mrs. Orman H., 2101 Hiawatha
VanDeventer, Mrs. Loyd R., 1610 St. John
Whiting, Mrs. Walter B., 1708 Victory

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Wilson, Mrs. Charles H., 2521 Fain
Wilson, Mrs. Claude, 3519 Sheridan
Wilson, Mrs. Oscar, 1006 Brook
Yeager, Mrs. Ben G., Box 300

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Allen, Mrs. C. C., 2724 Texas
Borchardt, Mrs. A. L., 2525 Tolar
Coleman, Mrs. W C., 3226 Yamparika
Dodson, Mrs. Emma B., 2204 Wilbarger
>Featherston, Mrs. E. W., 1309 Cleburne
Garland, Mrs. A. B., 2624 Paradise
Hollar, Mrs. Emory D., Mansard St.
Lemee, Mrs. Raymond A., 2603 Mansard
Miller, Mrs. B. W., 2117 Beaver
Moore, Mrs. M. J., 2829 Paradise
Moore, Mrs. W. R., 3021 Paradise
Muirhead, Mrs. Jas. J., 2821 Bismarck
Reger, Mrs. H. J., 2222 Wheeler
Rogers, Mrs. A. C., 3103 Texas
Slaugenhop, Mrs. J. J., 3600 Beaver
Spaar, Mrs. A. P., 2511 Mansard
Steele, Mrs. F. B., Castlebury Park

FOURTEENTH DISTRICT

Mrs. Emmett Essin
Sherman
Council Woman

COOKE COUNTY AUXILIARY†

Atchison, Mrs. James W., 515 Lindsay
Cirone, Mrs. Vincent C., 816 S. Rusk
Davenport, Mrs. Howard S., 912 S. Rusk
Evashwick, Mrs. George, 910 S. Dixon
>Fisch, Mrs. Ben R., 711 S. Rusk
Lusk, Mrs. C. F., 927 Ritchey
Mills, Mrs. C. K., 901 Lindsay
Myrick, Mrs. Thomas S., Muenster
Powell, Mrs. William F., 714 S. Denton
Shea, Mrs. John D., Old Highway 77
Thomas, Mrs. Ira L., 628 Lindsay
Yarbrough, Mrs. Silas M., 312 S. Grand

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Aagaard, Mrs. George N., 3837 Stratford
Abrams, Mrs. Raymond H., 5843 Waggoner Dr.
Addison, Mrs. R. P., 5429 Gaston
Adin, Mrs. Louis, 1131 N. Edgefield
Aldredge, Mrs. George N., Jr., 3721 Marquette
Alexander, Mrs. Jo C., Stoneleigh Hotel
Alexander, Mrs. Lee J., 4329 Greenbrier
Alexander, Mrs. Sam A., 4464 Rheims Pl.
Alfieri, Mrs. A. L., 5324 Livingston
Allday, Mrs. L. E., 4224 Stanhope
Allen, Mrs. Burton W., 5647 Ridgedale
Allen, Mrs. John B., 5427 Emerson
Allison, Mrs. W. J., 6948 Lakeshore Dr.
Allison, Mrs. Joe M., Grapevine
Altick, Mrs. Frank J., 3883 Merrell Rd.
Altman, Mrs. William A., 1528 Oak Knoll
Anderson, Mrs. T. McDowell, 3732 Normandy
Armstrong, Mrs. James O., 7913 Stanford
Arnold, Mrs. Lawrence E., 3644 Greenbrier
Aronoff, Mrs. B. L., 6540 Oriole
Aronson, Mrs. Howard S., 5414 Montrose
Ashby, Mrs. John Edmund, 3429 Cornell
Ashe, Mrs. W. M., Military Service
Aten, Mrs. Eugene L., 6532 Kenwell
Atkinson, Mrs. George N., Jr., 910 Avon
Ault, Mrs. C. A., Jr., 9514 Alta Mira
Austin, Mrs. Dale J., 8358 Santa Clara
Austin, Mrs. Frank H., Rt. 1, Box 137-A, Roanoke
Bagwell, Mrs. John S., 7040 Vassar
Bailey, Mrs. Herbert, 7039 Fisher Rd.
Baird, Mrs. Sydney S., 3549 Southwestern
Baird, Mrs. W. Leroy, 3448 Rosedale
Baker, Mrs. Bryant O., 1443 Michigan
Baker, Mrs. John O., 2911 Idaho
Baldwin, Mrs. Alvin, Jr., 6215 DeLoache
Ballard, Mrs. John E., 6327 Mimosa Lane
Barner, Mrs. Bruce S., P. O. Box 5, Lancaster
Barnes, Mrs. Dorsey K., 5419 Farquhar Lane
Barnes, Mrs. T. S., 1506 Eastus
Barnett, Mrs. W. E., 5727 Nash
Barzune, Mrs. Benjamin, 4845 S. Lindhurst
Baskin, Mrs. John L., Military Service
Bassett, Mrs. Wallace H., 211 S. Montreal
Beall, Mrs. John R., 3304 Beverly Dr.
Beckering, Mrs. H. H., 4321 Beverly Dr.
Bell, Mrs. Marvin D., 6347 Tremont
Bennett, Mrs. Thomas R., Jr., 3205 Purdue
Berger, Mrs. B. J., 3916 Stonebridge
Berk, Mrs. W. R., 6143 Joyce Way
Biggart, Mrs. James F., 10014 Losa Dr.
Black, Mrs. J. H., 3624 Princeton
Blair, Mrs. D. Shelton, 4728 Livingston
Blanton, Mrs. Bassel N., 4661 Southern
Blend, Mrs. Max H., 6614 Tulip Lane
Block, Mrs. Harold M., 4923 Brookview
Bloss, Mrs. Charles L., 6725 Avalon
Boland, Mrs. G. L., 2831 Clydedale Dr.
Bookatz, Mrs. Allan, 5327 Wenonah
Bornstein, Mrs. David, 4400 University Blvd.
Bounds, Mrs. Murphy, 4420 Normandy
Bourland, Mrs. J. Wilbur, Jr., 4438 Arcady
Boutland, Mrs. John B., 3409 Beverly
Boyer, Mrs. L. A., 5914 Parkdale
Bradfield, Mrs. James Y., 6562 Sunnyland Lane
Bradford, Mrs. William H., 4679 Westside
Branch, Mrs. George R., 4005 University Blvd.
Branch, Mrs. W. M., 6506 Walnut Hill Lane
Brannin, Mrs. Dan, 5942 Averill Way
Brannin, Mrs. Edward B., 7800 Forney Rd.
Brau, Mrs. J. Gilmore, 9339 Hathaway Rd.
Brereton, Mrs. G. E., 5847 Velasco
Brooksaler, Mrs. Fred, 4332 Grassmere Lane
Brown, Mrs. C. Frank, 5558 Edlen
Brown, Mrs. Donald S., 3980 Rochelle
Brown, Mrs. Samuel R., 1403 Lansford
Browning, Mrs. Carol W., 2510 Anzio Dr.
Bruton, Mrs. Emmett B., 5218 Vickery Blvd.
Buchanan, Mrs. J. Forest, 4001 Druid Lane
Buehler, Mrs. Martin S., 4600 Bluffview
Bumpass, Mrs. S. R., 8367 San Fernando
Burford, Mrs. R. W., 6465 Northport
Burkett, Mrs. Howard M., 6946 Junius
Burnett, Mrs. Jack F., Military Service
Burns, Dr. Maudie Marie, 4337 Livingston
Burnside, Mrs. Ronald M., 7518 Robin Rd.
Bush, Mrs. Oliver F. Mike, 6538 Desco
Bush, Mrs. W. Leslie, 6031 Norway Rd.
Bussey, Mrs. Charles D., 5601 Greenbrier
Butte, Mrs. Felix L., 6616 Northhaven Rd.
Bywaters, Mrs. T. W., 5414 Falls Rd.
Caillet, Mrs. O. Rene, Rt. 4, Box 406
Cairns, Mrs. A. B., 8514 Bluebonnet Rd.
Calhoun, Dr. Nina Fay, Medical Arts Bldg.
Campbell, Mrs. Allen D., Jr., 815 Salmon Dr.
Campbell, Mrs. Robert G., 4545 Arcady
Carlson, Mrs. Glenn D., 9438 Inwood Rd.
Carman, Mrs. H. Frank, 6228 Preston Rd.
Carpenter, Mrs. R. G., 806 Evergreen Hills Rd.
Carrell, Mrs. Brandon, 4429 Belclaire
Carrell, Mrs. W. B., 3701 Maple
Carroll, Mrs. Benjamin Hollis, 4509 San Carlos
Carswell, Mrs. W. E., 6722 Lakeshore Dr.
Carter, Mrs. C. B., 6701 Inwood Rd.
Carter, Mrs. Charles F., 4204 Potomac
Carter, Mrs. David W., Jr., 5329 Nakoma Dr.
Carter, Mrs. Earl L., 6660 Lakeshore Dr.
Carter, Mrs. H. Gray, 3215 Amherst
Cary, Mrs. Edward H., 4712 Lakeside Dr.
Chandler, Mrs. H. Norman, 6940 S. Ridge
Chaney, Mrs. C. E., 3305 Lovers Lane
Chapman, Mrs. J. S., 3606 Lovers Lane
Cherry, Mrs. Glen R., 5343 Merrimac
Chester, Mrs. John B., 1451 Cedar Oaks
Cinnamon, Mrs. A. M., 6938 Casa Loma
Clark, Mrs. Arthur L., 6714 Williamson Rd.
Clark, Mrs. Harold G., 5401 W. Mockingbird Lane
Clark, Dr. Helen, Southwestern Medical School
Cleveland, Mrs. E. M., 6292 Revere Pl.
Cobb, Mrs. Joseph B., 6600 Vandera
Cobb, Mrs. S. W., 1402 Dominion
Cochran, Mrs. H. W., 3308 St. Johns Dr.
Coggeshall, Mrs. H. C., 5537 Wateka
Cole, Mrs. Charles Max, 6715 Joyce Way
Cole, Mrs. Gillon M., 1315 Eastus Dr.
Colip, Mrs. W. L., 330 N. W. 2nd, Grand Prairie
Cook, Mrs. Chester E., 4017 Bryn Maur
Copeland, Mrs. F. R., 3506 Springbrook
Cotton, Mrs. Avery, 633 College, Grand Prairie
Cowart, Mrs. Robert W., 4313 Worth
Cox, Mrs. E. R., 6604 Bob-O-Links
Crutcher, Mrs. Howard K., 215 W. Greenbrier Lane
Culwell, Mrs. Jerry, 103 E. Scotland Dr., Irving
Daniel, Mrs. R. H., 4308 Avondale
Dathe, Mrs. Richard A. (Deceased), 4222 Gloster Rd.
Davidson, Mrs. G. A., 1025 Cordova
Davidson, Mrs. V. A., 8214 San Fernando
Davis, Mrs. Milton, 6615 Sunnyland Lane
Dean, Mrs. John H., 4221 Lorraine
Dean, Mrs. William B., 405 Mayrant Dr.
Deatheridge, Mrs. William, 4517 Reiger
Decherd, Mrs. H. B., 3704 Alice Circle
DeLange, Mrs. Arnott, 2845 W. 8th
DeLatios, Mrs. Arthur, 3325 Amherst
Denton, Mrs. Guy T., Jr., 1550 Stemmons
D'Errico, Mrs. Albert P., 4818 Brookview
Devereux, Mrs. W. P., 3725 Potomac
Dickey, Mrs. E. V., 3508 Harvard
Dierolf, Mrs. L. W., 1308 Glenfield
Donald, Mrs. Homer, 4507 Manning Lane
Dorman, Mrs. G. W., 2610 Reagan
Dorman, Mrs. J. H., 3636 Lovers Lane
Downs, Mrs. James T., III, 4011 University
Driggs, Mrs. Guy, 3339 Dawes Dr.
Duckett, Mrs. J. Warner, 3529 Caruth
Duncan, Mrs. Charles N., 3140 Caruth
Dunlap, Mrs. Elbert, 5339 Nakoma
Dunlap, Mrs. Hudson, 3915 Southwestern
Dunlap, Mrs. John E., 5365 Montrose
Dykes, Mrs. Thomas L., 2616 Fowler
Edwards, Mrs. J. Bruce, 2622 Salerno
Edwards, Mrs. William L., 6721 Del Norte
Emmert, Mrs. John A., 2908 E. Binkley, Apt. 4
Evans, Mrs. Edward L., 1038 E. Kessler Parkway
Evans, Mrs. W. G., 4065 Purdue
Ferguson, Mrs. D. W., Military Service
Fink, Mrs. Frederick, 5806 Joyce Way
Finlayson, Mrs. A. J., 6131 Lupton Dr.
Fischer, Mrs. Philip, 4315 Brookview
Fogleman, Mrs. James D., 1312 Hansboro
Fowler, Mrs. H. M., 451 Mayrant
Fowler, Mrs. W. W., 5240 Vanderbilt
Fox, Mrs. Everett C., 4022 Stonebridge
Franklin, Mrs. Floyd S., 4675 Edmondson
Fromm, Mrs. Charles S., 6446 Stefani
Fry, Mrs. Murdock D., 6445 Lakewood
Funk, Mrs. Presley Clyde, 3050 Norwalk
Fuqua, Mrs. Foster, 4530 Rheims Pl.
Fuqua, Mrs. W. N., 3901 Normandy
Gaines, Mrs. Sydney, 522 Hill, Grand Prairie
Galt, Mrs. Jabez, 3000 Southwestern
Galt, Mrs. Sydney, 10626 Lennox Lane
Gauldin, Mrs. Robert J., 6118 Llano
Geary, Mrs. F. B., 2918 Canberra
Gessner, Mrs. F. E., 6344 Goliad
Gibbons, Mrs. O. W., 4329 Lorraine
Giles, Mrs. Robert B., 3900 Potomac
Gill, Mrs. A. J., 7021 Lakeshore Dr.
Gill, Mrs. D. C., 6611 N. Ridge Dr.
Girard, Mrs. P. M., 3101 Caruth
Goff, Mrs. G. F., 3605 Cedar Springs
Goforth, Mrs. J. L., 6907 Westlake
Gogans, Mrs. Roy, 4215 Rawlins
Goode, Mrs. John V., 4656 Miron Dr.
Goodfried, Mrs. M. Paul, 3607 Asbury
Gordon, Mrs. E. S., 511 Brookside Dr.
Gottlich, Mrs. Arthur P., 5349 Drane Dr.
Grafton, Mrs. E. G., Jr., 4126 Shenandoah
Graham, Mrs. James F., 614 N. Rosemont
Graham, Mrs. Marion F., 414 Easton Rd.
Graham, Mrs. R. B., 10451 Fern Dr.
Green, Mrs. A. D., 6139 Palo Pinto
Green, Mrs. F. Ray, 8327 Santa Clara
Green, Mrs. Tim, 1650 Oak Knoll
Griffin, Mrs. J. B., 6333 Royal Crest
Grow, Mrs. M. H., 6014 Lupton
Hacker, Mrs. Guy L., 3600 Colgate
Hackler, Mrs. Garfield M., 3928 University
Hackney, Mrs. U. P., 5703 Vanderbilt
Hale, Dr. Martha Helen, 6133 DeLoache
Haley, Mrs. Arvel H., 225 N. Rosemont
Haley, Mrs. W. E., 4720 St. Johns Dr.
Halley, Mrs. B. C., Jr., 6338 Azalea Lane
Halpern, Mrs. S. R., 9520 Hathaway
Hamilton, Mrs. C. F., 7014 Southridge Dr.
Hampton, Mrs. J. A., 4433 S. Versailles
Hampton, Mrs. James C., 8410 Chadbourne
Hannah, Mrs. Calvin R., 3921 Potomac
Harder, Mrs. Ira E., 4126 Rawlins
Hardy, Mrs. Douglas, 1915 Wilbur
Harper, Mrs. J. C., 534 Monssen
Harrel, Mrs. Don G., 967 Kessler Parkway
Harrington, Mrs. F. T., 9962 Rockbrook
Harrington, Mrs. M. R., 3832 Stratford
Harrington, Mrs. S. F., 3722 Cragmont
Harris, Mrs. A. W., 9323 Gurnsey
Harris, Mrs. N. J., 5422 Farquhar Lane
Harris, Mrs. Worth W., 500 S. Ebright, Mesquite
Harrison, Mrs. Ben F., Jr., 3115 Amherst
Harrison, Mrs. Gaston G., 4308 Arcady
Hart, Mrs. G. A., 4340 Valley Ridge Rd.
Hartin, Mrs. Richard B., P. O. Box 655, Garland
Harvill, Mrs. T. Haynes, 4440 Larchmont
Hawkins, Mrs. H. F., 2100 Kessler Parkway
Hawkins, Mrs. W. C., 9228 Poppy Lane
Hayes, Mrs. E. R., 3612 Caruth
Henderson, Mrs. H. C., Jr., 1010 N. Winnetka
Henry, Mrs. A. C., Jr., 7019 Southridge Dr.
Henry, Mrs. D. J., 6715 Starling Circle
Herndon, Mrs. James H., 6801 Hunters Glen
Herrick, Mrs. Richard B., 2807 Lovers Lane

*Address is Vernon unless otherwise stated.
†Address is Gainesville unless otherwise stated.
‡Address is Dallas unless otherwise stated.

AUXILIARY MEMBERS, 1954—*continued*

Hesser, Mrs. Rohert N., 3500 Fairmount
Heyer, Mrs. Howard E., 9451 Thornherry Lane
Hill, Mrs. J. M., 6752 Avalon
Hill, Mrs. S. M., 3617 Lexington
Hodges, Mrs. J. Shirley, 3516 University
Hodges, Mrs. Leon, 4272 Bordeaux
Hodges, Mrs. T. Wiley, 6323 Brookshire Dr.
Hoekstra, Mrs. C. S., 6330 Steffani
Holland, Mrs. John, 6330 Desco
Holt, Mrs. J. O. S., Jr., 4225 Arcady
Hopkins, Dr. May Agnes, 4517 Highland Dr.
Horgan, Mrs. John D., 1326 Barlow
Horn, Mrs. Fred W., 3132 Southwestern
Horn, Mrs. J. Morris, 6207 Stefani
Howard, Mrs. Ben K., Military Service
Howard, Mrs. George W., 628 Haines
Howell, Mrs. James B., 6225 Mercedes
Huhbard, Mrs. David G., 4639 Fairfax
Hudson, Mrs. Lee, 4312 Overhill Dr.
Hurt, Mrs. L. B., 3917 Miramar
Hutton, Mrs. S. B., 9317 San Fernando
Irving, Mrs. W. N., Military Service
Jackson, Mrs. M. C., Military Service
Jackson, Mrs. Rueben W., 5823 DeLoache
Jackson, Dr. Ruth, 3504 Brown
James, Mrs. George Taylor, 5402 Ridgedale
James, Mrs. George Truett, 4542 Belfort
Jenkins, Mrs. John L., Rt. 7, Forest Lane
Jenkins, Mrs. M. T., 4245 Shorecrest Dr.
Jenkins, Mrs. Speight, 9909 Preston Rd.
Johnson, Mrs. Alvis, Jr., 6358 Bordeaux
Jones, Mrs. J. Guy, 6875 Tokalon Dr.
Jones, Mrs. W. D., 5808 Gaston
Jordan, Mrs. J. Russell, 6137 Ravendale Lane
Kantor, Mrs. Herman I., 4129 Shenandoah
Katz, Mrs. Sol M., 6330 Lupton
Keene, Mrs. Alhert H., Military Service
Kelley, Mrs. Charles W., 4316 Lorraine
Kelly, Mrs. Tom E., 5625 Lovers Lane
Kerr, Mrs. Jack G., 6214 Lupton
Kethley, Mrs. Jerald, 10206 Inwood Rd.
Kilgore, Mrs. Donald G., 4324 St. Johns Dr.
Kindley, Mrs. George C., 5211 Live Oak
King, Mrs. Carey G., Jr., 3204 Marquete
King, Mrs. Karl B., 3809 Purdue
Kipp, Mrs. Dean C., 3809 Villanova
Kirksey, Mrs. T. M., 4521 N. Versailles
Kleinsasser, Mrs. L. J., 6407 Glendora
Koch, Mrs. William T., 6777 Lakefair Circle
Knapp, Mrs. Joseph L., 9981 Rockhrook
Knickerhocker, Mrs. Bruce A., 6123 DeLoache
Knight, Mrs. Marvin P., 4833 Royal Lane
Knowles, Mrs. W. Mood, 4305 Emerson
Krafft, Mrs. C. James, 5920 Penrose
Krebs, Mrs. David E., Box 248, Lancaster
Kregel, Mrs. Louis A., 6907 Lakewood
Krempin, Mrs. H. O., 722 N. Windomere
Kreymer, Mrs. George C., 6116 Del Norte
Krusen, Mrs. Edward M., 3500 Colgate
Kugler, Mrs. Joseph S., 1010 High School Lane, Irving
Kurilecz, Mrs. Michael, Military Service
LaDue, Mrs. Charles N., 6139 Lupton
Lair, Mrs. Nard, 1322 Easton Rd.
Lancaster, Dr. Mary Agnes, 3519 Fairmount
Lancaster, Dr. Minnie Lee, Grapevine
Landress, Mrs. J. B., 1609 Marion Dr., Garland
Langston, Mrs. W. G., 6230 Prestonshire Lane
Lanier, Mrs. J. E., 2606 Community
Lanius, Mrs. John W., 6815 Southridge
Laugenour, Mrs. D. P., 5446 Emerson
Launey, Mrs. G. V., 4536 S. Lindhurst
Lee, Mrs. Ridings E., 3834 Shenandoah
Legg, Mrs. Eugene P., 4847 Walnut Hill
Lehmann, Mrs. J. R., 3921 Potomac
Levin, Mrs. Paul M., 4524 Arcady
Levy, Mrs. H. R., 5923 Luther Lane
Lively, Mrs. W. M., Jr., 1650 Eastus
Lodowski, Mrs. Charles, Military Service
Loftis, Mrs. Earl L., 4145 Stanhope
Loiselle, Mrs. Alhert O., 6807 Prestonshire Lane
Long, Mrs. Gerald D., 5520 W. Hanover
Long, Mrs. Troy F., 3317 Caruth
Looney, Mrs. W. W., 1536 Sylvan
Lott, Mrs. M. E., 5318 Edmondson
Love, Mrs. T. Stafford, 4242 Cochran Chapel Rd.
Ludden, Mrs. K. F., 2848 Maryland
Luecke, Mrs. P. E., 5912 Reiger
Lyday, Mrs. Victor I., 6138 Woodcrest Lane
Madison, Mrs. Leonard L., 8630 Thackeray
Maffett, Dr. Minnie L., 3636 Armstrong
Magers, Mrs. M. E., 8204 Barharee
Mahon, Mrs. G. D., Rt. 2, Box 304, Garland
Mahon, Mrs. Ralph D., Jr., 988 Sylvania
Mantooth, Mrs. Walter, 722 S. E. 10th, Grand Prairie
Marchman, Mrs. O. M., 5328 Live Oak
Marchman, Mrs. Oscar, Jr., 5539 Montrose
Marshall, Mrs. J. H., 6006 Stefani
Martin, Mrs. Charles L., Rt. 6, Box 55
Martin, Mrs. James A., 3709 Potomac
Martin, Mrs. John G., 1019 Evergreen Hill Rd.
Martin, Mrs. T. A., Jr., 6240 Kenwood
Martin, Mrs. W. E., Seagoville
Martinak, Mrs. Richard E., 6104 Del Norte
Mason, Mrs. Eugene F., 6943 Wild Grove
Mason, Mrs. Porter K., 6506 North Haven Rd.
Massey, Mrs. Warren E., 3137 Southwestern
Mathews, Mrs. Paul W., 5409 Wateka
Mattson, Mrs. H. A., 3223 Tennessee
Maxfield, Mrs. Jack G. S., Maxfield Ranch, Josey Lane, Carrollton
Maxfield, Mrs. J. R., 3601 Milton
Maxfield, Mrs. J. R., Jr., 5918 Lomo Alto
Mazer, Mrs. Morton L., 618 N. Zangs
McBride, Mrs. Dayton C., 3629 Beverly
McBride, Mrs. R. B., 3812 Beverly
McClung, Mrs. Hugh L., 4443 Westway
McCracken, Mrs. Joseph H., Jr., 4401 Highland Dr.
McCrory, Mrs. Tom M., 818 Salmon
McFarland, Mrs. Gordon B., 8626 Inwood
McIver, Mrs. Julius, 3224 Southwestern
McKinney, Mrs. James M., Military Service
McLaurin, Mrs. Hugh L., 5036 Seneca
McLaurin, Mrs. John G., 5542 Wenonah
McLeod, Mrs. J. N., 6722 Lakewood
McNamara, Mrs. James C., Jr., 12525 Hillcrest
McNeill, Mrs. Arch J., 3509 Stanford
McNeill, Mrs. J. P., 5431 Yolanda Lane
Meisenhach, Mrs. A. E., Jr., 6454 Aberdeen
Mendel, Mrs. E. B., 6827 Northwood
Mendenhall, Mrs. Elliott, 4221 Belclaire
Mengert, Mrs. William F., 7544 Ramhler Rd.
Merrick, Mrs. Ben A., 3520 Cedar Springs
Metz, Mrs. M. Hill, 6811 Hunters Glen Rd.
Mewhinney, Mrs. Logan U., 10914 Strait Lane
Miller, Mrs. J. E., 6407 Forest Lane
Miller, Mrs. John F., 401 N. Willomet
Miller, Mrs. Tate, 8937 Devonshire
Mills, Mrs. James T., 5336 Rockcliff Pl.
Millwee, Mrs. Rohert H., 3821 McFarlin
Minnett, Mrs. J. S., 3300 Hanover
Mitchell, Mrs. H. J., Jr., 4806 Swiss
Mitchell, Mrs. Joseph D., 4437 Larchmont
Montgomery, Mrs. Henry G., 3605 Shenandoah
Montgomery, Mrs. P. O. B., Jr., 9039 Devenshire
Moody, Mrs. Joe V., 1534 Junior
Mooney, Mrs. Ken, 8604 Chadhourne Rd.
Moore, Mrs. H. Leslie (Hon.), 4204 Beverly
Moore, Mrs. Halcuit, 2924 Rosedale
Moore, Mrs. Ramsay H., 5453 Neola
Moore, Mrs. Rohert L., 5217 Shadywood Lane
Morris, Mrs. A. Truett, 1430 San Rafael
Morris, Mrs. Charles R., 4232 Colgate
Morris, Mrs. Don P., 4708 St. Johns
Mueller, Mrs. H. A., 707 Winter
Mullikin, Mrs. Gerald, Military Service
Munsell, Mrs. D. W., 3504 Cornell
Muirhead, Mrs. E. E., 6723 Norway Rd.
Murphy, Mrs. Joseph B., 4436 Purdue
Murphy, Mrs. Rohert E., Military Service
Mustain, Mrs. Rhoads, 9314 Forest Hills
Myers, Dr. Magda, 4803 Alan Dale Lane
Nash, Mrs. C. C., 1217 Lausanne
Neel, Mrs. Joseph C., 3812 Amherst
Neumann, Mrs. Albert, 3829 Hall
Newell, Mrs. P. D., 2803 Salerno
Newsom, Mrs. Asa A., 5906 McComas
Newsom, Mrs. Asa A., Jr., Military Service
Newton, Mrs. F. H., 4005 Miramar
Noonan, Mrs. Richard L., 1118 Lausanne
Nordenhrook, Mrs. G. J., 3453 Stanford
Ohenchain, Mrs. T. H., Jr., 4309 Bordeaux
O'Brien, Mrs. J. Dennis, 4524 Arcady
Pace, Mrs. John M., 5310 Montrose
Park, Mrs. B. E., 1102 N. Edgefield
Parker, Mrs. Edward R., 8254 Forrest Hill
Paternostro, Mrs. Charles J., 5444 Northhrook
Patterson, Mrs. Casey E., 5205 Brookview
Patterson, Mrs. Cecil O., 3537 Southwestern
Patton, Mrs. Walter H., 5704 Swiss
Paulson, Mrs. D. L., 5359 Drane
Payne, Mrs. William T., III, 6338 Desco
Pearcy, Mrs. Frank, Rt. 5, Box 662
Peden, Mrs. J. K., 6747 Winton
Pence, Mrs. C. P., 5423 Gaston
Pence, Mrs. Ludlow, 4611 Cherokee Trail
Perkins, Mrs. Jack F., 3526 Cedar Springs
Peyton, Mrs. J. B., 8301 Santa Clara
Pickard, Mrs. J. M., 2505 Maple
Pickett, Mrs. Taylor T., 1400 Wildwood Circle, Garland
Pierce, Mrs. Franklin A., 6120 Gaston
Pierson, Mrs. Milton A., 6239 Parkdale
Piranio, Mrs. J. C., 914 N. Avon
Popkess, Mrs. F. G., 6154 North Haven
Porter, Mrs. Louis H., Military Service
Portman, Mrs. R. K., 926 Stevens Woods Cts.
Powell, Mrs. John, 2603 Nicholson
Powers, Mrs. H. W. S., Jr., 6237 Meadow Rd.
Prejean, Mrs. O. V., 3503 Arrowhead Dr.
Quinn, Mrs. Lester H., 4505 Edmondson
Range, Mrs. Haskell, 6630 Lake Circle
Rattan, Mrs. Paul M., 9301 Sunnybrook
Reaves, Mrs. L. M., 4553 Bordeaux
Reddick, Mrs. W. Grady, 4731 Wildwood
Reisman, Mrs. David D., 5118 Lahoma
Reuss, Mrs. G. T., 4309 Stanhope
Reynolds, Mrs. W. S., 3815 Valley Ridge Rd.
Richardson, Mrs. Edward R., 6823 Stefani
Richmond, Mrs. Marion B., 3928 Bryn Mawr
Richter, Mrs. Paul A., Keller Springs Rd., Rt. 1, Plano
Riddle, Mrs. Penn, 964 Sam Dealey
Rippy, Mrs. Edwin L., 5371 Montrose
Ritchey, Mrs. Lloyd F., 8106 Chadbourne
Roach, Mrs. Joe G., Jr., 6330 Norway Rd.
Rohhins, Mrs. J. H., 7514 Caruth
Roherts, Mrs. Joe H., 209 S. Iowa, Irving
Roherts, Mrs. T. R., 6212 Oram
Rogers, Mrs. G. W., 2227 Berwick
Rosenberg, Mrs. M. L., 5718 Anita
Rosenthal, Mrs. Raoul S., 5535 Wenonah
Ross, Mrs. Edward S., 4220 Shenandoah
Ross, Mrs. James K., 6022 DeLoache
Rothschild, Mrs. Joseph E., 5936 Woodland
Rounsavill, Mrs. J. Q., 701 Rainbow
Rouse, Mrs. Milford O., 8326 Garland Rd.
Rowe, Mrs. Robert J., 6520 Starling Circle
Rumpf, Mrs. William H., 1418 Kings Highway
Saldivar, Mrs. J. T., 3626 S. Versailles
Sams, Mrs. Lewis C., 834 Salmon
Sanders, Mrs. O. P., Military Service
Sazama, Mrs. John J., Jr., 1051 Waterford
Scales, Mrs. John G., 328 W. Colorado
Schaefers, Mrs. J. G., 4622 Walnut Hill
Schenewerk, Mrs. George A., 6246 DeLoache
Schmaltz, Mrs. W. F., 5442 Richmond
Schoch, Mrs. Arthur G., 5902 Averill Way
Schoolfield, Mrs. Ben L., 5025 Junius
Schuett, Mrs. Albert J., 6672 Avalon
Scott, Mrs. George W., 1422 Ben Dr., Irving
Scurry, Mrs. M. M., 4300 Larchmont
Seay, Mrs. Frank O., 3840 Villanova
Sebastin, Mrs. F. J., 6044 Royal Crest
Seely, Mrs. M. S., 3911 Gaston
Seidel, Mrs. Clifford C., Military Service
Seldin, Mrs. Donald, 6447 Bordeaux
Selecman, Mrs. Frank, 3609 Rosedale
Sellers, Mrs. D. R., 7130 Wildhriar
Sellers, Mrs. Lyle M., 3412 Southwestern
Sellman, Mrs. W. C., Jr., 6327 Mimosa Lane
Sewell, Mrs. James W., 1818 Hilhurn
Shane, Mrs. J. Howard, 4629 Belclaire
Shannon, Mrs. Arthur, 3851 Potomac
Shannon, Mrs. Hall, 4230 Fairfax
Shannon, Mrs. Manning B., 8637 Chadhourne
Shapiro, Mrs. Alvin P., 7155 Pasadena
Sharp, Mrs. J. W., 4520 W. Amherst
Shaw, Mrs. Robert R., 5430 Surrey Circle
Shelhurne, Mrs. S. A., 5543 Waneta
Sheldon. Mrs. Lawrence B., 5427 Wateka
Shelmire, Mrs. Bedford, 3813 Miramar
Shelton, Mrs. William P., 5505 Emerson
Shoecraft, Mrs. Warren A., 1551 Junior
Short, Mrs. Robert F., Jr., 3520 Dartmouth
Shortal, Mrs. W. W., 2806 Swiss
Shuey, Mrs. Charles B., 3413 Southwestern
Siehel, Mrs. E. K., 1127 Turner
Sigel, Mrs. Z., 1900 Forest
Singleton, Mrs. J. Dudley, 3716 Amherst
Small, Mrs. Andrew B., 3700 Stratford
Smith, Dr. Alice Lorraine, 3326 Blackburn
Smith, Mrs. Charles L., 4207½ Lemmon
Smith, Mrs. DeWitt, 4126 Normandy
Smith, Dr. Lois Weir, 3524 Fairmount
Smith, Mrs. Ralph C., 4212 San Carlos
Smith, Mrs. Richard M., 3659 Maplewood
Smith, Mrs. Sydnie G., 6820 Cornelia Lane
Smith, Mrs. Tom E., 3300 Beverly
Smith, Mrs. Wright K., 227 Freddie Dr.
Sorrels, Mrs. C. C., 619 N. Mont Clair
Sowers, Mrs. Harry B., 4618 San Jacinto
Spangler, Mrs. Davis, 4404 Westway
>Sparkman, Mrs. Rohert, 4224 Lomo Alto
Speegle, Mrs. Jackson H., 921 Kessler Parkway
Spegal, Dr Doris V., 6144 Anita
Spence, Mrs. H. M., 4533 Lorraine
Stanley, Mrs. E. Stephen, 8426 Ridglea
Stayer, Mrs. Glen C., 2511 Alco
Stell, Mrs. Cecil, 6905 Inwood
Stephenson, Mrs. J. H., 4523 Cedar Springs
Stephenson, Mrs. W. O. (Deceased), 4005 Hall
Stock, Mrs. John W., Mesquite
Strauss, Mrs. Elias, 6307 Glendora
Strother, Mrs. W. K., 6001 St. Andrews
Super, Mrs. A. R., 6015 Norway Rd.

AUXILIARY MEMBERS, 1954—*continued*

Talkington, Mrs. P. C., 6309 Westchester
Taylor, Mrs. H. Earl, 4218 McFarlin
Terrill, Mrs. J. J., 711 Dumont
Terry, Mrs. J. Glenn, 3528 Mockingbird
Terry, Mrs. J. S., 4311 Rawlins
Thomas, Mrs. Harold R., 4429 Potomac
Thomas, Mrs. Maxwell, 7614 Southwestern
Thomas, Mrs. Paul J., 3534 Greenbrier
Thomasson, Mrs. A. R., Jr., 4421 McFarlin
Thomasson, Mrs. Arthur R., 4229 Arcady
Thompson, Mrs. Barrett M., Box 686, Williams Rd., Irving
Thompson, Mrs. Leone S., 3620 Princeton
Thompson, Mrs. L. S., Jr., Military Service
Thornton, Mrs. C. W., 337 W. Sunset
Tittle, Mrs. Guy A., 4201 Belclaire
Tittle, Mrs. Lloyd C., 5242 Park Lane
Tobolowsky, Mrs. D., 3303 Perryton
Tobolowsky, Mrs. Nathan, 6530 Lupton
Tocker, Mrs. Albert M., 6122 Norway
Tomkies, Mrs. James S., 6011 Meadowlake
Trumbull, Mrs. Robert A., Rt. 5, Noel Rd.
Tubb, Mrs. Cullen L., 3525 Caruth
Turbeville, Mrs. Louis, 5627 Loring
Underwood, Mrs. George M., 3908 McFarlin
Usry, Mrs. R. S., 1835 N. Garrett
Van Duzen, Mrs. R. E., 5238 DeLoache
Vassallo. Mrs. A. L., 6738 Glendora
Vassallo, Mrs. H. R., 3337 Greenbrier
Veal, Mrs. George T., 6410 Velasco
Veninga, Mrs. F. W., 6246 Kenwood
Vermooten, Mrs. Vincent, 4404 Fairfax
Vieaux, Mrs. Jules W., 4429 Livingston
Wagner, Mrs. W. O., Box 417, Carrollton
Walcott, Mrs. H. G., 5304 Key
Waldman, Mrs. Morris F., 5414 University
Waldron, Mrs. W. Doyle, 3205 Tennessee
Ware, Mrs. Elgin, 4533 Livingston
Ware, Mrs. F. L., 6123 Prestonshire
Warren, Mrs. Charles H., 4922 Northwest Highway
Watkins, Dr. Margaret, 4556 Bordeaux
Weary, Mrs. W. B., 3613 Marquette
Webb, Mrs. Robert W., 4301 Livingston
Webb, Mrs. Sam, 4317 University
Weisz, Mrs. Stephen, 5511 Greenbrier
Welch, Mrs. Mark L., 4930 W. Hanover
Wells, Mrs. J. T., 4015 Colonial
Wharton, Mrs. T. A., 6212 Tremont
White, Mrs. C. Vincent, 3525 Cedar Springs
White, Mrs. Edward, 4319 Arcady
White, Mrs. H. D., 3429 University
White, Mrs. W. T., Stoneleigh Hotel
Whitten, Mrs. Merritt B., 4335 Lorraine
Wilkinson, Mrs. Albert, 1021 N. Mont Clair
Wilkinson, Mrs. Wallace B., 9800 Rockbrook Dr.
Williams, Mrs. Paul C., 3844 Turtle Creek
Williams, Mrs. T. S., 318 Beckleywood
Wilson, Mrs. Ben, 5538 Bryn Mawr
Wilson, Mrs. C. M., 3326 Hedgerow
Winans, Mrs. Henry M., 3825 Beverly
Winborn, Mrs. Claude D., 3629 Caruth
Winn, Mrs. Robert E., 5366 Montrose
Winn, Mrs. Watt W., 3520 Hanover
Witt, Mrs. Guy F., 6519 Oriole
Wittstruck, Mrs. Kenneth P., 6237 St. Moritz
Wolfe, Mrs. Joseph, 8511 Bluebonnett
Wolfram, Mrs. J., 5327 Edlen
Womack, Mrs. Jack L., 4020 Centenary
Wood, Mrs. Joe B., 6637 Golf Dr.
Woodard, Mrs. G. T., 1606 Junior
Woodard, Mrs. T. L., 5711 Vanderbilt
Woods, Mrs. Ozro T., 3501 Harvard
Wright, Mrs. R. E., 3904 Greenbrier
Yarbrough, Mrs. D. C., Jr., 3800 Marquette
Young, Mrs. John G., 3514 Rockcreek
Youngblood, Mrs. J. Wade, 5807 Lupton

DENTON COUNTY AUXILIARY*

Adami, Mrs. Gilbert, 710 Roberts
Allen, Mrs. Joe, Justin
Amos, Mrs. H. Culberson, 1615 N. Locust
Boyd, Mrs. Dickson, 1120 N. Locust
Burgess, Mrs. H. M., 520 Roberts
Carrigan, Mrs. Tom, 1716 W. Hickory
Davis, Mrs. Bert, 2020 Bell
Farber, Mrs. Harry, 2227 Houston Pl.
Hayes, Mrs. Lindley, Old Fort Worth Hwy.
>Hinkle, Mrs. George, Decatur Dr.
Holland, Mrs. Joe, 606 Woodland
Jones, Mrs. J. H., 503 Panhandle
Kinard, Mrs. Conrad, 827 Greenwood
Maddox, Mrs. Gordon, Highway 24
Miller, Mrs. Walter, Jr., 2229 Houston Pl.
McClendon, Mrs. Harry, 218 Bonnie Brae
Norgaard, Mrs. Hal, 2016 Brown
Palmer, Mrs. Bruce, Lewisville
Patterson, Mrs. Tom, 1712 W. Hickory
Remley, Mrs. William, 2008 Cherrywood
Sullivan, Mrs. John, Sanger
Thomas, Mrs. J. David, 1111 W. Mulberry
Weathers, Mrs. Paul, Pilot Point
Wyss, Mrs. Albert, Sherman Dr.

*Address is Denton unless otherwise stated.

ELLIS COUNTY AUXILIARY*

Ball, Mrs. William P., 1004 W. Marvin
Campbell, Mrs. W. E., 807 N. Preston, Ennis
Clark, Mrs. J. Lawrence, Box 308, Ennis
Donnell, Mrs. Herbert, Box 373
Estes, Mrs. T. G., Overhill Dr.
Hastings, Mrs. Miles E., 808 W. Main
Jenkins, Mrs. John B., 607 Sycamore
Jones, Mrs Joseph Edward, 1303 W. Main
King, Mrs. John David, 806 Bryson
Kochevar, Mrs. Gerald J., Midlothian
McCall, Mrs. Walter P., Ennis
McLean, Mrs. R. N., 1419 Ferris Ave.
Silman, Mrs. J. B., 711 Gibson
Skrivanek, Mrs. Dan A., Ennis
Skrivanek, Mrs. E. J., Ennis
Stein, Mrs. Ben, Ferris
Story, Mrs. Fred L., Box 316, Ennis
Swanson, Mrs. Laverne R., Ferris
Sweatt, Mrs. O. P., 600 Ferris Ave.
Tenery, Mrs. Robert Mayo, 819 Main
Tenery, Mrs. William C., 1412 Ferris Ave.
>Wallace, Mrs. B. C., Jr., 205 Overhill Dr.
Watson, Mrs. Seaborn Harris, 510 Ferris Ave.
West, Mrs. Norman L., 416 W. Parks

GRAYSON COUNTY AUXILIARY†

Bates, Mrs. I. C., 602 W. Birge
Blassingame, Mrs. W. Doak, 1106 W. Sears, Denison
Boyd, Mrs. Arthur M., 708 S. Maxey
Brandt, Mrs. Donald, 631 W. Woodard, Denison
Brown, Mrs. B. T., 506 N. Grand
Brown, Mrs. H. L., 511 S. Travis
Clayton, Mrs. Stanley L., 1431 W. Chestnut, Denison
Dimmit, Mrs. J. Sterling, 711 N. Crockett
Duncan, Mrs. R. W., Bells Hwy., Denison
Ellis, Mrs. John, 517 W. Birge
Enloe, Mrs. D. C., 1307 Hopson
Essin, Mrs. Emmett, 1102 S. Crockett
Fowler, Mrs. F. F., 1112 W. Walker, Denison
Gerard, Mrs. Rene G., 2301 S. Woodlawn, Denison
Gleckler, Mrs. Arthur, Loy Lake Rd.
Gleckler, Mrs. John D., 915 W. Gandy, Denison
Hailey, Mrs. E. L., 1165 W. Bond, Denison
Hardy, Mrs. John, 1144 N. Lockhart
Kepler, Mrs. Corliss C., 51 Parnell, Denison
Lay, Mrs. James, 623 N. Wood
Lee, Mrs. W. A., 1201 W. Gandy, Denison
Lewis, Mrs. S. O., 1430 W. Gandy, Denison
Mayes, Mrs. J. A., 1301 W. Gandy, Denison
McFarling, Mrs. J. E., 1011 W. Sears, Denison
Mize, Mrs. W. B., 1403 N. Travis
Monroe, Mrs. Stanley, 706 Kessler
Moorman, Mrs. T. A., Bells Hwy., Denison
Pierce, Mrs. Paul, 1400 W. Walker, Denison
Reid, Mrs. Creighton, 1409 N. Harrison
Rowland, Mrs. Robert H., 1134 W. Brockette
Rowlett, Mrs. G. S., 1702 N. Wharton
Savage, Mrs. H. B., 1704 S. Woodlawn, Denison
Shytles, Mrs. Harry, 1103 W. Brockette
Southerland, Mrs. W. I., 1221 Preston Dr.
Sporer, Mrs. Frank, W. Houston, Van Alstyne
Stoolfire, Mrs. Arthur W., 1402 N. Ricketts
Stout, Mrs. H. I., 811 S. Crockett
>Stout, Mrs. Joe Henry, 522 Westwood Dr.
Strother, Mrs. C. D., 1308 Preston Dr.
Triplett, Mrs. Neal, 1402 N. Wood
Tuck, Mrs. Vernon, 902 S. Travis
Weisberg, Mrs. M. A., 902 W. Morton, Denison
Woodard, Mrs. Max, 1020 Leslie

HOPKINS-FRANKLIN COUNTIES AUXILIARY‡

Bonner, Mrs. Dan E., 914 N. Davis
Chandler, Mrs. H. E., Mt. Vernon
Connor, Mrs. W. E., Cumby
Hanna, Mrs. W. Ray, Gilmer St.
Hodges, Mrs. Lester, Radio Rd.
Kirkpatrick, Mrs. Omar, Connally St.
Long, Mrs. Frank, Church St.
Longino, Mrs. Joseph B., Cooper Hwy.
Longino, Mrs. S. Byrd, 504 N. Davis
Longino, Mrs. Stephen B., Jr., Church St.
McConnell, Mrs. T. H., Gilmer St.
Peeples, Mrs. George, Mt. Vernon
>Stevens, Mrs. T. H., Houston St.
Stirling, Mrs. Earl, Jefferson St.

*Address is Waxahachie unless otherwise stated.
†Address is Sherman unless otherwise stated.
‡Address is Sulphur Springs unless otherwise stated.

HUNT-ROCKWALL-RAINS-DELTA COUNTIES AUXILIARY*

Arnold, Mrs. B. F., 1804 Stonewall
Becton, Mrs. Joe, 1320 Park
Bruce, Mrs. Grady, 3504 Lee
Cantrell, Mrs. Will, 3414 Lee
Carruthers, Mrs. F. S., 4516 Stuart
Cooper, Mrs. J. S., 4104 Lee
Crim, Mrs. E. T., 2506 Park
Hanchey, Mrs. J. M., 1830 Speedway
Jenks, Mrs. Ralph, 3916 Park
Kennedy, Mrs. C. T., Jr., 2206 Park
Kennedy, Mrs. C. T., Sr., 2206 Park
Leberman, Mrs. Lowell, Commerce
Little, Mrs. Frank, Rt. 5
Maier, Mrs. H. W., 2808 Pine
>Mehmert, Mrs. H. E., 2412 Stanford
Morrow, Mrs. W. C., 2704 Polk
Peak, Mrs. Fred, Mineral Hgts.
Phillips, Mrs. W. P., 2101 Park
Savage, Mrs. C. D., 2316 Park
Strickland, Mrs. T. C., 2500 Park
Swindell, Mrs. J. W., 1812 Walnut
Trentham, Mrs. J. C., Rt. 2
Turbeville, Mrs. Fred, 3818 Houston
Vallancey, Mrs. John C., 4504 Stuart
Ward, Mrs. J. W., 1612 Park
Weis, Mrs. C. B., 2208 Park
Welsh, Mrs. W. C., Caddo Mills
Whitten, Mrs. S. D., 5045 Wesley

KAUFMAN COUNTY AUXILIARY

Conradt, Mrs. L. W., Terrell
Lane, Mrs. E. W., Terrell

LAMAR COUNTY AUXILIARY†

Armstrong, Mrs. James Edward, 854 S. Main
Barker, Mrs. Carl DeVaux, 1028 Thirteenth, S. E.
Barker Mrs. Nym Lou, 2252 Cleveland
Fitzpatrick, Mrs. William Wando, 637 Clarksville
Gilmore, Mrs. Clarence Edgar, 145 Eighth, N. E.
Hammond, Mrs. Davis Scott, 1249 Lamar Ave.
>Hunt, Mrs. Thomas Ewell, Jr., 540 Fitzhugh
Hunt, Mrs. Thomas Ewell, Sr., 528 Fitzhugh
Janes, Mrs. Olin, Cooper
Johnson, Mrs. Malcolm Liddell, 503 E. Sherman
Jopling, Dr. Anna Hammond, Clarksville Rd.
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President's Page

COUNTY SOCIETY ATTENDANCE

Stimulation of attendance at county medical society meetings is one of the major objectives to which I have pledged my efforts this year.

Widespread lack of interest in the county medical society is perhaps the greatest defect in organized medicine. A recent statewide survey showed attendance has been far short of the desired level at the meetings of our 116 county societies in Texas.

This survey revealed a correlation between the numerical membership of a county medical society and the percentage of attendance at meetings. In general, the larger the membership of a society, the smaller is its percentage of attendance. The smaller county societies with membership of five to ten averaged a healthy 71 per cent attendance at meetings last year. A 68 per cent average attendance was reported by those societies with eleven to twenty-five members. In contrast, the average attendance at meetings of those organizations with 100 to 215 members was 38 per cent. The large metropolitan societies showed a combined average attendance of only 15 per cent.

Increasing attendance and stimulating the interest of membership are primarily responsibilities of the county medical society, but the State Association can and should contribute in several ways.

At the 1954 annual session in San Antonio, the House of Delegates adopted an amendment to the By-Laws which gives component county societies the right to provide a probationary period for applicants seeking membership. County societies might consider employing this probationary period, which cannot exceed twenty-four months, to encourage attendance by new members. In further pursuit of this same principle, several individuals have suggested that county societies should be permitted to install compulsory or semicompulsory attendance measures which would apply to all members. For example, a county medical society might set up requirements of attendance at one-third of the meetings for a given year for a physician to continue his membership in good standing.

Your state officers are fully aware that, particularly in the large cities, compulsory hospital staff meetings command a large share of

the physician's time. Compulsory hospital staff meetings work to the disadvantage of county medical societies which rely upon the voluntary initiative of the physician. The implications of compulsory attendance at hospital staff meetings should be reviewed critically on national and state levels. Many substitute provisions might be considered; perhaps the busy physician can receive some hospital credit for attendance at his county medical society meetings.

The central office of the Texas Medical Association is completing an analysis of outstanding attendance records by a select group of county medical societies. Forty-six county societies with above average records were asked to cite factors which contributed to good attendance. This study was undertaken with the belief that many of the societies are employing techniques which might benefit other groups.

Replies have indicated that there is no magic formula for guaranteed attendance. However, secretaries responding to the inquiry have pointed out that there are at least six factors which contribute to good attendance. They follow:

1. Outstanding scientific or socio-economic programs.
2. Food, fellowship, and social hour.
3. Adequate notification of the time, date, and place of the meeting.
4. A central location which permits the majority of physicians to attend without hardship.
5. Concurrent meetings of the medical society and the woman's auxiliary.
6. Individual initiative and good human relationships displayed by officers of society and members.

Physicians need to give much thought to the causes and remedies for the lack of interest in the county medical societies and correct this defect in organized medicine. While these efforts by state and county society officers are noteworthy, the individual physician is the only one who can accomplish the desired result—improved attendance at meetings. Attendance in any organization that is not compulsory must come from a personal desire to contribute to that organization. All physicians should be interested in contributing to the organization which is most important to their professional welfare.

J. J. L. Blasingame, M.D.

PR diagnotes

REPORT OF COMMITTEE ON PUBLIC RELATIONS: In a determined effort to aid county societies to strengthen their membership, attendance, and programs and to learn their needs, a visitation team was formed, and late in June the first visitation was made to the Brown-Comanche-Mills-San Saba Counties Medical Society in Brownwood. Since that time, more than thirty-one dates have been set with county societies--more than twice the number of visits made last year. The team will endeavor to gain firsthand information on the problems confronting the society and report on current activities, programs, and problems which are vital to organized medicine --a concrete step to strengthen intercommunication among the county societies.

An attendance improvement brochure is now in production at the central office. Research of forty-six societies with better than average attendance shows at least six basic factors contribute to increase. TMA received AMA recognition on its Medical Students' Day program of last year, with write-up in July PR Doctor. Thorough coverage included reprints of detail sheets, invitation, program, survey card, and final analysis.

FROM OVER THE STATE: Taylor-Jones Counties Medical Society recently sponsored newspaper ad series. Readers were reminded of local 'round-the-clock medical service, invited to discuss fees, and urged to secure a personal physician before illness strikes. The Abilene Reporter-News went along with a series of articles mirroring the doctor as a human being instead of a machine and reminding lay public of his intensive training, untiring availability, and dedication to his high code of ethics.

Individual efforts across the state fully rewarded in primary defeat of reinsurance bill. Proves effectiveness of active interest in legislative matters. No group did a better job than the doctors of Texas. Issue is not final, however--supporting forces are pulling no stops for reconsideration.

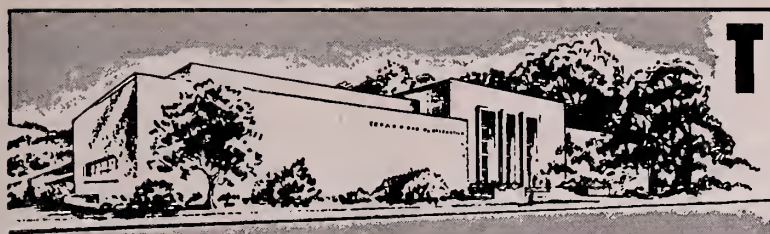
ON THE NATIONAL FRONT: Associations and societies are countering summer laxity with to-the-point mailing pieces. In Spokane, Washington, the county medical society has prepared an attractive booklet, "Your Doctor Speaks," urging readers to contact the society for qualified physician-speakers on health subjects (public service feature also provides panel of physicians when requested for large meetings). Designed to spotlight society's Speakers' Bureau, the folder lists available topics, explains bureau service.

AMA snowballed on requests for four new leaflets "Why Wait," "Health Today," "Quack," and "On Guard." So popular in Texas that central office has already reordered, these readable leaflets provide excellent material for distribution at fairs, in doctors' reception rooms, and as stuffers in statements and other mailings.

A two-day series of informal discussions on medical public relations is on the agenda for AMA's third PR Institute at the Drake Hotel, Chicago, September 1 and 2. Emphasis this year is placed on the exchange of ideas in all areas of medical PR, including major sessions to discuss how to solve conflicts between the medical profession and health and welfare workers, how to stimulate interest in reading material mailed to medical men, how to evaluate the medical assistant and his training requirements, and how to promote and present medical society-sponsored TV programs. Program, entitled "The Idea Exchange--A Public Relations Seminar," will brief audiences on a unique method worked out by a county society to sell its public relations program to local physicians and to the community. Will also premiere new AMA television film, "A Life to Save."

TIP OF THE MONTH

Since PR Institute subject matter is carefully keyed to developing and carrying out public relations programs at all levels, the seminar is invaluable to executive secretaries, public relations directors, and other representatives of state and county medical groups. Medical societies are strongly urged to have their representatives attend.



TEXAS State Journal of Medicine

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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GUEST SPEAKERS BEING INVITED

Invitations are being extended to distinguished physicians throughout the nation to be guest speakers at the forthcoming annual session of the Texas Medical Association, and at press time a dozen acceptances already had been received.

Nominated by specialty societies and section officers and approved by the Council on Scientific Work, the guests and other possible guests compose an impressive list. From Minnesota to Tennessee and from California to Massachusetts noted men of medicine are making plans to address various groups during the 1955 convention.

The Section on Clinical Pathology in collaboration with the Texas Society of Pathologists has received an affirmative reply from an invitation to Dr. Russell Fisher of Baltimore, and Dr. Hugh R. Leavell of Boston is to be the guest of the Section on Public Health and the Conference of City and County Health Officers.

Those speakers already committed to section programs along with the names of the section which nominated each follow: Dr. William J. Kerr, San Francisco, Section on General Practice; Dr. Robert L. Sanders, Memphis, Section on Surgery; Dr. Frank Lock, Winston-Salem, N. C., Section on Obstetrics and Gynecology; Dr. Clair M. Kos, Iowa City, Iowa, Section on Eye, Ear, Nose, and Throat; and Dr. John A. Anderson, San Francisco, Section on Pediatrics.

The following physicians have accepted the invitation to participate in specialty society programs: Dr. Walter A. Fansler, Minneapolis, nominated by the Texas Society of Gastroenterologists and Proctologists; Dr. John S. Lundy, Rochester, Minn., nominated by the Texas Society of Anesthesiologists; Dr. James C. Sargent, Milwaukee, nominated by the Texas Urological Society; and Dr. William Bickel, Rochester, Minn., nominated by the Texas Orthopedic Association.

Remember the Second Primary on August 28

Dr. John Caffey of New York will participate in the annual session program as a nominee of the Council on Scientific Work.

These twelve guests, with a number of other out-of-state and Texas physicians, will contribute to an outstanding scientific program in 1955.

The annual session, planned for April 25-27 in Fort Worth, will bring to Texas twenty to thirty out-of-state physicians to participate in the specialty society and section programs and in the refresher courses, a new addition on the agenda.

A Texas doctor, no matter what his field or special interest, will be provided an opportunity by this program to learn from some of the country's foremost physicians.

TUBERCULOSIS CONTROL IN COLLEGES

Great strides have been made in controlling tuberculosis in Texas college students in the past decade, and even greater goals are in view. Those physicians who are most interested in tuberculosis and its control can see in the not too distant future the day when a thorough program is carried out by the family doctor. He will be responsible for giving the tuberculin skin test and if necessary following up with a chest roentgenogram as a part of the regular physical examination for college admission.

Until that day, the problem of control is the responsibility of the colleges with the wholehearted support of local physicians. In 1953, only nine of forty-six colleges in the state which replied to a questionnaire reported that a tuberculin test or a roentgenogram was required for admission.

The Texas Tuberculosis Association, under its Committee on Student Health, Dr. J. Edward Johnson, Austin, chairman, has suggested the minimum standards for tuberculosis control in Texas colleges. The report, prepared by a subcommittee composed of Dr. Daniel E. Jenkins, Baylor University College of Medicine, Houston, chairman; Dr. John W. Middleton, University of Texas Medical Branch, Galveston; and Dr. John S. Chapman, Southwestern Medical School of the University of Texas, Dallas, combines the most favorable points of the control programs followed by each of the three medical schools in the state.

The members of the subcommittee agree that the tuberculin test, being highly sensitive and relatively inexpensive, is the method of choice for surveying students in colleges and universities throughout the state. They recommend the use of a single medium strength dose of tuberculin as the only test in college students. If the purified protein derivative of tuberculin is used, the initial testing dose would be 0.0001 mg. given intradermally; if old tuberculin is used, the dosage of 0.1 cc. of a 1:1,000 dilution of a commercial preparation is suggested. In either case the minimum number of readings should be one at forty-eight hours. However, twenty-four, forty-eight, and seventy-two hour readings are preferable with recording of both the erythema and the induration in millimeters.

A tuberculin test once a year is sufficient for students whose test is negative, the subcommittee believes. All students whose tuberculin test is positive should receive a chest roentgenogram at least once a year throughout their college program, and those students whose tuberculin test converts from negative to positive should have a roentgenogram made every six months. A 70 mm. microfilm is acceptable for the former provided that any suspicious shadow is followed up on a standard 14 by 17 inch film, whereas for the latter a 14 by 17 inch film is preferable.

Minimum effective standards should in all probability require a preemployment chest roentgenogram of faculty members and other adult employees on the campus. This is now required by approximately 80 per cent of the

Texas colleges. The subcommittee further recommends that annual follow-up chest roentgenograms be obtained on all faculty members and campus employees and that it be done on a mass microfilm basis as an economy measure for the institution.

With the encouragement and assistance of physicians, this program may lead to the complete control of tuberculosis among college students in Texas.

CONSTITUTION OUT

An up-to-date issue of the Constitution and By-Laws of the Texas Medical Association has been printed and will be mailed to officers of the Association and every county medical society secretary by September 1. Although the supply is limited, a copy for other interested doctors may be obtained from the Executive Secretary, Austin.

Amendments passed by the House of Delegates at the 1954 annual session have been incorporated in this edition.

SALK VACCINE FOLLOW-UP

The emphasis of the Salk poliomyelitis vaccine has shifted from the inoculation to the evaluation study. The validity of the evaluation depends upon data gathered on poliomyelitis cases in the test groups, including those children in the first three grades who did not get the vaccine.

Early diagnosis, prompt reporting and follow-up, and the securing of necessary epidemiologic information and laboratory specimens are important factors in the study which is under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health, Ann Arbor.

Physicians in areas in which vaccinations were not given also are asked to assist in the study by notifying local or state health officers of cases occurring among children who participated in the trials and then moved to another area and children who go to summer camps. Health officials also need information on participating children who receive injections of gamma globulin and on cases developing among family members of participating children.

The cooperation of every practicing physician is necessary to make this study a success.

CURRENT EDITORIAL COMMENT

EMPLOYMENT OF DIABETIC PATIENTS

Employment of the diabetic patient by industry is a challenge to industry and the physician alike. Such authorities as Joslin, Sprague, Tolstoi, Metropolitan Life Insurance Company, and United States Department of Labor agree that the diabetic can be employed in industry, with industrial hazards, except as an engineer or pilot or in a similar job.

Diabetes in industry is not a major problem, but the number of persons with diabetes who are employed, particularly at the younger ages, has been growing. The adult diabetic patient lives longer today and is in better condition to take a job than he was two decades ago. The prognosis, death rate, and accident rate for the person with diabetes is strikingly improved, and the working record of the diabetic, despite an absence of statistical information, appears to be good.

With good medical care, diabetic patients can carry on their jobs as well as they did before the onset of the disease. They do well enough to warrant continued employment without restriction except in a few jobs. The guiding principle is that a diabetic should not be in any position where, experiencing a reaction

This department of the JOURNAL *presents editorial comments on current items pertaining to the science, art, and practice of medicine, contributed by members of the Texas Medical Association and scientists closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the Texas Medical Association to submit such discussions for this department. The discussions should not be more than 500 words in length.*

or other diabetic emergency, he might endanger the lives of others as well as his own.

The Committee on Employment of the American Diabetes Association has suggested the following standards and procedures for persons with diabetes seeking employment and for employers planning to hire diabetics:

"1. A diabetic seeking employment should be required to present a note from his physician or clinic to the plant physician or the personnel manager, stating that he is a controlled diabetic and is examined at regular intervals.

"2. Diabetics are capable of performing any type of work for which they are physically, mentally and educationally equipped. Those diabetics who are taking large doses of insulin should not, however, be assigned work in which hypoglycemic attacks might result in injury to themselves and others.

"3. An effort should be made to see that diabetics work the same hours on a steady shift; or, if they must work on a rotating schedule that they avoid the 'grave-yard' shift from midnight to 8 a. m. This is the only concession in terms of hours that a well-controlled diabetic should ask.

"4. Wherever diabetics are employed, it is often wise to inform certain key people in labor and management organizations, as well as the plant physician and personnel managers, as to the nature of diabetes and the possibility of coma or insulin reactions. (This is not always a necessary procedure, since in some instances it may create prejudice against the diabetics. The decision as to the advisability of indoctrinating key plant personnel on the problem should usually be left to the plant physician, or in the absence of such a physician, the personnel manager.)

"5. Diabetics should carry cards or tags identifying their condition at all times, particularly when on the job.

"6. The plant physician can save time for the company and also help the employee by performing blood sugar and urine examinations, whenever the patient's usual laboratory facilities are available only during working hours. Ordinarily, of course, this should be done only after consultation with the family physician.

"7. A complete physical examination of each diabetic should be made regularly, at least once a year.

"8. A plant physician is within his rights if he re-assigns a diabetic employee to other work whenever the arising of new complications creates new risks for himself or for other employees.

"9. The diabetic requiring insulin should be considered controlled if the fasting blood sugar is not below normal limits and not above 150 mg. per 100 cc. by the Folin Wu method and the blood sugar three hours after a meal is not higher than 250 mg. per 100 cc. by the Folin Wu method and if the patient is under regular medical supervision. Although these or more nearly normal blood sugar levels are desirable, greater hyperglycemia alone, if not extreme or habitual, need not be considered a disqualification for employment in those cases where the patient's personal physician and the industrial physician both feel that other limits should be observed."[1]

There is no denying that occasionally real problems are associated with employment of diabetic patients, but they no longer have the importance they once had, and in these days they should not stand in the way of a more liberal attitude on the part of management toward such employment.

REFERENCES

1. Employment of Diabetics, Statement of Committee on Employment, Am. Diabetes A., July, 1952, Diabetes *1*:336 (July-Aug.) 1952.

HENRY A. CROMWELL, M. D.,
Houston, Texas.

5000 Montrose Boulevard.

Modified from a presentation for a postgraduate course in diabetes mellitus at Baylor University College of Medicine, Houston, October 27, 1953.

ORIGINAL ARTICLES

SOME PHYSIOLOGIC MECHANISMS OF AGING

ROBERT A. HETTIG,* M. D., Houston, Texas

THROUGHOUT the past hundred years medicine has been making great strides in the therapy of diseases which have stricken principally the young and the productive portions of our population. As the result of these tremendous scientific and humanitarian contributions the expected span of life has been greatly lengthened. Between the years of 1870 and 1950 the number of older persons living in the United States increased from about 1,000,000 to more than 12,000,000. Not all of this increment can be accounted for simply by the over-all increase in population in this country since during this same period the ratio of persons past 60 years of age to the entire productive group has increased by more than 140 per cent.[8] By helping to provide many of the therapeutic advancements which have prolonged life, medicine has aided in the creation of a new problem—that of geriatrics.

Unfortunately, despite our current emphasis on medical research, relatively little money and interest have been devoted to the specialized problems of the aged and, in fact, to the more basic problem of how and why people grow old and nonproductive in the first place. It is of interest to note that the first edition of a well known text on geriatrics appeared only sixteen years ago. The Gerontological Society was founded as recently as 1945 and its *Journal* in 1946. Our understanding of many of these problems has been delayed by the meager interest of medical research in the study of senescence. Now that the aged seem here to stay it is high time that we learn something of the physiology of the senile state in order to cope adequately with its many problems.

In the recent literature many data concerning physiologic aspects of aging have been accumulated, but unfortunately much of this information has been obtained in the study of laboratory animals and can be applied to the human being only by analogy. There still remains a paucity of large scale studies on the problems of human aging. It becomes necessary then to offer an apology for what is to follow, for the answers to many of even the commonest problems of senescence are simply not forthcoming at this time.

Read as part of a symposium on geriatrics for Section A (Medical), Texas Medical Association, Annual Session, San Antonio, May 4, 1954.

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FACTORS IN AGING

One of the basic problems in studying the effects of age has been to separate the factors which are due to prolonged life alone from those which may be the result of stresses, illnesses, and traumas. On the other hand practical studies of human aging must take into account that both hereditary and environmental factors are to be included in the composite state which is clinically recognized as senility. Anton Carlson[2] has said: "The debate on heredity vs. the strain and the accidents of living as the cause or causes of aging is from now on a waste of time and paper. It is not an either/or. Evidence now at hand shows conclusively that both play a role in the aging process of man and animals."

At the outset let it be said that to define aging with any exactness is difficult. Because of its simplicity the definition of Lansing[9] is as satisfactory as any: A process of unfavorable progressive change, usually correlated with the passage of time, becoming apparent after maturity and terminating in death. Dock[4] has defined aging as "the sum of the losses of function and structure and of the callosities, scars, and nodular hyperplasias due to 'wear and tear' and involution. 'Wear and tear' includes trauma, infection, overstimulation by emotional, dietary, or other abuses, dietary inadequacies, exposure to inclement weather, exhausting activity, and so on." These definitions may seem rather vague, but in the present state of our ignorance one cannot hope to be more explicit.

Despite these difficulties in separating aging from disease processes there remains a group of progressive changes which have not as yet been shown to be due to specific diseases. The most important of these follows:[1, 2]

1. Gradual retardation of cell division, cell growth, and tissue repair.
2. Gradual retardation in the rate of oxidation of tissues (lowering of the basal metabolic rate).
3. Cellular atrophy, degeneration, and fatty infiltration.
4. Increased cell pigmentation.
5. Gradual decrease in tissue elasticity and degenerative changes in elastic tissue.
6. Progressive degeneration and atrophy of the nervous system, including impaired vision, hearing, attention, memory, and mental endurance.
7. Gradual impairment of the factors which in the normal person in his earlier years maintain a fairly constant internal environment for the cells and tissues (homeostasis).

DEGENERATIVE CHANGES

It may be said that the process of aging begins in utero, for during this stage of development the embryonic ovary commences a lifelong involutional pattern in the gradual reduction of the number of ova. This involution continues throughout childhood and is accelerated just before the onset of puberty. Another example of intrauterine aging is the placenta, which at birth demonstrates evidence of a process of deterioration which may be termed senescent. Its vessel walls have lost much of their elasticity, and there are patches of necrosis and fibrosis scattered throughout.

Immediately after birth involution of the ductus arteriosus and of the umbilical vessels is observed—a process not dissimilar to that of aging.

Between birth and puberty relatively little regressive activity is encountered in the healthy child, but with the advent of adolescence the thymus gland commences its involution so that by the age of 30 years, extensive atrophic and degenerative changes are observed.[12] These include disappearance of the lymphoid tissue, calcification of Hassell's bodies, striking thickening of the arteries, and interstitial fibrosis.

These youthful involutions, although evidence of aging, are not deleterious to the functioning of the organism as a whole but act rather as landmarks in growth and development. Contrariwise, the alterations which occur after maturity are of importance in gauging the physiologic age of the human machine, the presence of these aging phenomena indicating decreased efficiency or decreased functional reserve.

One of the commonest involutionary patterns recognized in the fifth decade of life is the menopause. This termination of the reproductive life of the human female may be altered in its timing by disease, but it cannot be prevented merely by the presence of good health. Its regular occurrence at a fairly consistent age in most women bespeaks of some type of unknown physiologic "time clock" of inherited nature. At this time of life the ovary loses its ability to respond to the follicle stimulating hormone of the anterior pituitary gland, and no further ovarian follicles are formed. Consequently no ovarian estrogenic and corpus luteum hormones are secreted. Senile atrophy of the uterus and thinning of the vaginal mucosa soon follow the withdrawal of the ovarian hormones. Why the ovary loses its ability to respond to pituitary stimulation is the great mystery, the answer to which would help solve many of the problems of sexual aging in the human female.

Of paramount importance to the welfare of the human animal is the aging of the cardiovascular system. Deterioration of the vital structures of this system not only threatens man's life and limits his joie de vivre but also endangers his economic value. It is of interest to reflect that cardiovascular-renal disease is responsible for 25 per cent of all deaths in the fifth decade, 40 per cent in the sixth decade, and 52 per cent in the seventh decade.[5] Yet in all probability the incidence of cardiac disease within any age group is not on the rise; the apparent increase is a matter of greater longevity. Man now has a far greater chance to live long enough for this type of vascular degenerative disease to catch up with him.

The aged heart demonstrates an atrophy of the muscle fibers, accumulation of brown pigment at the nuclear poles of the muscle cells, disappearance of perinuclear striations within the cells, and minimal interstitial fibrosis unless coronary disease is present. Functionally, senile heart muscle shows a diminished ability to consume oxygen and to recover during diastole. The muscle may become irritable and arrhythmias develop. The senile heart despite the abiotrophic atrophy of the muscle is not a small heart. Because of the loss of myocardial efficiency the fibers may become elongated so that clinically and roentgenographically it may appear definitely enlarged, and anatomically it is found to be dilated. There is as yet a paucity of data on the physiology of the normal aging heart, one reason being that the high incidence of heart disease in the older population makes it difficult to ascertain beyond doubt that the cardiac status of an elderly experimental subject is suitable for research purposes. Obviously the final determinant of life is the myocardium, but it is not altogether certain that the myocardium ceases to function on the basis of old age alone. Some toxic or pathologic process seems to end the cardiac stroke in practically every person.

Turning to the vascular side of the picture, the tremendous emotional impact which sudden death due to coronary occlusion and to cerebrovascular accidents has had on our civilization has created an intense interest in the study of arteriosclerosis. It is utterly impossible to review this extensive literature in the limited time at hand. It should be pointed out that it is not definitely established that arteriosclerosis is an essential part of the aging process, but it is so commonly encountered in geriatric practice that its presence or absence must be assessed in each aged patient.

Heredity may play a role in the development of arteriosclerosis. It has been cited that among Chinese people in their native environment coronary occlusion is relatively infrequent and that this finding is due to a racial inheritance. However, in American-born Chinese coronary heart disease occurs with a much greater frequency, suggesting that factors other than heredity determine its incidence.

Anatomic variations of arteries, such as the redun-

dancy of the intima of the coronary vessels of males, described by Dock,[3] may be important in the production of a higher incidence of coronary disease in the male sex.

Biochemical changes of vessel walls are being investigated in relation to the development of arteriosclerosis. Lansing and his group[11] have found that with aging there is an increased content of aspartic and glutamic acids in arterial elastic tissue and that, because of the free carboxy groups of these acids, an affinity of the elastic tissue for calcium may develop. This diffuse calcium deposition in the wall together with alterations of the elastic fibers may pave the way for the deposition of lipid materials.[10] The many studies of lipids with reference to arteriosclerosis are far too numerous to outline in this paper, but mention should be made of the investigations of Steiner, Kendall, and Bevans[13] in producing vascular lesions in dogs by means of high lipid diets and antithyroid drugs as well as the research of Gofman,[6, 7] who has made extensive studies of lipoproteins in serums by means of ultracentrifugation. From the immense amount of research currently being conducted in this field it is hoped that the first truly significant steps will be taken in the conquest of arteriosclerosis.

Arteriosclerosis and its consequent circulatory disturbances play an important, if not dominant, role in the senescent changes of several viscera. The diminution of glomerular filtration, of effective renal plasma flow, and of excretory and resorptive tubular capacities as measured in the senile kidney are due principally to changes in the renal parenchyma secondary to sclerotic vascular lesions. Arteriosclerotic changes are observed also in the arteries of the aging thyroid gland, thymus gland, and spleen.

The senile brain likewise often demonstrates degenerative lesions resulting from arteriosclerosis of the cerebral vessels. However, alteration of nerve elements may occur independently of vascular degeneration. There are well authenticated cases of senile dementia in the absence of any striking abnormalities of intracranial circulation. Atrophy of the ganglion cells of the cerebrum, reduction of the number of cortical cells, changes in the glia and intercellular matrix, hypertrophied astrocytes, and increased pigment content of nerve cells are characteristic of the structural alterations of the aged brain. Functionally, loss of adeptness at skilled movements, poor coordination, and resistance to passive movements are noted at the motor level while progressive retardation of the ability to learn, inability to form new interests, and nominal aphasia gradually develop at the cortical level —all of these changes terminating in the full blown senile psychosis. In most of these far advanced cases both atrophy and vascular changes are responsible for the diminished function of the brain.

In the geriatric changes of the lung on the other hand we must consider muscle and elastic tissue degeneration once more. In this organ a myelo-elastic-fibrous stroma forms the interstitial architecture. During inspiration this stromal tissue elongates and develops kinetic energy which permits the lung to collapse during expiration. The action is similar to that of a rubber band which alternately stretches and shrinks back to its original dimension. In senility disruption of the elastic fibers, increasing fibrosis of the interstitial tissue, and rupture of alveolar walls result in a poor bellows action with the result that the chest tends to remain in an inflated position.

In the skin disruption of the elastic fibers of the dermis together with a loss of subcutaneous fat produces the many wrinkles associated with aging. There is also an associated atrophy of the epidermis with focal areas of increased pigmentation, graying or loss of hair, and possibly atrophy of the sweat and sebaceous glands.

Another example of the mechanism of atrophy is senile osteoporosis. This clinical entity, which usually makes itself evident by severe and at times incapacitating low back pain, is really a soft tissue defect brought about by a failure of bone matrix formation due to a lack of osteoblastic activity. Bone resorption proceeds at a normal rate, but the matrix into which calcium is to be deposited fails to form. Hence the bones become thin, radiolucent, and susceptible to pressure deformities and fractures.

As we have seen, the foregoing physiologic mechanisms of atrophy, vascular change, elastic tissue degeneration, and increased cell pigmentation may interact in many organ systems to produce the changes which are termed "old age." It should be pointed out that not all of the organs age and wear out at the same rate. In one person striking arteriosclerosis of the kidneys is discovered, whereas in another person excellent renal function is preserved but a deplorable loss of pulmonary function is the limiting factor of aging. The basic reasons for this "hit and miss" process of aging can only be surmised, and definite answers are not available from compiled data at this time. One is led to query again how much of senility is due to aging per se and how much is the result of stresses, illnesses, and traumas.

Equally mysterious is the ability of certain organ systems to function as efficiently in old age as in youth. Except for minor alterations the gastrointestinal tract of the aged never seems to cause death simply by wearing out, and despite its ability to produce several millions of cells daily throughout life, the hematopoietic system rarely fails to function simply because it is old.

THEORIES OF AGING

So far we have been dealing with certain basic physiologic and histologic alterations which occur in aging, but we have not dealt with the question of prime importance: What sets off the process of aging in the first place? This question has been asked ever since the world was young. Expeditions have crossed oceans in quest of magic potions which would provide eternal youth. Alchemists concocted noxious mixtures guaranteed to ward off senility. Yet even today with all of our scientific acumen we are no closer to the solution of the problem than were our more primitive forebears.

In recent years several attractive theories of aging have been promoted, but none of them have been proved correct. One hears the oft repeated phrase that man "is as old as his arteries." Certainly arteriosclerosis with its attendant vascular insufficiencies is a common factor of aging, but what of the senile person who demonstrates but little sclerosis? He is no blooming rose. The correlation between age and vascular status is highly imperfect. Hence we must look elsewhere.

Another attractive hypothesis is that old age is a gradual failure of the endocrine glands. This theory gained impetus from the fact that the ovarian failure of the human female at the menopause precedes senescence by but a few years. However, if ovaries are surgically removed in youth, there is little evidence of premature aging and no shortening of the life span. Myxedema and senility are often compared because of a superficial resemblance of the skin, hair, and musculature, but the administration of thyroid hormone to the aged person produces no rejuvenation. Likewise the administration of pituitary extracts and adrenal hormones has failed to turn back the inroad of time. Even the popular craze of sex hormone injections of recent years has not prevented anyone from becoming old. It is obvious that no single endocrine gland is responsible for the multitudinous changes of senility, and unless these glands interact in some unknown manner it seems unlikely that senescence ever will be considered an endocrinopathy.

CONCLUSION

This sketchy presentation has not been intended to try to explain the aging process of man. It is hoped that it has called attention to some of the mechanisms involved and to some of the fragmentary data in the medical literature. Our state of knowledge is much as if we had a few pieces fitted together in an immense jigsaw puzzle. These bits fall in place, but we cannot visualize the entire picture as yet. This is not surprising when it is considered that despite the tremendous energy which has been poured into the research of growth and development of the young, we still have no clear concept of that process in toto. Aging should be considered as the logical sequence of growth and development, and through correlating research studies of both ends of this problem a far greater understanding of the essential nature of life and of living is bound to result.

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PROCTOLOGY AWARD

The International Academy of Proctology has announced its annual cash prize and certificate of merit award contest for 1954-1955. An award of $100 and a certificate of merit will be given the author of the best unpublished contribution on proctology or allied subjects. The contest is open to all physicians whether or not they are affiliated with the International Academy of Proctology.

Entries should not be more than 5,000 words, and five copies should be submitted no later than February 1 to the academy, 43-55 Kissena Boulevard, Flushing, N. Y.

World Health Assembly

At the close of its three-week session in May in Geneva, delegates to the seventh World Health Assembly returned to the more than seventy countries represented. Included on the program were the presentation of international health prizes to three scientists, one of whom was G. R. Coatney, Ph. D., Bethesda, Md.; technical discussions on public health problems in rural areas; and the decision to meet in Mexico in the spring of 1955. Dr. Joseph Togba, Liberia, served as president.

PSYCHIATRIC ASPECTS OF CARE OF THE AGED

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THE care of elderly people calls for a particularly fine degree of skill and understanding on the part of the physician in general practice. Alfred Noyes[6] has pointed out that in the year 1900 one person in 25 was more than 65 years of age, and in 1950 one person in 13 was more than 65 years of age. This increase in the percentage of elderly people living among all the complexities of modern civilization results in changing medical, economic, and public health problems. The patient himself finds increasing stress in adapting himself to the civilization in which he lives.

Helping the elderly person to adjust his way of life to his changing capacities and to external demands depends upon two principal factors: (1) the possibility of reduction of stress in the demands of his everyday life and (2) the ability of the patient, figuratively speaking, to walk the tight rope of adaptation to those demands. The psychiatric status and the emotional stability of the patient are integral parts of the total picture of his health, his happiness, and his adjustment. Just as his digestion, his circulatory efficiency, and his resistance to infection will change with advancing age and will be affected by daily habits, so will his intellectual and emotional capacities and adaptability be dependent upon his age, his habit pattern of reaction, his general health, and the environmental stresses. The psychiatric problems of the aging person frequently equal or exceed his physical and economic difficulties.

In the familiar picture of the normal process of aging we see a decline in energy, drive, enthusiasm, and physical and mental endurance. The novelty of life, of new enterprises and new things to learn, and of people as such has worn thin. It becomes more difficult for the old man to learn new techniques or to change the habits of a lifetime. He recognizes his reduced efficiency and his inability to compete with new blood. He becomes irritable, partly because of organic cerebral changes and partly because of his recognition of his increasing limitations. Add to this the physical discomfort of his rheumatism, the pain that he gets every time he eats a pork chop, the inconvenience of that unsteadiness on his feet, and the increasing difficulty in hearing over the telephone and reading the fine print even with his best glasses —all these make things worse. Then, in addition, he forgets what it was he wanted at the store, and can't remember where he parked his car, and things have come to a sorry state.

Usually aging is a gradual process, and the intellectual and emotional effects of aging in the majority of instances develop gradually, as just outlined. The line of distinction between the normal usual changes of advancing age and the pathologic manifestations may be vague. In some patients rapidly developing organic psychoses, sudden vascular accidents, and abrupt depressive reactions occur. Most personality disorders or disruption may be visualized as falling into one of four general categories, namely, (1) senile or arteriosclerotic mental deterioration, (2) depressive reactions, (3) paranoid reactions, and (4) a simple, gradual aging process with irritability, impatience, forgetfulness, defects of judgment and concentration, and declining drive and vigor.

MENTAL DETERIORATION

In the first category, that of organic deterioration (table 1), there are the classical signs of severe memory and concentration failure, disorientation, confusion, restlessness, carelessness in dress and in cleanliness and toilet habits, and pronounced defects in judgment. Such persons are likely to wander away from home and become lost. The defects of concentration and attention and defects of sight and hearing increase the hazards in traffic. Patients may think they are in another town or may relive childhood days, thinking they are in the old home. They collect innumerable little odds and ends of worthless things, conceal such things as food or clothing or money in unsuspected places, and forget about hiding them, or if they do remember having had the articles, accuse others of stealing them when they are unable to remember the hiding places. Oftentimes they sleep poorly and may be up and puttering around the house at all hours of the night. They have trouble keeping warm and occasionally just sit down and build a fire on the floor in the middle of the living room. Some may have the additional misfortune of having gross vascular accidents, with resulting paresis, paralysis, or aphasia.

TABLE 1.—*Management of Patients with Organic Deterioration.*

Home care for mild cases
Protection and custody.
Simple tasks.
Food, vitamins, and hygiene.
Exercise, rest, and recreation.
Treatment of organic disease.
Mild sedation.
Hospitalization if disturbed, noisy, combative.

Read as part of a symposium on geriatrics for Section A (Medical), Texas Medical Association, Annual Session, San Antonio, May 4, 1954.

The patient who shows mild organic deterioration may be handled in the home in most cases, provided the relatives are intelligent, willing, and able. It means a considerable responsibility, since these old people must be protected against injury or against becoming lost in their wanderings. Simple tasks under supervision may be possible, and home care of the quiet and pleasant-mannered little old lady or man with moderate deterioration may be entirely feasible. It may mean simply keeping Grandma or Grandpa in sight most of the time; giving her a dishtowel to hem or giving him a hoe or a trowel to putter around with outside; preparing adequate meals with supplementary vitamins; encouraging normal elimination, reasonable exercise, and rest; and seeing that the bedroom door is locked from the outside at night. If organic disease of any type is present, adequate treatment is essential, since older people are particularly susceptible to toxemias and infections. Many senile and arteriosclerotic patients improve on a high nicotinic acid intake, up to 900 mg. per day orally and 100 mg. parenterally as suggested by Gregory.[3] Other workers[7] have reported excellent results from the use of chlorpromazine for control of the restlessness and irritability in these patients. My experience with this drug is encouraging, but it is too early to draw definite conclusions at present.

The disturbed, noisy, soiling, and combative deteriorated patient usually must be hospitalized in a psychiatric hospital or adequately equipped and well operated convalescent home. Some of these patients make surprising improvement under competent supervision and treatment. They respond better to association with groups of patients under as little individual restraint and restriction as possible. Clow[1] reported that in his series no patients with senile psychoses recovered, but 20 per cent of those with arteriosclerotic psychosis showed substantial improvement. Ginzberg's[2] experience demonstrated that even intellectually deteriorated elderly psychotic patients responded well to respect, consideration, and group therapy under hospital conditions. An attitude of kindliness, patience, and an absolute minimum of restraint frequently gives surprisingly good results.

DEPRESSIVE REACTIONS

Depressive reactions (table 2) occur rather frequently in advanced age. They may represent recurrent depressions of the manic-depressive type, late involutional depressions, psychotic depressions, or psychoneurotic reactive depressions. The symptoms are easily recognized. Depression may be manifested by simple restlessness and agitation, or by a more obvious and agonizing sense of despondency, blueness, hopelessness, and self-blame. There may be preoccupation with organ functions or with real or fancied organic disease. Insomnia usually is troublesome, the appetite usually is impaired, and the patient usually loses weight and may become incapable of decision or action. Where depression is present, suicide is a real danger. Many times the relatives, and occasionally the physician, will be misled by the patient's apparent "cheering up" as a result of reassurance and pep talks by family, friends, and doctor. The suicidal risk should be remembered constantly and precautions taken wherever this risk is apparent. In addition to reducing opportunities for self-injury by removing all weapons, poisons, and even potent drugs, the best single factor in minimizing suicidal risk is the constant presence of a member of the family or an attendant. Rarely will a person attempt to take his own life in the presence of another person. These precautions, however, must be only supplementary to adequate treatment.

TABLE 2.—*Management of Depressed Patients.*

Conservative program.
Precautions against suicide.
Dextro-amphetamine and mild sedatives.
Adequate diet and vitamins.
Neutral tub baths.
Intensified program.
Home management as in conservative program.
Standard electric convulsive therapy as out-patient procedure.
Hospitalization as alternative.

In the very mild depressions of short duration dextro-amphetamine may be given in several divided doses, from breakfast time until about midafternoon. The addition of a small dose of an intermediate acting sedative (I prefer Amytal, Butisol, Mebaral, chloral hydrate, or Dormison) may be used both day and night. Large doses of sedatives or the use of those having strong cumulative tendencies such as bromides are contraindicated. Adequate diet, with additional snacks one and one-half hours after each meal are helpful. In the absence of physical contraindications, neutral tub baths taken by the patient in his own bathtub at home are useful. The technique of taking such baths is for the patient to stay in the tub twenty to forty minutes at a time with the water at a constant temperature of 98 F. running continuously into the tub and out the overflow drain. Careful precautions against exposure to drafts or chilling are necessary. The neutral tub baths may be repeated as often as necessary, day or night. Tonic insulin in doses of 10 units (regular) half an hour before the morning and noon meals may be helpful. High vitamin intake, using multiple vitamin preparations by mouth, with additional vitamin B complex factors, amounting to about four times the minimal daily requirements of the B complex factors, are helpful.

Any depressed patient who does not respond promptly to such conservative management should be given the advantage of electric convulsive therapy, unless definite contraindications exist. Patients who can be cared for at home, with adequate precautions against the suicidal risk, are treated by preference as out-patients for the course of electrical treatments. I prefer to have the patient continue living at home, but come into the treatment room usually three times a week. At the time of treatment intravenous sedatives are given, followed immediately by succinyl choline chloride (Anectine) intravenously to prevent vigorous muscular contraction; then the electrical treatment is administered. The patient remains in the treatment room for the recovery period of approximately one hour, then returns to his home and to relatively unrestricted activities until time for the next treatment. Satisfactory recovery from the depressive symptoms after a series of such treatments occurs in the majority of patients, with a minimal disturbance of the home living situation and the family routine.

Recognition by the physician of a depressive reaction, his taking stock of its intensity and estimating the hazards promptly, treating conservatively as outlined if suitable, and instituting electrical convulsive therapy promptly if and when indicated are the important considerations.

PARANOID REACTIONS

In the severe paranoid reactions (table 3) delusions of persecution are prominent. These delusions often are bizarre and fantastic and are associated with irritability. Hallucinations of hearing are frequent in these reactions. In people showing this type of reaction unjustified hostility, bitterness, and suspiciousness may be intense. Denunciation of the fancied enemies, legal action, or even physical attack may occur. Patients with mild paranoid trends may be managed in the home, just as the patient with mild deterioration is managed, except for more careful avoidance of restraint and irritation if possible. If strong emotional reactions and intense bitterness and hostility occur, hospitalization is necessary.

TABLE 3.—*Management of Patients with Paranoid Reactions.*

Conservative management for milder cases at home as in mild deterioration. Electric convulsive treatment indicated in selected patients. Hospitalization for custody, protection, and treatment in more severe cases.

Electric convulsive therapy may be given in selected cases on an out-patient or in-patient treatment basis. Such therapy tends to reduce the tension and make adjustment to living conditions in the home or hospital somewhat easier. The paranoid trends usually are persistent, however, and usually they do not subside under electric convulsive therapy as rapidly or as satisfactorily as do depressive trends. The prognosis in patients with pronounced paranoid trends is distinctly guarded.

SIMPLE CHANGES OF AGING

In the simple changes of advancing age (table 4), even with mild degrees of organic deterioration, the situation is ideal for management by the family doctor. These patients may show a simple, mild to moderate memory failure and recognize their difficulty in concentrating on tasks requiring mental effort particularly. Usually there is a restlessness, a tendency to be up and about and rambling through the house at night, searching through drawers and cabinets, often without being able to say what is sought. There is impatience, querulousness, and sometimes defect of orientation.

TABLE 4.—*Management of Patients with Simple Usual Changes of Aging.*

Adequate diet; added snacks if desired.
Long rest at night and nap at midday.
Daily light exercise.
Hygiene and elimination.
Treatment of any organic disease.
Program of mental hygiene.
Regular duties and work. Productive work where possible in a field in which patient has had experience and skill.
Affection, friendliness, and appreciation at home.
Identification with a group.
Sense of independence and self-sufficiency.
Recreation.

Effective techniques of management of such patients in the home usually are possible under the direction of the family physician. General hygienic principles apply as in the case of any other person of advancing years. It is important to recognize that an older person is more susceptible than a younger one to dietary deficiency, fatigue, and either endogenous or exogenous toxemias. It is especially important to recognize that mental aberrations and emotional reactions, as well as exaggerations of the less desirable personality traits of the aged patient, are precipitated more readily by such factors as malnutrition, exhaustion, toxemia, or physical disease.

From the practical standpoint this means that the diet should be adequate in caloric intake, easily digestible, and well balanced. The total caloric intake should be between 2,200 and 4,000 calories dependent upon the degree of physical activity. Kountz[4] recommended a daily protein intake of 1.2 Gm. per kilogram of body weight, with fat intake up to 80 Gm. and relatively little sugar. High calcium and phosphorous intake with multiple vitamins and added trace minerals are important. It is well to plan a light to moderate meal at each regular mealtime, and to allow a light snack between meals and at bedtime if this is tolerated by the patient. Adequate time for sleep at night is important, and certainly an early

afternoon rest period of one to two hours, during which the patient rests lying down, sleeping if possible, should be a regular routine. In the absence of physical contraindications, daily light exercise, outdoors when possible, should be prescribed. Bowel elimination, preferably with the aid of methyl cellulose or other bulk-forming preparations, and adequate fresh or dried fruit intake is important.

From the standpoint of mental hygiene, it is essential to recognize that the aging person is subject to increasing emotional stress and trauma with the change in his daily habits. He finds it necessary to slow down and reduce the total of his activities because of decrease in energy, endurance, and drive. Further conflict emanates from his feeling of being "on the shelf" in comparison with his previous activities. Instead of his former position of being dominant to some degree in his household, his work, and his neighborhood, he finds now that failing strength and judgment prevent his taking a dominant position, or competing with other younger and more vigorous associates for positions of attention and respect and authority. It is a discouraging realization when it dawns on him that he is less essential to his own family and is approaching the stage of being excess baggage so far as their lives are concerned. To top it off, if his intellect is well preserved and his insight is sound, he realizes fully the futility of attempting to reverse the process, to regain youth and vigor, and to recapture the enthusiasm and motivation for long-term future plans.

To counterbalance these stresses, the elderly patient should be so situated that his emotional needs will be supplied adequately with the following basic requirements:

1. He should have a regular working schedule. Preferably the work should be productive and within the limits of his capacity, and similar to his former occupation if he is retired. If he can keep a regular job, even working only an hour or two a day, with only light pressure of responsibility, he will be happier. If he is unable to work for pay, or incapable of doing work related to his regular job, the nearest possible approach to this should be arranged. Regular duty, keeping him in contact with some productive activity program, is important, even if it is only answering the telephone and taking messages, or soliciting orders by telephone, or greeting customers. He should receive some pay for his efforts. If it is impossible for him to do any work for pay, either because of complete inability to get such work or because of his own incompetence to perform even simple jobs, improvised work around the home within the limits of his capacity is important. Any one of dozens of little chores about the household (sweeping the kitchen, making the beds, putting out the garbage, dusting the window sills) or the business or the farm are helpful. If possible, such work should be planned a day or two ahead, giving it an aura of importance, and giving the individual patient the savor of planning ahead and impressing him with the fact that other people count on his help.

2. Another basic requirement is an openly and frequently expressed friendliness and affection on the part of others in the home environment. The elderly person feels deeply any lack of attention, love, and appreciation, and he is more keenly aware of such lacks because of his inability to keep pace with activities of others. The divergence of interests between himself and other younger people, his increasingly limited activities and contacts with other people, and deaths of increasing numbers of friends of his own age intensify his loneliness. Warmth, respect, and affection and attention are important in offsetting these stresses.

3. Acceptance by and companionship with others in the neighborhood and in the community is of almost equal importance. If possible, association with other people of his own general age range and interest level should be arranged and encouraged. He needs to have that highly important feeling of "belonging" and of identifying himself with others in the form of formal organizations of some type, either in the working situation, community activities, or recreation. Church group work, veterans' organizations, hobby clubs, political activity, and charity solicitation all help. If no formal organization is available, the less formal basis of friendship and companionship outside the immediate home environment is helpful.

4. He needs as much of a feeling of independence and self-sufficiency as possible. It is important not only to contribute to his own support, but to be in the position of helping other people in some way. If he is unable to help financially, his morale is lifted enormously by having the family ask advice, even on small things. Members of the family can make a point of listening attentively to his words of wisdom, whether or not they follow his advice. If they ask small favors of him, and ask him to do things which he feels he can do better than others, either because of longer experience, skill, or special knowledge, he will feel much better. If he writes letters or attempts to conduct any business correspondence on his own responsibility, he should have his own letterheads and envelopes printed. The tonic effect of his independence, expressed in small ways of this sort, is enormous.

5. He should have recreation regularly. The type should be of his own choosing, within the limits

of safety and reason, but friendly competition at an easy pace should be encouraged. Dominoes, horseshoe pitching, shuffleboard, croquet, miniature golf, and cribbage are popular and cheap, and music, either instrumental or vocal, often stimulates interest. Square dancing, post-office, and dating may appeal to the more enduringly optimistic. Suffice it to say that some recreation, with some variation in its form, should be encouraged as a daily pleasure and relaxation.

SUMMARY AND CONCLUSIONS

Helping the elderly person to a wholesome adaptation to his everyday life requires skill, tact, and understanding on the part of the family and the physician. The areas of help and guidance include the physical and the mental and emotional fields. Abnormal psychologic reactions in many forms occur in the older age groups, the most frequently encountered being the senile or arteriosclerotic deteriorations, the depressions, and the paranoid reactions. Techniques of management at home and techniques of out-patient treatment are available for the milder forms of these reactions. Hospitalization of the more severely ill patient is advisable.

Management of the problems of the majority of elderly patients involves adjustment to the home situation and flexibility and adaptability of family attitudes in the home. The basic requirements for such patients showing the usual changes of aging include the physical factors of proper diet, hygiene, rest, and treatment of any organic disease. The satisfaction of the emotional needs of such patients demands a program of regular work, an atmosphere of affection and acceptance in the home, an opportunity for identification with a group and a community, the privilege of being both independent and helpful to others, and the opportunity to have regular and wholesome recreation.

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ABSTRACT OF DISCUSSION

AUDIENCE MEMBER: Would Dr. Cooper comment further about the choice of sedatives for the usual elderly patient and give his opinion about the use of alcoholic drinks?

DR. COOPER, closing: Sedatives which may be used instead of barbiturates must be selected according to the needs of the individual patient. If the blood pressure is not too low, chloral hydrate is useful and rarely produces toxic symptoms. Dormison and Isoval are useful and relatively safe. Chlorpromazine may prove to be very satisfactory in that it tends to reduce tension and keep the patient on a more uniformly stable emotional level throughout the day and night without producing the confusion and disturbing drowsiness noted with many sedatives. My experience with chlorpromazine has been too short for me to feel justified in drawing definite conclusions just now. It must be used cautiously and the dosage individualized since it does produce a drop in blood pressure which might be dangerous in the elderly arteriosclerotic patient with low blood pressure, and it might be equally hazardous if given to the patient with severe hypertension since too great a drop in blood pressure in such patients might make vascular thrombosis more likely. Chlorpromazine appears to have a synergistic effect when used with sedatives.

I believe that the use of a limited amount of alcohol in the form of wine or distilled liquor is beneficial, provided the patient's history indicates that he has never had any tendency to addiction or to the use of alcohol or any other drugs in excess periodically. I think that the use of one to three highballs in a day, or an equivalent amount of wine, helps in the relaxation and gives the patient a sense of well being which adds to the total picture of his comfort and health. The use of alcohol, of course, should never be allowed to interfere with food intake and should not be permitted if unfavorable gastrointestinal or other reactions occur.

OBSTETRICS AND GYNECOLOGY EXAMINATIONS

Applications for certification by the American Board of Obstetrics and Gynecology for the 1955 Part I examinations are now being accepted by the secretary, Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6.

Candidates for admission to the examinations are required to submit with their application a typewritten list of all patients admitted to the hospitals in which they practice for the year preceding their application or the year prior to their request for reopening of their application, with the diagnosis, pathologic diagnosis, nature of treatment, and end result. These applications must be received prior to October 1, 1954. Under a change of requirements for the Part I examination, candidates must submit twenty case abstracts, five of which can be from their residency service.

"Our danger at home is fixed and constant. Right at this moment, every major city in the United States is within reach of Russian bombers. We know that Russia has atomic bombs. We know that Rusisa has the facilities to wage biological warfare. We know that Russia is supplied with all of the modern war gasses. So long as those things are true—and every one of them is true—America's Main Street must be on the alert day and night."—FCD Administrator Millard Caldwell.

MEDICAL CARE AND SOCIAL AND ECONOMIC PROBLEMS OF THE AGED

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THE meaning of the word "aged" suggests various connotations, possibly depending upon a person's own age or perhaps on the association he has had with older persons. Since the usual age of retirement in many industries and professions has been fixed at about 65 years, many persons think of the aged as being 65 years or older. This is not necessarily true, as some people age or deteriorate earlier than others. There is often a difference in the chronologic age and the age as determined by mental and physical capabilities. It is said, aging is a process that sets in during the late forties or early fifties.

Because of the advance of medical science, there has been a rapid increase in the population of the aged. In 1953, the number of persons 65 years or older exceeded 13,400,000 or 8.4 per cent of the total population. This group is increasing at the rate of about 325,000 annually.[5] In 1949, the life expectancy at 65 years of age was 14.6 years for women and 12.4 years for men. At the age of 75 years, the life expectancy was 8.5 years for women and 7.5 years for men, and there was a fifty-fifty chance of outliving the expectancy. Of the 50 per cent that survive past the expectancy, some may live for an indefinite period. It has been estimated that there are more than 4,000 persons in this country who are more than 100 years of age at this time.

INCOME OF AGED

The income of the aged may be from private resources, relatives, old age assistance, social security or old age and survivors insurance, or pensions from one source or another. Last year, of the 13,400,000 persons 65 years or older, 4,100,000 were employed or were the wives of employed persons. About two-thirds were receiving payments under some public plan or earnings from employment.[5]

A person is not eligible for old age assistance until he has reached 65 years of age, and the amount varies in different states. In Texas, one must be a citizen of the United States, and he must have lived in the state for five years or more including at least one year just prior to his making application for assistance. He cannot possess more than $300 besides his homestead. A resident of any state institution is not eligible. The Constitution of Texas does not permit more than $20 to be paid to each recipient per month. The federal government pays $20 of the first $25, and anything over this amount up to the federal matching maximum of $55 is paid equally by both the state and federal governments. Thus the maximum old age assistance a person may receive in Texas is $55, of which $20 is paid by the state and $35 by the federal government.

In July, 1953, the highest average old age assistance in any state was $79.19, which was in Connecticut, and the lowest was $27.01 in Virginia.[4] Texas was fortieth on the list, with an average payment of only $38.47. The Texas Constitution also does not permit more than $35,000,000 for the three programs of old age assistance, aid to dependent children, and aid to dependent blind. There is a statutory limitation of $31,000,000 for old age assistance. Monthly payments often vary, as the number of recipients may increase or decrease from time to time.

When one makes application to the State Welfare Department for old age assistance, a budget is worked out for him, allowing a certain amount for living quarters, food, medical expenses if ill, and so forth. If he has an income from social security or other sources, the department will supplement this to the extent of his budget, but not in excess of $55. For instance, if his budget is for $75 and his income is $35, his old age assistance payment will be $40 per month. There were 220,980 persons on the old age assistance roll in Texas as of September 1, 1953.[4] The amount one may receive from social security varies, but the maximum payment for a family is about $127 per month. There is a bill before Congress that, if passed, will increase this amount considerably. One can readily see the predicament of the multitude of old people whose resources are meager or nothing when they are forced to retire.

OTHER PROBLEMS

Retirement, no matter at what age, brings to most people a new way of living. To a few, who have equipped themselves for this milestone, it means an opening of new vistas, time to travel and to do the things they have long wanted to do. However, only a small percentage can provide for themselves adequately as long as they live. To the majority, retirement brings untold problems and adjustments. Often

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their income is so reduced that their scale of living drops. Some find full or part time jobs. Many find that time hangs heavily on their hands; they have been too busy concentrating on their work to develop outside interests.

Often, old people are unable to make the necessary adjustments that retirement brings without some assistance. In some localities, classes are sponsored by boards of health, boards of education, industry, and social agencies for those who have reached or are nearing the retirement age. They are taught what kind of job they should apply for and how to go about getting it, how to invest what money they may have, how to utilize the existing facilities in the community, where to get help when sick, and numerous other things that may be of aid to them. Older people need counseling, and more facilities should be developed to provide this service. One out of three who seek jobs needs advice. Each should be placed in a job in which his past experience and training can be used. He can be trained for new work, but he is not as flexible as when he was younger.

Many have gone through the years making efforts at what they thought would afford adequate income on which to retire, but the higher costs of living can play havoc with a fixed income. Fifty years ago, more than half of the country's population lived on farms, whereas today no more than 20 per cent compose the rural population. Living was cheaper on the farm, and accommodations could be stretched more easily than in the present day small house or apartment. Several generations living together in crowded quarters is not conducive to happiness, as the younger may feel imposed upon and the older may feel unwanted. It is not surprising that the older people often develop a feeling of insecurity as they, no doubt, wonder what will happen to them since they are no longer able to provide for themselves.

Unfortunately, there is a general trend in industry to employ the younger people. Consequently, there is a tremendous waste of the older person's resources and experience which could be utilized and could be an aid to the economy of the nation. There has been an increase in the number of aged persons but not a corresponding increase in employment opportunities. In April, 1945, which was during wartime, 51 per cent of the men 65 years and older in this country were in the labor force, but by April, 1952, the number had dropped to about 42 per cent.[1]

All too often a passive attitude is taken toward the problems of the aged. Perhaps it is because most of us are too busy with our own problems, or maybe it is due mainly to the fact that we are not made aware of these problems. The aged need (1) an adequate income to meet the requirements for healthful living, (2) adequate medical care and facilities when they become ill, (3) suitable living quarters, (4) opportunity to obtain counseling, (5) opportunity for new social contacts, (6) recreation of various types, (7) some occupation, whether gainful or a hobby, and (8) rehabilitation which should include not only the physical but the mental and social aspects as well.

There is a gradual development of public awakening and consciousness to these needs. Facilities are being provided to correct these problems. Most communities provide for the young, but few give much attention to the aged. Perhaps they expect their respective families to shoulder this responsibility, and, usually, when possible, they do. But think of the many old persons who are alone in the world or whose families are unable financially to contribute to their support. In many cities where funds are raised each year for charitable organizations, frequently only a small amount of money is allocated to the needs of the aged. Many of the social agencies so financed are not equipped to assist them with their problems. Surely, there is the usual "poor farm" or "home for the poor," and I suppose they do the best they can with the money allotted to them. If we could but project ourselves into the future, how many would like to spend the twilight of our lives in such a place?

If a community would help its older people in making their adjustments, there would be less tendency for them to migrate. Unfortunately, for many their hoped for Utopia is disappointing as they find themselves in unfamiliar surroundings, and the problems they thought they had left behind are still with them. Many, however, migrate because they are seeking a better climate; too, because they know there will be others with common interests. St. Petersburg, Fla., is such a place. In 1950, there was 22.2 per cent of the population 65 years of age or older.[2]

SOLUTIONS

There is a brighter side of the picture since there are many private and community agencies working to make living for the aged happier. Clubs and community centers are being formed. Recreational programs and classes in subjects of interest to them as well as instruction in the various crafts are being developed. There has been a rapid growth over the country of Golden Age Clubs through which old people are brought together for planned recreation. This is good, for many lack initiative and depend more and more on others, even to planning their everyday activities. When interest is stimulated in such projects, mental outlook improves, and a decrease in physical complaints frequently follows. It

is believed that such activities reduce the number applying for admission to homes or institutions.

More so, in the last decade has there been a trend to provide for the aged in building projects. Villages are being built to provide community centers, dispensaries, workshops, recreational programs, and so forth. Certain areas are reserving units in large public projects. The New York Housing Authority has placed aside approximately 5 per cent of the available space for the aged. Many of the better homes for the aged have been developed by various church groups, fraternal orders, philanthropic and nonprofit associations, and private foundations. As increasing illness comes with increasing age, facilities for such are being incorporated in most building projects. Before the advent of public assistance, many such places were essentially for the indigent 65 years and older, and often only the well ambulatory ones were admitted. There is still a number of homes to which one must sign over most of his personal resources before he is admitted.

An example of existing projects for the aged is one the Upholsterers' Union in Philadelphia has developed. It is a retirement village in Florida located on about 600 acres, and it has a model community center, shopping center, and convalescent home.

"Moosehaven" is another project, located near Jacksonville, Fla., and operated by a fraternal organization. The guests, about 350, must be members of the fraternal order or widows of members. The average age is 76 years. Medical service is provided, but the facilities are usually strained because of the average age of the inhabitants.[1]

More private nursing homes are being opened. Some are good, but others are not properly or sufficiently staffed to give the attention needed. I recently had a patient in one that appeared above the average. One day she climbed over the sideboards and fell to the floor, and I was called only after she had complained bitterly of pain for three days. She had a fracture of the right femur.

We are still far from providing adequately for the aged, but we are going in the right direction. However, our pace must be speeded if we expect to attain that goal. Surely this will be accomplished eventually, once there is a realization and understanding of the problem by the general populace.

GROVE HOME

I have been associated closely in an advisory capacity with the W. H. Grove Home for the Aged in Fort Worth. Mr. Grove had the happy idea that he would like to provide a home for both men and women who had reached that period of life when they were faced with the problem of how and where to live. He realized that many were alone and that many were without resources to enable them to live in healthful and happy surroundings. Before his death he bought the land and left provisions in his will to build such a home. It was opened in the fall of 1951 with a capacity of 26 guests. Because of so many more applicants than the home could possibly care for, accommodations for 16 more guests were added, bringing the total to 42. There is still a long waiting list.

The E. D. Farmer Foundation took over the responsibility of running the home and makes up any deficit, but for the past year and a half or more, it has paid its own way. The Etta Newbury estate has been responsible for most of the furnishings. Occasionally, the home is the recipient of small gifts. A guest in a double room pays $55 each month, and those in single rooms pay $58.

The only requirements for admission are that the applicants must be mentally and physically fit to the extent that they can care for themselves and their own rooms and that someone must be responsible for them should they become ill. The home is not equipped to care for those who are acutely ill or have a disabling chronic illness. There is not even a nurse in attendance. The city nurse comes by to give the guests any parenteral medications prescribed by their physician. Those unable to pay for medical care are taken to the City-County Hospital and Clinic. It was thought by some that such a plan would not work, but it has so far.

A happy, cheerful, homelike atmosphere prevails. The guests take great pride in how the home looks. No one is asked to take over any duties, and all work is done on a volunteer basis. Interests are encouraged. One may ask to look after certain flowers, another something else. There is a spirit of comradeship and a helpful attitude toward each other. There is a feeling of independence as each has the privilege of coming and going as he pleases. Many have told me that they are happy and enjoying living for the first time and that for the first time they have a feeling of security. They have regained their self respect, and frustration is a thing of the past.

Parties and planned entertainment are arranged by the hostess. Only a few need any urging to participate. A camping trip for two nights near some lake is planned twice each year, and members of the Golden Age Club are invited. Also held twice each year is a bazaar at which items made by the guests are sold. This creates an incentive and desire to keep busy and gives to some a little extra spending money.

They all feel that they are paying guests, although all the income some have is from public assistance

except for that added by the Farmer Foundation. There are 38 living in the home at present, as some have moved, mostly because of illness. Vacancies are readily filled from the long waiting list. Guests are between 64 and 83 years. The following shows their source of income: 12 have independent incomes; 3 receive money from their families; 17 receive old age assistance; 3 are retired on pensions; and 3 receive old age assistance and a small amount from social security.

I fully realize that this type of home for the aged is not the solution to the over-all picture but only a small part. It does show, however, that once the physical setup is made available, it is possible to operate with little or no outside assistance.

SUMMARY

There has been a marked increase of the aged in the total population. With age comes increasing illness and many problems and adjustments. The trend is toward their solution. One new project for the aged is discussed.

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PUBLIC HEALTH ASPECTS OF THE AGING POPULATION

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IN referring to the aspects of public health as applied to the aged, attention is given to those conditions or diseases considered preventable or controllable. The indicated control measures are commonly implemented through programs operated by public agencies, complemented by the usual role of the practicing physician.

A concept of the physical picture encountered in old age might be considered a result of the total changes of maturity in an aging person in whom may be manifested varying degrees of physiologic changes and the earmarks of superimposed physical conditions or diseases of a chronic nature.

The health status of the elderly person thus in some respects represents the accumulated effects of survival. The application of the principles of preventive medicine and environmental sanitation, therefore, has an important bearing on the final product in old age. The traumatic effects on the surviving organism from contagious diseases that could have been prevented by immunization and the isolation of infected cases, infectious diseases that could have been prevented by proper handling of water and milk supplies, nutritional diseases preventable by suitable measures taken as regards food intake, the ravages of contact diseases such as venereal disease that are controllable, and the crippling effects of preventable accidents name but a few of the factors affecting indirectly the problem of old age.

As to the future of those aged persons who are surviving, many of the established public health programs are applicable for preventing certain disease conditions that otherwise might result in earlier death, disability, or dependency. As a result of the institution of such measures, the remaining years of life instead of being a liability may well become ones of usefulness and enjoyment. The general public or certain classes or age groups to a considerable degree might be motivated to adopt more favorable modes of living, particularly in relation to their environment, through public health education. An example of this technique might be creating awareness for correction of existing household structural defects that would result in lessening the possibility of home accidents.

Attention has been drawn to general public health programs already in effect that help prevent disease. Such programs that can be carried out on a public scale in several instances consist in the early detection of disease by means of screening procedures, followed by exact diagnosis and treatment through proper referral to private practitioners or, in the case of those unable to pay, to designated public clinics for final diagnosis and treatment. The role of mental health should be considered a vital part in this picture. A public attitude of appreciating the positive aspects as well as the limitations of old age, and where applicable instituting physical rehabilitation,

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would make for alleviation of many of the problems of older persons.

Vital statistic reports, as well as information obtained from health surveys, indicate some of the major health problems of the aged that may be altered appreciably for the better through the initiation of appropriate public health programs. At the same time the indications found in these data should point out to the practicing physician those disease conditions, particularly those of a preventable nature, that might not necessarily be anticipated in caring for older patients. Furthermore, the physician in his handling of the elderly patient also might bear in mind certain remedial or control measures that he himself can bring about in the patient's household.

MAJOR PROBLEMS

Home Accidents.—In recent years attention has been drawn to the heretofore overlooked role that accidents play as a cause of disability and death. It has been found that one-third of the nation's accident fatalities are home accidents. This fact has stressed the wide field that preventive measures can play in this category. Home accidents and old people are intimately related in view of the fact that in 1949 more than half of those killed in 30,500 deaths were caused in the home, and that in that year more than one-half of those killed in home accidents were 65 years and older. "Approximately 50% of all fatalities are caused by falls, and six out of seven such persons killed are 65 years of age and over."[11] The remedy to be sought undoubtedly is principally through correcting household hazards that create unsafe conditions.

Diabetes.—It has been established that the prevalence of diabetes increases with age. Diabetes, therefore, needs emphasis in health programs concerned with older persons. In the screening survey conducted in Dallas from 1950 to 1952, it was demonstrated that 5.2 per cent of those between the ages of 65 and 74 years either had or were clinically suspected of having diabetes.

Tuberculosis.—In communitywide chest roentgenray surveys recently made in four cities, it was found that the prevalence of diagnosed active tuberculosis (per 1,000 of population surveyed) in those persons 65 years and older ranges from .9 to 3.5. This range among the older population indicates a higher prevalence of tuberculosis than would be suspected from the results of other case finding procedures and also indicates that the problem of hidden tuberculosis in all probability is more serious in older persons than in the younger population groups.

Cancer.—The incidence of cancer increases rapidly during old age. From about the age of 60 and on, the male rates are higher than the female rates. In the survey of cancer illness among residents of Dallas made in 1948 by the United States Public Health Service the percentage distribution of all cases of cancer diagnosed at that time by primary site in the age group from 65 to 75 years and older was buccal cavity and pharynx 42.4 per cent, respiratory system 26.3 per cent, breast, 23.3 per cent, male genital organs 64.6 per cent, skin 34.5 per cent, and lymphomas 25.9 per cent. Attention particularly is drawn to the high incidence of skin and buccal cavity cancer in old age, both of which conditions are considered amenable to a more favorable prognosis when detected and treated early.

Heart Disease.—Arteriosclerotic heart disease, the leading cause of death, begins to be prominent in persons 35 years of age and continues to rise through the age group of 85 years and older. Next in order is hypertensive heart disease deaths, which are usually preceded by long periods of high blood pressure and often are accompanied with disablement. At the present time a great deal can be done in alleviating the distress of hypertension and hypertensive heart disease even more than in other cardiovascular conditions. It also might be pointed out that there is a high death rate from the effects of rheumatic fever and rheumatic heart disease in those persons 65 years and older. A significant point is that preventive measures on rheumatic fever in the early years of life can have a considerable bearing on lowering the death rates resulting from rheumatic fever in the later years.

Syphilis.—Syphilitic infection plays an important role in the older age group as compared with other age groups in the population. As late as 1949, of all patients first being admitted to state mental institutions with psychoses due to syphilis 16 per cent were 60 years of age and older. In 1950, more than 35 per cent of deaths from syphilis recorded in the expanding death registration area were in the age group of 65 years and older. In 1953, it has been estimated that in five American cities among the white population of 65 years and older from 0.45 to 2.45 per cent had syphilis needing treatment.

Nutrition.—Problems of nutrition deserve recognition in the care of the aged. It has been stated that in the case of obesity and its bearing on disease conditions (including vascular changes, diabetes, gallbladder disease, cancer of the endometrium, degenerative arthritis, hernia, and impaired kidney function), as many as 60 per cent of obese adults are women 50 to 70 years of age. Malnutrition with concomitant vitamin deficiency occasionally may be associated with institutional care where an undue attempt is made to keep down food costs. There seems to be a tendency on the part of old persons to eat improperly, because they either are sick, do not have or use

properly fitted dentures, cannot afford the proper food, do not prepare their food properly, are subject to dietary fads, or otherwise are subjected to unbalanced diets. A grossly inadequate diet followed for a prolonged period of time can lead to anemia in elderly persons and may be manifested in multifarious aspects of ill health, including mental confusion. Secondary anemia resulting from blood loss due to hemorrhoids also may be associated with mental confusion and can be alleviated by simple measures such as corrective surgery and the addition of iron to the diet.

Environmental Conditions.—Some types of air contamination can be particularly deleterious in respect to older persons. In the smog episode of Donora, Pa., in 1948, it was clearly indicated that more than half of the severely affected persons were 65 years of age and older. Whereas serious technical and economic considerations often are involved in the control of air pollution, nonetheless reduction of gaseous contaminants in many instances can be accomplished. Also may be mentioned the adverse effect of prolonged heat waves in the older age groups. Examples have been cited, particularly in the East, where the death rate experience in institutions housing the aged is pronouncedly increased during prolonged excessively high temperatures. The elderly are highly susceptible to heat cramps, heat exhaustion, and heat stroke, particularly those already in a debilitated condition. However when old persons are under medical observation, a considerable amount can be done toward early detection and consequent preventive measures taken to forestall heat syndromes.

SUMMARY

In recapitulation it is evident that public health programs carried out during the lifetime of a person have an accumulative beneficial effect on the health condition of the aged population as a whole. There is also a special appropriateness to the direct application of public health programs to the benefit of older age groups. Such activities may be in terms of creating a more suitable environment from the standpoint of correcting conditions hazardous to the aging population as well as offering activities directly affecting the health status of the individual. Attention is drawn to the fact that in the old age group are found many debilitating diseases and conditions that are preventable or susceptible to amelioration through control measures. Taking these into consideration, special attention is drawn to the importance of home accidents, diabetes, tuberculosis, heart disease, cancer, syphilis, poor nutrition, and the effects of contaminated environment by air pollution and excessive exposure to heat.

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HOUSTON SCHOOL FOR DEAF CHILDREN

The Houston School for Deaf Children celebrated its seventh anniversary on May 16. The program included an explanation of the type of training that is given to the children and how it is accomplished, including examples of training in memory and observation, auditory skill, speech, lip reading, and language. Robert Goldstein, Ph. D., Central Institute for the Deaf, St. Louis, spoke on "Problems of the Education of the Deaf." Children from the school presented nursery rhymes as a part of the program.

The school was organized seven years ago with one teacher and five students and now has a staff of six teachers and thirty-five pupils. It is a nonprofit, charitable institution charging a nominal monthly rate which covers only a small part of the actual cost per child. A few scholarships are given by local civic clubs.

A Houston Council for the Deaf was organized in October, 1953, with one point of its program to make scholarships available for people wishing to teach the deaf.

ACCIDENTS CAUSE HIGH DEATH TOLL

In every state accidents take a higher toll of life than any other cause of death except the cardiovascular diseases and cancer, statisticians of Metropolitan Life Insurance Company report.

Death rate based on accidents is highest in the mountain region, Nevada and Wyoming having the highest accidental death rates in the country for 1949-1950, and is lowest in the middle Atlantic and New England areas, with New Jersey having the lowest rate.

Contributions to Medical Schools

More than 48,000 physicians contributed $2,459,102 in unrestricted funds to medical education through the American Medical Education Foundation and directly to the medical schools last year. This is an increase of more than 10,000 contributors over the previous year.

SURGERY OF THE AGED

JOHN V. GOODE, M. D., Dallas, Texas

A BABY born in 1953 can be expected to live to the age of 69 years. This is about twice the age that was expected for babies born in 1800. As a result of increased individual longevity the population as a whole is aging. According to the most recent estimate by the Bureau of the Census,[3] there were about 12,759,000 persons at ages 65 and older in July, 1951. These old people have problems of survival that are quite different from the problems faced by young or middle aged adults. These two facts, the increasing number of old people and the fact that their problems differ from problems of other adults, justify the medical specialty designated as geriatrics.

As babies are not just small adults, so the aged person is not just an old adult. Old people have decreased reserves of protein and electrolytes; also they are much more sensitive to fluid and electrolyte imbalance. Because the extremes of normal electrolyte balance are more rigid in the aged, these patients may become either dehydrated or overloaded with fluid much more quickly than would a younger person. It is wise to estimate that both liver and kidney function are below par in older patients. These organs may function adequately in health but may be inadequate when faced with the added load of operative trauma and/or infection. As a result of decreased liver and kidney function and the commonly found low basal metabolic rate in the aged, drugs are excreted more slowly and must be used in decreased amounts in elderly patients. Because their aging circulation operates on such a narrow margin of safety, old people are unusually sensitive to oxygen lack. They must not be allowed to have long periods of hypotension or long periods of hypoxia. Because of all these physiologic changes and because the heart has been working so long, it is probably wise to consider all surgical patients in the old age group as cardiac patients and take all the precautions with them that would be taken if a cardiac lesion were known to be present.

SURGICAL CONDITIONS

Although most of the diseases of old age fall into the medical category (heart disease, mental disease, arthritis, and renal disorders), there remain a sizable number of serious disorders that must be treated by the surgeon. It is useful to group these surgical diseases under three headings.

Read before Section B (Surgical), Texas Medical Association, Annual Session, San Antonio, May 5, 1954.

In the first group are diseases immediately dangerous to life. These include intra-abdominal suppuration, obstructive lesions, gangrene of an extremity, massive hemorrhage or infection, and certain fractures. Since these disorders must be corrected even at great risk or the patient is lost, it is rarely difficult to decide what course to follow in the management of such lesions.

The second group is comprised of disorders not immediately dangerous to life but remotely dangerous to life. In this group are found the large benign intra-abdominal cysts and tumors, certain goiters, cholecystic disease, peptic ulcers, diverticulitis, and certain slow growing malignant lesions. It is difficult to be sure just what treatment is best for diseases in this group. Careful balancing of reserves, risks, expected years of life at a given age, all must be taken into consideration. It is here the surgeon must ask himself whether the good he will do justifies the pain, expense, and possible harm he might do.

The last of the three groups mentioned contains diseases that are not dangerous to life but are uncomfortable or painful. In this group may be found most hernias, hemorrhoids, bunions, cataracts, rectoceles, prolapse of the uterus, extraction of teeth, and so forth. Fortunately the relief obtained by correction of diseases in this group is great and the operative risk relatively small. It should be remembered that elderly people often are ready to die but are exceedingly intolerant of pain. It seems that constant slight nagging pain in an elderly patient breaks his morale and makes his life seem not worth living. For these reasons I usually advise operation for this group of painful or uncomfortable disorders.

PREOPERATIVE STAGE

Diagnosis of a surgical disease in the aged is difficult for several reasons. In the first place the patient's attitude toward his disease and his younger physician presents a problem. We have all heard such patients say, "Why did this have to happen to me?" "No one cares if I die, just leave me alone." "I'm too old anyhow." These old patients are suspicious of young doctors. They feel they know more than any young upstart, so they are prone to treat themselves through the early stages of a disorder. The physician's attitude may be at fault as when he looks at his very old patient and, accepting senility as an excuse for withholding treatment, says "Let him die in peace." There are other real difficulties present in making diagnosis in these older patients, for example, their variable

reaction to pain. They may seem less sensitive and minimize severe pain which they localize poorly, or be intolerant of slight irritating pain which they exaggerate. Also examination may be difficult because of obesity, arthritis, or poor muscle tone. Finally, there often is more than one lesion present in these old patients, and it may be difficult to tell which is causing the symptoms of which the patient complains.

Medical consultation should be obtained for all patients more than 60 years old who are to have a serious operation. It should be added that most operations on these old patients are serious. During the preoperative treatment an attempt should be made to determine by appropriate tests the functional reserves of the heart, liver, kidneys, and bone marrow. Also during the preoperative stage a careful attempt should be made to reveal and correct all deficiency states. Hypoproteinemia and avitaminosis are best recognized by a careful history of the patient's dietary habits. Electrolyte imbalance should always be suspected because, as stated previously, these old patients usually have inefficient kidneys resulting in a state of chronic dehydration. Serious illness quickly throws them into a sodium deficit, and after a few days there may develop a potassium deficit which further complicates the picture. The routine blood count may be misleading because there may be, as Champ Lyons has described, a contracted vascular bed and contracted blood volume.[2] If a patient has recently lost weight, such a condition should be strongly suspected and transfusions given before as well as during the operation.

Careful watch must be made not to overlook diabetes, which is often latent in the aged. Also important is the problem of pulmonary disease either chronic or acute. No elective operation should be carried out in the presence of even a slight infection of the upper respiratory tract. If possible, old patients should be encouraged to get up early the morning of operation and walk about so they will cough thoroughly and clean out the bronchial tree. Toward this end heavy premedication is contraindicated the night before operation and the preoperative hypodermic injection is postponed until after this coughing has been carried out. The last and one of the most important functions of the physician in the preoperative preparation of his patient is the building up in the patient's mind an optimistic attitude toward his disease and its treatment by operation. A well prepared patient feels that his surgeon really cares for him, that his family wants him to get well, and, most important, he is sure he wants to get well. If a patient wants to get well, he probably will get well; if he does not want to get well, he may not get well. It is my opinion that the surgeon, the family, and the patient's pastor must work together to produce if possible this will to live before any operation is carried out.

OPERATIVE STAGE

In planning the operation itself the surgeon must always remember that the aged stand blood loss and oxygen lack poorly and that they may enter shock rapidly and recover from it slowly. Also it should be recognized that low levels of blood pressure are much more dangerous in the elderly patient than in the young or middle aged patient. Hypotension is dangerous to the older patients because it may bring about coronary or cerebral thrombosis. With these facts in mind the operation should be carried out with the minimum blood loss and the least possible trauma to the tissues. Since extreme operative speed is rarely possible without sacrifice of gentleness and since blood loss and shock are so dangerous to elderly patients, it stands to reason that operations on them should be done slowly and very carefully rather than very rapidly.

The choice of operation in any given case should come after a balancing of several factors: the number of years of comfortable life that could reasonably be expected for the patient if all goes well, his reserves to withstand trauma or infection, the statistical hazards of the various operations, and, most important, what is the risk of the operation in question when the physician in the case carries out that operation. A good rule to follow is to carry out the less dangerous of two procedures whenever there is a choice of more than one procedure that will greatly improve the patient's condition. This does not mean the exclusion of all hazardous curative procedutes in favor of some palliative procedure. At times the definitive operation is the only one that will palliate, and the easier so-called palliative operation brings only suffering and grief to the patient.

The point I wish to make is that because of senility occasionally a gastroenterostomy is wiser than gastric resection, a cholecystostomy with removal of stones is more desirable than cholecystectomy, and even at times it is wiser to remove a slow growing ulcerating cancer of the breast by simple mastectomy than to remove it by radical mastectomy. While we dread the idea of throwing away a patient's last chance for cure of his disorder, we must keep in mind the first law of medicine, "at least do no harm."

There can be no question that emergency operations in the elderly group of patients are more hazardous than elective operations. Anglem[1] has reported that where the mortality rate was 6.9 per cent for elective operations it was 19.5 per cent for emergency operations. This was in a group of 621 patients more than 70 years of age in whom the over-

all mortality rate was 9.98 per cent. Such figures give support to the idea that operation should be carried out in the aged before the emergency arises.

Since most of the postoperative deaths in this group are caused by cardiac or pulmonary complications, special attention must be given to the problem of anesthesia for these older patients. It is probably wiser for the surgeon to spend his energies in selecting an anesthetist than to worry about the anesthetic agent to be used. The anesthetist should be urged to use the drug he considers safest in his hands, not the agent that is popular for this operation at some large medical center. For certain lesions spinal anesthesia is best, but it is dangerous for patients with very high diastolic pressures or for patients with central nervous system disease. I prefer 1 per cent Novocain used as a nerve block or for local infiltration whenever the resulting anesthesia will suffice for the operation at hand. By either or both of these procedures the abdomen can be entered and many operations completed without the addition of general anesthesia. However, when exploration is indicated or pulling on the viscera required, light general anesthesia should be added before the patient feels pain and starts to push down with his diaphragm and unanesthetized abdominal muscles.

POSTOPERATIVE STAGE

Proper care of the elderly patient during the postoperative period is quite important and often more difficult than the operation itself. Every effort should be directed toward preventing atelectasis. To this end the patient must be told of the danger of shallow breathing, must be urged to cough up thick secretions, and must be forced to move about both in bed and out of bed. Occasionally it is necessary to help the patient cough or even to aspirate the tracheal secretions to secure satisfactory aeration of lungs. Deep sedation is to be avoided. Early ambulation (walking, not just sitting up) is highly desirable. It not only encourages deep breathing, but by increasing the circulatory rate in the extremities probably helps prevent vascular thrombosis and embolism. When there is a history of previous phlebitis or when varicosities exist, bandaging the legs with Ace bandages and rarely the administration of anticoagulants are indicated.

The maintenance of a proper fluid and electrolyte balance in the postoperative period is a delicate problem in the aged patient. It is much easier to make sure the fluids and electrolytes are in good balance before the operation and to replace fluids as lost than to have to make up large deficits in the postoperative period. For this reason unless there is some cardiac or other contraindication I prefer to give all elderly patients 1 or more liters of 5 per cent dextrose in saline solution the day before operation. This helps to control the subclinical dehydration before the inefficient kidney it temporarily injured by the trauma of the operation. Also it removes the necessity of administering salt solution immediately after operation when kidney function is still depressed. A fluid intake and output chart must be kept for all these patients in order to calculate their daily fluid requirement. In planning the fluid requirement the physician must plan to replace the 1,000 cc. of fluid lost through sweating and breathing plus the amount of fluid lost as urine. This urine volume should be at least 1,000 cc. daily. It should be remembered these requirements will be elevated in the presence of fever, during the high temperatures of summer, or if there are other losses of fluid such as by vomiting, fistulas, and weeping open wounds. Fluid replacement should be made at a slow rate because it is so easy to overload the circulation and bring about pulmonary edema. In fact it is probably wise to keep the elderly postoperative patient a little on the dry side but not too dry, because there is evidence available that intravascular clotting is more likely in the dehydrated than in the normally hydrated patient.

Although the postoperative nutritional requirements of an acute illness in the aged may pose no problem, at times when the illness drags on for weeks, failure to manage this phase of the postoperative course properly may result in failure of the entire procedure. The surgeon must watch out for loss of appetite in his elderly patient. It does not take many days for a vitamin and potassium deficit to develop. With a potassium deficit the voice becomes high pitched, muscles become flabby, the patient states he cannot raise his arms, and the surgeon may notice a paralytic type of ileus. At this time the serum potassium level is likely to be low, and the electrocardiogram is likely to show low T waves. Treatment should consist of high level vitamin supplement and 3 to 10 Gm. of potassium chloride daily until satisfactory levels of potassium are obtained. To prevent this condition it is wise to add 40 milliequivalents of potassium chloride to one of the liters of fluid given daily if a patient is being carried entirely on intravenous fluids.

Amino acids and protein hydrolysates are useful in maintaining nitrogen balance in patients who cannot eat, but it must be remembered that patients receiving protein hydrolysates should also receive about 30 calories per kilogram of body weight as glucose daily. This prevents the proteins being burned by the body as fuel rather than used as sources of nitrogen for protein synthesis. Alcohol, testosterone, and small doses of cortisone may be used to increase the sense of well being and thus the appetite. In this

problem of getting sick people to eat we should pay particular attention to the way the meals are served. A small attractive serving may be enjoyed, whereas a huge serving of the same food looks impossible and is sent back untouched. All disagreeable dressings, conversation, and relatives should be avoided at meal time. Every effort should be made to make eating a pleasure and not an ordeal. In spite of the fact we can keep a patient alive with intravenous fluids and supplements, he is never cured until he can eat and gain weight.

Old patients require special attention to the genitourinary system and the bowels. If possible, the evidences of prostatism should be sought and corrected before operation, especially if the operation is herniorrhaphy. After operation early ambulation helps empty both bladder and bowels. Nevertheless, if there is any question of bladder overflow, early catheterization and occasionally the use of an indwelling catheter is preferable to overdistention and atony of the bladder. When it is necessary to leave a catheter in the bladder, the administration of small doses of Gantrisin daily is desirable. All old people seem to feel that a daily bowel movement is highly desirable. In fact it seems that the day is made or ruined by the presence or absence of a bowel movement. For this reason the surgeon should see to it they have this pleasure. Petrogalar at night and occasionally a saline cathartic such as Fleet's Phospho-Soda in the morning usually suffices. If an enema is needed, a saline enema is probably the best one to use since it causes no irritation if partially retained. Since old people are so prone to develop fecal impaction, careful attention should be given to any complaints of fullness in the perineum, unsatisfying frequent small bowel movements, and the fact that an enema does not enter the colon easily.

The last but one of the most important rules for the management of elderly postoperative patients is the rule that they must be protected from emotional upsets. Old people are suspicious that they are not being told all the truth, they frighten easily, and they become despondent easily. For these reasons the surgeon must always present an optimistic outlook. He must point out some favorable development of the case each day. He should scrupulously avoid gruesome details. He should never brag how difficult the operation was or how near the patient came to dying. Keep the patient interested in visitors, books, family, other patients, and above all make him feel that everyone is interested in him and wants him to hurry and get well. It is not advisable to break his habits of years' duration during the postoperative period. Unless contraindicated by the particular operation it is wise to let him chew, dip, smoke, or have an occasional toddy. Get him out of bed and brag on how strong he is rather than keep him in bed and feel sorry for him.

CONCLUSION

It should be remembered always that at age 70 a patient can expect ten more years, at 80 five more years, and at 85 three more years. Also when there is no pain and when the mind is alert, these old people seem to love life even more than young people. Therefore we should not withhold surgical relief when it is indicated. These older people stand operations remarkably well if the operation is done gently, the anesthetic is not too deep, sedatives are used to the barest minimum, and early ambulation is practiced really early. It is my opinion that these older patients as a group present our most challenging problems, call for our nicest surgical judgment, and finally become our most grateful patients.

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High Blood Pressure Remedy

Three Houston physicians reported in the July 17 *Journal of the American Medical Association* that an old Indian snakeroot remedy offers "good reason" to expect that high blood pressure and its complications can be relieved in both the early and late stages.

Dr. William R. Livesay, Dr. John H. Moyer, and Dr. Sam I. Miller state that with the drug alseroxylon high blood pressure may be controlled after it starts, and the serious later complications may be prevented. The doctors used alseroxylon, an extract from the snakeroot drug Rauwolfia serpentina, in treating 43 hypertensive patients at the Cardiac Clinic of Jefferson Davis Hospital.

The authors report that this drug has the distinct advantage among hypotensive agents in being associated with no serious untoward side effects. They reported that it often produces certain desirable effects such as mild sedation without somnolence. They stated that the drug reduced blood pressure and pulse rate, increased appetite, and produced "a sense of well-being or tranquillity."

Barbiturate Poisoning

Deaths from barbiturate poisoning in the United States are about one and one-half times the number immediately prior to World War II, according to Metropolitan Life Insurance Company statisticians. The victims of barbiturate poisoning, more than 400 per year, are mostly adults, and women outnumber men two to one.

BONE GRAFT IN RECONSTRUCTIVE SURGERY

T. WILEY HODGES, M. D., Dallas, Texas

BONE tissue has been employed with increasing frequency as grafting material by surgeons engaged in carrying out reparative procedures. The use of bone grafts reached a peak during World War II with the high incidence of wounds involving extremities, and lessons learned during this period regarding the management of bone grafts have continued to be utilized by surgeons during the postwar years.

It should be emphasized initially that the reconstructive surgeon must have familiarity with skin plastic procedures and with the handling of peripheral nerve lesions in order to repair and carry to a successful conclusion many of the cases of severe multiple tissue damage. Bone grafts will fail in a high percentage of cases unless careful planning and preparation for proper skin management have been carried out prior to the grafting procedure. The importance of covering the bone graft with full thickness skin carrying its own blood supply and applied without undue tension can be exemplified by the nonunited fracture which often heals after excision of all overlying scar tissue and coverage with healthy skin.

PREOPERATIVE CONSIDERATIONS

The patient's general condition should be at its optimum operative state prior to surgery.[4] Antibiotics, blood transfusions, and other therapeutic agents are employed as needed to effect this optimum operative level. In the presence of a recognized nonunion or of a defect of bone, a carefully planned and supervised program of physiotherapy is used for the extremity to mobilize the joints, improve muscle tone, and increase circulatory efficiency. The preoperative use of an ischial bearing caliper to allow ambulation in the presence of a bone defect in an inferior extremity is an example of a valuable adjunct used to improve the status of the extremity.

Many cases having failure of union or actual loss of bone substance have had the serious complication of infection, or the infection may still be present at the time it becomes evident that a bone graft must be used to effect osteogenesis.

The necessity of control and elimination of the infection is self evident. Bacterial cultures afford early recognition of the offending organism and sensitivity tests demonstrate the antibiotic or chemotherapeutic agents which will render effective control of the infection. Many injuries have resulted in severe scarring about the bone fragments. Scar tissue with its impaired blood supply is indeed poor wound soil to receive a bone graft and often bacterial foci are retained enmeshed in this tissue. A preliminary wound toilet to eradicate completely all scar tissue and necrotic bone debris so as to allow early wound closure is an essential prerequisite to the proper preparation of the graft bed. This is an important step as the graft bed must furnish nourishment to the bone graft.

At times a bone defect of the nature of an exteriorized cavity is encountered. These difficult problem cases can be successfully handled by first controlling the infection, invariably present, and then covering the walls of the cavity with thin split thickness skin grafts maintained in position by splints. After a dry cavity is thus attained, the split thickness skin grafts are removed, a graft bed is prepared in the bone, the cavity is obliterated with iliac bone chips, and then the area is covered with full thickness skin.

The decision as to when to carry out the bone grafting procedure following an infection is based upon several important considerations. The nature of the infecting organism, the severity and duration of the infection, and the reaction of the patient's tissues are important factors, as are the length of time the wound has remained closed, and whether or not any evidence of activity is still present. It is my opinion that the bone graft operation may be successfully carried out four to six weeks following closure of the wound provided a careful preliminary wound toilet was performed where necessary and provided that the patient's tissues show no reaction indicative of a low-grade or smoldering infection. The latter must be carefully searched for, and if unfavorable soft tissue reaction is present, operation had best be deferred.

PURPOSE OF GRAFTING

The purpose of bone grafting is to bridge a gap between bones or to reestablish the continuity of a long bone, as in (1) nonunion of bones with or without loss of bone substance; (2) filling of defects or cavities in bone caused by trauma, tumor, or infection; (3) joint arthrodesis, as following tuberculosis or poliomyelitis, or for fusion of the spine; (4) stabilization procedures such as bone block for drop foot; (5) correction of deformities; and (6) establishment of union in a pseudarthrosis.

Read before Section B (Surgical), Texas Medical Association, Annual Session, San Antonio, May 4, 1954.

GRAFTING MATERIAL

Each case requiring the use of bone grafting material demands mature consideration of the individual problem presented. The type of bone material to be used, that is, whether cancellous or cortical bone; the location at which the bone graft is to be employed; the character of the host bone to which the graft is to be attached; and the nature of the bone lesion all require careful appraisal. In all instances the plan should be for the graft to become incorporated as a part of the living bone structure on which or into which it is placed and for it thereafter to subsist as living bone across the gap which it bridges.

Bone grafts generally consist of cortical bone or of cancellous bone, although it is recognized that no graft specimen is composed entirely either of cortical or of cancellous tissue. Cortical bone is a solid mass of mature elements, the surfaces of which are covered with periosteum and endosteum. Grafts of this type possess considerable strength but little osteogenic power. Cancellous bone is of a loose construction with branching and interlacing trabeculae, each covered by endosteal or bone forming cells, and thus having a high osteogenic power. Abbott[1] has shown that the loose structure of cancellous bone allows adequate accommodation space for the invasion of capillaries and their accompanying cellular elements, thus permitting early and thorough revascularization. Rapid revascularization insures survival of the endosteal cells covering the trabeculae, and early osteogenesis occurs. Cortical grafts structurally contain inadequate accommodation space for the ingrowth of capillaries and, being composed almost entirely of mature osseous elements, will not survive. This type of graft serves as an internal splint which must eventually be replaced by new bone by the process of "creeping substitution" described by Phemister. A considerable portion of the cancellous bone graft lives and forms new bone.

Bone tissue, whether cancellous or cortical, may be obtained as an autogenous graft from the patient on whom the graft is to be performed or as a homograft, usually secured from a relative, or as preserved bone from a bone bank. The use of preserved homograft[7] has the particular advantage of lessening the operative trauma and operation time to the patient, as additional exposure of sites for removal of grafts is eliminated. At times it is difficult if not impossible to secure sufficient autogenous bone for grafting large defects or filling large cavities, and the hazard of fracture at the site of removal of a bone graft from an extremity must always cause concern and be guarded against, usually with a cast or a well fitted molded leather cuff.

TECHNIQUES

Several types of bone graft have been described of which (1) the inlay graft of Albee, (2) the self sustaining wedge only of Kirk, (3) the massive onlay graft of Campbell, (4) the barrel-stave grafts of Steele, and (5) the key graft of Bunnell have been used most frequently.

The location at which the bone graft is to be employed is deserving of especial consideration. The upper shaft of the femur and humerus are subjected to powerful leverage forces exerted by muscles motivating the hip and shoulder. Rigid fixation is essential as a spica cannot effectively control the leverage action of the muscles. A cortical onlay graft, particularly if reinforced with a metal plate, affords the rigid fixation needed. The dual onlay graft of Boyd[3] also will provide adequate fixation with the additional advantage of offering greater osteogenic properties. In the forearm or leg an intact long bone component affords considerable splintage to the injured bone, and grafting may be successfully carried out with the use of the cortical onlay graft or by means of iliac bone having cortical surfaces for stability, but without the necessity of a metal plate. Horwitz[8] has demonstrated that a graft 5 inches in length and more than 1 inch in width may be obtained from an ilium. These grafts contain two thin but relatively strong cortical surfaces, and if the crest of the ilium is utilized, a third cortical surface is added affording considerable strength.

It is felt that any lack of rigidity of iliac bone is more than compensated for by its superior osteogenic qualities and that the addition of a metal plate imparts the required stability. The process of creeping substitution whereby the mature elements of the graft are replaced by new bone occurs in both cortical and massive iliac grafts and is last manifest in the center portion of the graft. The critical period is usually after three months at which time the center of the graft may begin to resorb and fracture may occur. In this area of structural weakness rigid support and prolonged protection are necessary and may be secured by the use of a metal plate applied at the time of grafting. Metal plates may thus be used in conjunction with bone grafts to impart additional strength and stability but are never to be considered as being a substitute for bone. Bone defects are best bridged by the use of dual, only cortical grafts plus the use of iliac bone placed in a lamellated fashion in the defect. The dual, only cortical grafts insure firm stability, and the iliac bone affords increased osteogenic properties. Bone cavities are best obliterated with iliac bone, and it should be noted that cancellous bone[6] often will survive in whole or in part in the presence of low-grade infection if the area has been well covered with full thickness skin without exces-

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sive tension. Spine fusions also are best accomplished with the use of cancellous iliac bone applied in the lamellated manner. Cancellous bone may be successfully used alone to promote healing of a nonunited fracture or to bridge a bone defect, but immobilization must necessarily be for a longer period than where a cortical graft has been employed or where a metal plate has been used with the cancellous bone.

Bishop[2] reported an end-result study of the healing time of bone grafts used in 358 cases in an Army general hospital during World War II. There were 40 failures or 11.2 per cent. "Iliac grafts used under the most favorable circumstances to secure union were the slowest to heal, averaging 27 weeks; onlay grafts used in the most favorable type of case averaged 20 weeks; and the dual type graft which was used only in those instances in which slow union was anticipated by other methods, averaged 19 weeks." Of 112 dual grafts used to bridge bone defect there were only 20 cases of delayed union (beyond sixteen weeks) and no failures without complicating factors. He concluded that the use of the inlay grafts should be reserved for those cases of delayed union showing evidence of some healing. The massive cortical onlay graft was the graft of choice for cases with uncomplicated nonunion of long bones. Cases having a bone defect, nonunion near a joint, or marked demineralization or sclerosis of the bone fragments were treated best by means of the dual onlay graft. The latter type of graft affords rigid fixation which is absolutely essential if early functional use of the extremity is to be allowed.

Eggers[5] has demonstrated the importance of the contact-compression factor in stimulating osteogenesis and producing union of fracture surfaces. This factor is described as being the "combination of contact and the force to promote contact, exerted on bone structures." It is therefore highly desirable to promote early activity of the extremity in order to gain a more ideal pressure and contact of bone structures with the resultant enhanced osteogenetic activity. The proper choice and placement of bone grafting material, whether used singularly or in combination, will allow early supported function of the extremity, thus hastening the formation of bone architecturally capable of sustaining the stress of muscle pull and weight bearing.

CONCLUSION

Bone grafts are utilized to bridge a gap between bones or to reestablish the continuity of a long bone as in (1) nonunion of bones with or without loss of bone substances; (2) filling of defects or cavities in bone caused by trauma, tumor, or infection; (3) joint arthrodesis as following tuberculosis or poliomyelitis, or for fusion of the spine; (4) stabilizing procedures such as bone block for drop foot; (5) correction of deformities; and (6) establishment of union in a pseudarthosis.

Each case requiring the use of bone grafting material demands mature consideration of the individual problem presented. This includes the determination of the type of grafting material most suitable, the location at which the bone graft is to be employed, the character of the host bone to which the graft is to be attached, and the nature of the bone lesion.

Bone grafts are highly successful when adequately planned, correctly applied, and properly placed.

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HEART DISEASE VICTIMS

Heart disease victims who recover from an initial attack have a good chance of living for many years after the attack, according to Metropolitan Life Insurance Company statisticians. More than 70 per cent of a group of white men, disabled by heart disease but later recovered sufficiently to return to work, were still alive after five years. Those disabled solely by arteriosclerotic heart disease showed a five year survival of 85 per cent and a ten year survival of 70 per cent. Of those with arteriosclerosis and coronary occlusion, more than 50 per cent survived for ten years.

TUBERCULOSIS SYMPOSIUM

Thirty-five doctors from twelve states, Canada, and Bermuda attended the third annual Symposium for General Practitioners on Tuberculosis and Other Chronic Diseases, which was held at Saranac Lake, N. Y., July 12-16. Sponsored by the American Trudeau Society and local medical societies, this symposium had the largest number of doctors ever present for the program.

In addition to lectures and panel discussions, there were demonstrations in fluoroscopy, roentgen-ray techniques, bacteriology, pathology, and physiology.

DIAGNOSIS AND CLINICAL MANAGEMENT OF METABOLIC BONE DISEASE

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THE final diagnosis of any widespread bone disease is proved only by the x-ray and the laboratory (table 1). Routine roentgenograms of selected bones; determination of serum calcium, phosphorus, and alkaline phosphatase; and measurement of urinary excretion of calcium following the Aub diet[2] are usually required for diagnosis. Often required are studies of serum proteins, urine for Bence Jones protein, stool for fat excretion, bone marrow aspiration, and renal function.

Bone is formed by osteoblasts which lay down an extracellular substance called osteoid or matrix; then alkaline phosphatase acts to precipitate inorganic calcium, phosphorus, and carbonate into this organic matrix to produce hard bone. Bone is resorbed by large multicelled osteoclasts. In both growing and adult bone, there is a dynamic balance of these processes. Generalized bone diseases are associated with an imbalance of these processes. Albright and Reifenstein,[1] from whose book I have drawn heavily for this presentation, have formulated a classification of metabolic bone disease based on these imbalances. The following classification is modified to include certain other bone diseases considered in differential diagnosis:

I. Generalized bone disease (so-called metabolic bone disease).
  A. Too little calcified bone.
    1. Too little bone formation.
      a. Deficient matrix formation (osteoporosis).
      b. Deficient calcification of matrix (osteomalacia).
    2. Too much bone resorption: osteitis fibrosa cystica (generalisata).
  B. Too much calcified bone (omitted in this paper).

II. Localized bone disease (usually not called metabolic).
  A. Fibrous dysplasia of bone (Albright's disease).
  B. Osteitis deformans (Paget's disease).
  C. Destruction by malignant disease.
  D. Destruction by granuloma.

TABLE 1.—*Usual Biochemistry of Bone Disease.*

Disease	Alkaline Phosphatase	Serum Phosphorus	Serum Calcium	Urinary Calcium
Osteoporosis	N	N	N	⇧⇩ or N
Osteomalacia	⇧	N to ⇩	N to ⇩	⇩ or ⇧
Primary hyperparathyroidism	N to ⇧	⇩	⇧	⇧
Renal osteodystrophy	N to ⇧	⇧	N to ⇩	⇧
Fibrous dysplasia	N	N	N	N
Osteitis deformans	⇧	N	N	⇧
Malignancy and granulomas	N to ⇧	N or ⇧	N or ⇧	N or ⇧

OSTEOPOROSIS

In osteoporosis the osteoblasts fail to lay down sufficient matrix, but that matrix which does appear is normally calcified since there is no disturbance of calcium and phosphorus metabolism. Osteoporosis may result from a lack of protein or vitamin C in cases of malnutrition, disuse atrophy, senility, hyperadrenocorticism resulting from Cushing's syndrome or excessive administration of cortisone, hyperthyroidism, and hypogonadism. The most common cause of all osteoporosis is postmenopausal hypogonadism. Occasionally the cause cannot be determined.

The level of serum calcium and phosphorus is normal; the serum alkaline phosphatase level remains normal or low. Urinary excretion of calcium will be altered according to the status of the process. If osteoporosis is progressing, as may be seen in disuse atrophy immediately following immobilization of a limb in a cast, calcium excretion will be increased. If osteoporosis is regressing, as may be seen immediately following removal of the cast and resumption of motion of the limb, the calcium excretion will be diminished; if the osteoporosis is stationary, as may be seen in long standing postmenopausal osteoporosis, the calcium excretion is normal. Hypercalciuria, and occasionally renal calculus formation in acute bone atrophy, may closely simulate hyperparathyroidism. These chemical studies are seldom required since usually the diagnosis is easily made from the history and radiologic findings.

Radiologic findings of osteoporosis are characteristic.[7] With the exception of localized disuse atrophy, there is a predilection for thinning of bone in the pelvis and spine, and to a lesser extent in the skull, and rarely in the extremities. The trabecular mark-

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ings are intact unless osteoporosis is severe. Pathologic fractures occur but not pseudofractures as seen in osteomalacia. The vertebral plates remain distinct even though compression of vertebral bodies occurs. There is no periosteal resorption in the phalanges, and the lamina dura of the teeth remains intact.

Treatment of osteoporosis requires correction of the causative factors and includes proper diet for nutritional inadequacy, adrenalectomy for Cushing's syndrome, release from immobilization for disuse atrophy, and use of androgens and estrogens for postmenopausal and senile atrophy. Often more than one factor needs correction; for example, in senile patients a high protein diet, increased physical activity, and administration of estrogens and androgens are all indicated.

Frequently the pain from compression fractures of the vertebrae is partially relieved by administration of steroids. Estrogen may be given daily by oral administration of any of several preparations, including diethylstilbestrol, 0.5 mg.; estrone sulfate, 2 to 3.75 mg.; or ethinyl estradiol, 0.5 to 1 mg. Intramuscular injections are not necessary and do not enhance results. To prevent irregular estrogenic bleeding, the treatment may be interrupted each month for a week to produce regular estrogen withdrawal bleeding. Testosterone when swallowed loses most of its therapeutic effect. Sublingual testosterone proprionate, 10 mg. each day, or intramuscular testosterone proprionate or slow acting testosterone, 25 mg. each week, may be given to enhance the calcium retention produced by estrogens. Only rarely will these doses cause masculinizing effects. Salt-retaining tendencies produced by these steroids usually may be overcome by a low salt diet or the administration of ammonium chloride. The patient must be examined carefully for a cancer which may be aggravated by these steroids. I have never seen or heard of a cancer produced in a patient by this treatment, but this possibility must be kept in mind.

OSTEOMALACIA

Osteomalacia results from generalized decalcification of bone. The osteoid or matrix is laid down normally, but there is a deficiency in its calcification. Osteomalacia is caused by deficient absorption of calcium from the intestinal tract or by excessive excretion of calcium by the kidneys.

The level of either the serum calcium or serum phosphorus, or both, is low so that the product of the two in milligrams is lower than normal, usually less than 35. The serum alkaline phosphatase is elevated as a result of the excessive activity of the osteoblasts, which attempt to form strong bone in the presence of abnormal decalcification.

Radiologic study reveals generalized decalcification. A characteristic finding is pseudofractures, which are ribbonlike zones of decalcification extending through the cortex of bones at right angles to the margins. Apparently these are partial fractures into which osteoid has formed but calcification has failed to occur. They are often bilaterally symmetrical and involve especially the scapulas, pubes, ribs, and femurs. Pseudofractures may appear even before general decalcification is obvious (Milkman's syndrome). Subperiosteal resorption in the phalanges and granular decalcification of the skull are not seen. Rarely loss of the lamina dura occurs. In cases resulting from renal acidosis there often may be bilateral, severe, and extensive nephrocalcinosis or nephrolithiasis.

Osteomalacia as a result of deficient absorption of calcium from the intestinal tract may occur as rickets or vitamin D deficiency in childhood and is corrected by small doses of vitamin D. In this country rarely, if ever, does simple rickets or vitamin D deficiency occur in adults, but this condition is said to occur in China. Resistance to vitamin D is said to produce osteomalacia and is curable with huge doses of vitamin D. Steatorrhea is the most common cause of osteomalacia and results from diminished intestinal absorption of fat-soluble vitamin D and calcium. Steatorrhea may result from sprue, chronic pancreatitis, or extensive destruction of the small bowel by disease or surgery. Treatment is attempted with a low fat, high protein diet and by large doses of vitamins, all of which are known to be poorly absorbed in this disease, and by the administration of cortisone.[9]

Osteomalacia as a result of excessive urinary excretion of calcium may occur in three unusual conditions. One of these is renal acidosis resulting from a form of nephritis in which there is extreme tubular damage without glomerular damage. The damaged tubules are unable to form sufficient ammonia to neutralize the acid ions which the kidneys are obliged to excrete. This results in the excessive excretion of base, including calcium, from the blood with the final result of decalcification of bone. The hypercalciuria often leads to extensive nephrolithiasis. Treatment is directed toward replacing the serum base as rapidly as it is excreted in the urine, thus sparing the bones as a source of base. This is accomplished by giving large doses of sodium citrate by mouth (50 to 100 mm. daily of Shohl's solution, 140 Gm. of citric acid and 98 Gm. of sodium citrate dissolved in 1 L. of water, as needed to produce an alkaline urine). Meanwhile calcium absorption may be enhanced by the administration of vitamin D.

The second form of renal acidosis with osteomalacia is Fanconi's syndrome.[6] This is one of several rare and incompletely understood syndromes characterized by urinary excretion of large amounts of

amino acids. Other features of Fanconi's syndrome include retarded growth, albuminuria, renal glycosuria with increased organic acids, ammonia, phosphorus and calcium in the urine, hypophosphatemia without hypercalcemia, and no azotemia. Degenerative changes in the renal tubules are found. Apparently these damaged tubules are unable to resorb certain solutes from the glomerular filtrate and the resulting excessive excretion of phosphate and calcium leads to decalcification of the bone. Treatment should be the same as for renal acidosis with tubular nephritis mentioned previously, including Shohl's solution, high calcium and phosphorus intake, and massive doses of vitamin D.[8]

The third form of osteomalacia results from idiopathic hypercalciuria. This is not associated with renal acidosis and is not benefited by administration of alkali. The hypercalciuria tends to produce a low level of serum calcium and decalcification of bone with negative calcium balance. Renal stones are common. If the kidneys have not been damaged by stones, treatment by a high calcium, high vitamin D intake effectively controls the bone changes.

HYPERPARATHYROIDISM

Adenoma, adenocarcinoma, and diffuse hyperplasia of the parathyroids may produce the identical picture of primary hyperparathyroidism.[5] Secondary hyperparathyroidism is a response to some condition outside the parathyroid glands. Excessive parathyroid hormone is thought to produce excessive excretion of phosphate by the kidneys, thus lowering the level of serum phosphate and disturbing the normal calcium-phosphorus equilibrium. This results in an increased level of serum calcium and an increased resorption of bone in an effort to maintain the high serum calcium. The high serum calcium level is responsible for an excessive excretion of calcium in the urine. In turn, there is an increased formation of bone to compensate for the increased resorption. This often leads to an increased serum alkaline phosphatase. Briefly this series of events is reflected in decreased serum phosphorus and increased serum calcium, increased urinary excretion of calcium and phosphorus, and often an increased serum alkaline phosphatase.

Symptoms result from one or more of the following three changes: hypercalcemia, depletion of calcium from bone, and hypercalciuria. Hypercalcemia produces polyuria; polydipsia; gastrointestinal symptoms of anorexia, nausea, vomiting, and abdominal pain; and neuromuscular symptoms of fatigue, weakness, stupor, loss of muscle tone, and constipation. Only a few cases of hyperparathyroidism have been diagnosed by these symptoms.

Symptoms resulting from depletion of calcium from the bones are responsible for about 25 per cent of the cases diagnosed. Minimal bone disease causes vague pains and backache, and more marked changes result in osteitis fibrosa cystica generalisata (von Recklinghausen's disease) with bone tenderness, pathologic fractures, decreased stature, deformities, bone cysts, and tumors. The disease produces characteristic roentgenologic changes. Early findings are moderate rarefaction of the bones of the hands, skull, or jaw, with ground-glass or miliary type thinning. Of great diagnostic significance is the lacelike subperiosteal resorption of cortical bone of the phalanges which Pugh considers to occur only in primary and secondary hyperparathyroidism.[7] Loss of the lamina dura around the teeth may be an early finding of special diagnostic value. Advanced bone changes are generalized decalcification, disordered trabecular arrangement, and variable sized cystic lesions.

Hypercalciuria is responsible for the most common clinical picture of hyperparathyroidism, that of renal calculi with colic or obstruction. In prolonged cases there is infection, pyelonephritis, and uremia. Rarely fulminating "parathyroid poisoning" may exhibit nephrocalcinosis or calcification of renal substance with renal failure.

Proof of the diagnosis of hyperparathyroidism depends on the demonstration of a combination of increased serum calcium of more than 10.5 mg. per 100 cc. or preferably 11 mg. and reduced inorganic phosphorus of less than 3 mg. per 100 cc. or preferably 2.5 mg. Repeated tests should be made. The patient should be given a standard low calcium diet for several days, after which the urinary excretion of calcium should be measured. Normally it should be less than 100 mg. daily, whereas patients who have hyperparathyroidism usually excrete more than 200 mg. daily. Increased serum alkaline phosphatase indicates only the presence of bone disease, not parathyroid disease. For ordinary exclusion of the disease a negative Sulkowitch test for excessive calcium in the urine is sufficient.

The two other diseases which produce hypercalcemia are hypervitaminosis and acute osteoporosis of disuse. These are the most difficult to differentiate, but all other cystic and demineralizing diseases of bone and secondary hyperparathyroidism must be considered in the differential diagnosis.

The only treatment is surgical removal of the adenoma or occasional multiple adenomas if present, or if diffuse hyperplasia is the cause, removal of all except about 100 mg. of tissue. One must be certain before operation that the diagnosis is correct since the tumor may not be found in the neck and it may be necessary to split the sternum and explore the mediastinum. Occasionally, however, the tumor may be palpated preoperatively in the neck.

If the serum alkaline phosphatase level is elevated, severe transient or permanent tetany may appear postoperatively requiring massive doses of dihydrotachysterol and calcium. Occasionally these tumors are malignant and metastasize beyond surgical reach. Radiation therapy may be of some benefit in such instances.

Secondary hyperparathyroidism due to long standing renal insufficiency may be indistinguishable roentgenographically from primary hyperparathyroidism except in children in whom chronic renal disease leads to the additional finding of altered epiphyses and calcium deposits around joints. These epiphyseal changes led to the term "renal rickets." Any condition which leads to glomerular insufficiency including chronic glomerulonephritis, pyelonephritis, polycystic kidneys, and congenital obstructions of the urinary tract may produce renal osteodystrophy. The mechanism of the bone changes is not understood, but Albright[1] has expressed the belief that elevation of serum phosphorus as a result of renal failure leads to a compensatory low serum calcium level and secondary hyperfunction of the parathyroids. The severe acidosis present leads to increased urinary excretion of calcium. Also found is a high nonprotein nitrogen and acidosis with low carbon dioxide level in the serum. Extensive vascular calcifications and calcium deposits around joints may be seen. Albright has claimed excellent improvement of the bone lesions following the administration of large doses of sodium citrate in Shohl's solution (mentioned previously) to conserve bone and administration of vitamin D (50,000 units daily) to increase intestinal absorption of calcium.

Vitamin D intoxication results from prolonged administration of vitamin D for arthritis. Since the advent of cortisone this treatment seems to be used less frequently and its complications are now seldom seen, but it should be mentioned since it may produce a chemical, roentgenologic, and clinical picture identical to hyperparathyroidism, the differentiation depending entirely on the history.

FIBROUS DYSPLASIA OF BONE

Fibrous dysplasia of bone is a localized disturbance of bone development and not a so-called metabolic disease. It produces cystic lesions similar to those of hyperparathyroidism. For years the two conditions were not segregated and the title osteitis fibrosa cystica or von Recklinghausen's disease was applied to both. The lesions usually appear in childhood and progress slowly into adult life.

Calcium and phosphorus metabolism are not disturbed. The alkaline phosphatase remains normal unless there is extensive bone involvement in which case it may be slightly elevated. Large solitary or multiple cystic areas appear in the marrow and the cortex in which bone and marrow are replaced by fibrous tissue. Intervening bone is normal. The overlying or nearby skin may be covered by cafe au lait nonelevated patches of pigmentation. The bone and skin lesions usually show a distribution in keeping with one or more of the nerve root segments. When the bone and skin lesions are accompanied by endocrine changes and precocious puberty in girls, it is called Albright's syndrome.

Roentgenographic changes include large cystlike areas with thinning and sometimes expansion of the overlying cortex. The lesions are usually multiple and unilateral, but when a single lesion is present, it may be confused with a giant-cell tumor or solitary bone cyst. When extensive, the lesions may be bilateral with a preponderance on one side of the body. Sometimes the long bones are shortened and exhibit bowing or pathologic fractures. When involved, the skull has characteristic expanding radiolucent areas resembling cysts. The base of the skull and maxillas may be thick and dense, obliterating the sinuses and deforming the orbits. The remaining bone including the lamina dura is normal.

Treatment is directed toward orthopedic correction of deformities resulting from pathologic fractures and crooking of the long bones. No treatment is yet available to correct the underlying developmental disturbance.

OSTEITIS DEFORMANS

The lesions of osteitis deformans or Paget's disease although usually widespread are well demarcated lesions with normal bone intervening. A vascular disturbance strongly suggestive of an arteriovenous shunt with active bone destruction followed by bone regeneration is thought to be the underlying cause. The skin overlying the active lesions is warmer and may be slightly reddened and swollen. The disease occurs in older patients and involves predominantly points of bone stress and muscle attachments of the pelvis, the femurs, the spine, and the skull. There is a high incidence of osteogenic sarcoma.

The serum calcium and phosphorus are usually normal or slightly increased. The alkaline phosphatase is elevated and may be extremely high. During active stages or following immobilization of pathologic fractures, there is hypercalcemia and hypercalciuria, and renal stones may form.

Roentgenologic findings are characteristic, the lesions exhibiting three zones, one of normal bone, one of bone destruction, and one of overgrowth of bone. Since there is no normal trabecular pattern in the regrown bone, it is weak and tends to develop fractures or bow. Patches of the process are scattered

through the bone in irregular sizes and shapes, producing a coarse moth-eaten appearance.

There is no effective treatment. A high calcium diet and vitamin D administration have not been appreciably beneficial and should be avoided following fracture and immobilization in order to prevent renal calculi. The patient should be kept as active as possible to prevent osteoporosis of remaining normal bone. Estrogen therapy has been suggested for its calcium-retaining property. Widespread pain may require narcotics, and localized painful areas must be observed with suspicion of complicating osteogenic sarcoma. Benefit following therapy with cortisone has been reported recently.[3]

DESTRUCTION BY MALIGNANT DISEASE

Primary and metastatic lesions of bone may produce pictures almost indistinguishable from hyperparathyroidism or other metabolic bone disease. The roentgenologic and chemical findings may be identical. Usually the metastatic lesions are well demarcated from areas of normal bone. Only rarely is diffuse involvement of bone seen, and in such instances bone marrow aspiration biopsy should be diagnostic. The primary malignant lesion also may be obvious. Although the serum calcium level is often high, the serum phosphorus is usually normal or slightly elevated. Hypercalciuria and renal stones may be seen. Carcinoma of the breast, prostate, thyroid, kidneys, or lungs; lymphomas; and many sarcomas are most prone to metastasize to bone. Multiple myeloma may produce a confusing picture, but Bence Jones proteinuria and altered serum proteins, when present, along with the findings in the bone marrow aspiration are diagnostic. Benign cysts and tumors of bone may be multiple and confused with hyperparathyroidism.

DESTRUCTION BY GRANULOMAS

Destruction by granulomas includes several rare diseases which usually are easy to differentiate from metabolic bone disease. The infectious granulomas of bone, such as syphilis and tuberculosis, are usually distinctive. Boeck's sarcoid may present hypercalciuria, renal stones, and high alkaline phosphatase. The high serum globulin level, the pulmonary changes, and the punched-out areas in the phalanges are diagnostic criteria. Xanthomas, hemangiomas, Gaucher's disease, and eosinophilic granulomas may produce widespread cystic changes which require biopsy for diagnosis.

SUMMARY

So-called metabolic bone disease may be the result of inadequate formation of bone matrix in osteoporosis, insufficient availability of calcium for bone formation in osteomalacia, and excessive bone resorption in hyperparathyroidism. Localized bone disease, usually not called metabolic, may be seen in fibrous dysplasia of bone (Albright's disease), osteitis deformans (Paget's disease), destruction by malignant disease, and destruction by granulomatous lesions.

The final diagnosis of metabolic or generalized diseases of bones is proved only by the x-ray and the laboratory. Selected roentgenograms and serum calcium, phosphorus, and alkaline phosphatase studies are required for diagnosis, and occasionally other tests are needed. Clinical management of each of the types of metabolic bone disease is different and dependent on the underlying cause.

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BORIC ACID IN BABY POWDER

Boric acid in dusting powders can be used safely for babies, two New York physicians, Dr. Alfred J. Vignec and Dr. Rose Ellis, said in the July *American Journal of Diseases of Children.* The doctors report that infant deaths from boric acid solutions have been caused only by "ignorant" or accidental misuse of strong preparations and that standard baby powders "carefully tested and manufactured by ethical firms" usually contain no more than 5 per cent boric acid and are not harmful.

The doctors consider it unfortunate that it has not been made clear that all deaths have been due to "accidental, ignorant, and at times negligent handling" of solutions, ointments, and powders containing high concentrations of boric acid. They state that the greatest number of fatal cases have been from the accidental swallowing of boric acid by newborn infants.

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PELLEGRINI-STIEDA'S DISEASE
Report of 6 Cases

A. ROSS DAVIS, M.D.; GEORGE V. MILLER, M.D.; and EDWARD T. SMITH, M.D., Houston, Texas

PELLEGRINI-Stieda's disease in the literature is also known as periarticular ossification of the tibial collateral ligament. This is a relatively rare condition as manifested by the fact that Russell and Smith,[16] in an examination of 9,218 roentgenograms of different knees in an Army general hospital, found only 8 cases of the disease. It is for this reason that we at Hermann Hospital are reporting on our 6 cases.

This disease was first described by Pellegrini[12, 13] in 1905 and by Stieda in 1908. Since that time numerous cases have appeared in the literature. The largest series reported in this country to date is of 42 cases presented by Dr. Jerome G. Finder[5] of the Cook County Hospital in Chicago. In March, 1942, Kulowski[7] found only 60 cases in the English literature, and in April, 1949, there were 8 cases recorded from the Mayo Clinic.[11] A much larger series has been reported in the European literature according to Kulowski[7, 14] and Pellegrini.

PATHOLOGY

The disease is characterized by a deposit of calcium or bone just over the medial femoral condyle. The disease is usually preceded by trauma, either of the repeated chronic type or by a single acute episode. The disease is more common in men, and particularly men in the younger age groups. However, cases of patients as young as 12 years of age and up to 71 years have been described. There appears to be no particular racial distribution.

The trauma that precipitates this calcification is either direct or indirect and occurs in most instances when the leg is flexed and externally rotated. The onset of the disease with calcification is usually less than three weeks following the initial trauma.

Anatomically the tibial collateral ligament, or the internal lateral ligament, is a fibrous or membranous band lying adjacent to the knee joint and extending from the medial condyle of the femur to the medial condyle of the tibia. The ligament bears a relationship to the tendons of the sartorius, gracilis, and semitendinosus muscles and associated bursas.[18] Brantigan and Voshell[1] believed this to be calcification of the bursa beneath the ligament and not actually of the tibial collateral ligament itself. This opinion, however, does not seem to be shared by the majority of writers on this subject. Since there is disagreement among the authors as to the exact location of the calcified or ossified mass, there is also much disagreement as to the possible etiology.

Some think the pathologic process is essentially the same as that seen in myositis ossificans.[6] Pelligrini believed that the calcification was due to subperiosteal hemorrhage and subsequent metaplasia of the medial collateral ligament. Callen[3] related the condition simply to well known factors that concern calcification in the tissues which are dead and in a state of reduced vitality. Since fatty degeneration precedes calcification, this may explain the interval of lag following injury until the shadow becomes manifest. Growth of the process then may be dependent upon the state of vitality of the tissues sensitized or affected. Since bone is a secondary tissue, it must be preceded by cartilage or fibrous tissue.

The etiology also has been variously ascribed to separation of a bone fragment from the femoral condyle, to development of a small hematoma within the connective tissues with subsequent calcification, and to fractureless callus as a result of periosteal tear and proliferation. Nachlas and Olpp[10] stressed the coexistence of chronic arthritis of the knee in their series of cases. In addition, they also thought that there was a membrane present which lay beneath the fascia and enveloped the entire medial femoral condyle. This membrane overlying the adductor tubercle became atretic, and hemorrhage and calcification followed.

We may conclude from this that trauma followed by degeneration and necrosis is certainly the pathogenic process, regardless of its location.[8] Histopathologically there have been three types of bone growth described. Finder[5] listed these three types as predominant primitive infiltrative type on the basis of connective tissue, callus-like bone formation, and enchondral bone formation. Early in its evolution the lesion may contain little calcium and have a poorly defined margin. As calcification progresses, the lesion becomes more mature and may remain in this state permanently. Usually, however, this calcium deposit is invaded by blood vessels, and the lesion becomes ossified. This ossification usually occurs in the center of the lesion and spreads peripherally, gradually enveloping the hyaline cartilage and fibrocartilage which precedes this ossification.

DIAGNOSIS

The diagnosis is established on the basis of roentgen-ray findings. A narrow space usually separates the lesion from the adductor tubercle. Some authors use this as a criterion for diagnosis; however, others feel that large masses may fuse to the medial condyle of the femur. Characteristically, on roentgen-ray examination a crescent shaped area of calcification is directed vertically or obliquely in the soft tissues just medial to the inner condyle of the femur and appearing to cap the epicondyle. Calcification can be distingushed from ossification on roentgen-ray only by the presence of trabeculations.[3] This calcification or ossification may be triangular or fusiform as well as crescentic. Various authors have described two different radiologic types of disease occurring in this region. The first is described as an evolutive type in which there is hazy or fuzzy opacification, which is not clearly demarked from the epicondyle. The second type has been described as the stabilized type with a dense sharply outlined ossified shadow clearly separated from the epicondyle.[9] Only a small number of cases that showed a tendency to deposition of calcium in other parts of the body have been reported.

The symptoms and physical findings include tenderness over the involved area with aching on weather changes, and tension on the ligament accentuates the pain. The patient will likely hold the involved joint in slight flexion, and extremes of flexion and extension will cause discomfort. Prolonged walking also seems to result in vague aching about the knee joint. Palpation over the adductor tubercle area reveals the local sensitiveness, and also the calcified area is sometimes palpable. In addition, some of the cases observed have shown atrophy of the thigh and calf muscles. On the basis of these symptoms and the history of trauma compatible with the establishment of this process, serial roentgen-ray study may be helpful in early recognition of the disease.

The differential diagnosis should include enchondroma, myositis ossificans, and paraosteal arthropathies in paraplegia. Characteristically on the roentgenogram there is a clear radiolucent space of varying degree between the shadow and the femoral condyle.

This is important in ruling out osteoma, periostitis, fracture of the femoral condyle,[15] and to a lesser degree the conditions mentioned previously. Other conditions which should be ruled out include semilunar cartilage tears, rupture of the cruciate ligament, avulsion of the tibial spine, detachment of the tibial tubercle, and joint mouse.

The disease may be prevented in some cases in which the trauma typical of that producing the lesion is suspected and the knee is put at rest. In other cases if pain has developed, roentgen-ray therapy may relieve the pain and prevent the characteristic calcification of Pellegrini-Stieda's disease from occurring.[2] If the disease already has begun, some of the cases will benefit from physical therapy, which should consist of diathermy, and some of these lesions will heal spontaneously.[17] Injection with local anesthetic is often helpful also. Finally, some cases will require surgical excision with plastic repair of the ligament thus releasing the tension.[4]

CASE REPORTS

CASE 1.—M. S., a 21 year old white football player, was injured on October 7, 1953, at which time he received a twisting injury to the knee which was in flexion at the time. This occurred while he was being tackled on the football field. The knee became painful immediately, but he continued to run and noticed that the knee was particularly painful when he attempted to cut to the left. That night swelling became marked in the knee, and he had difficulty bending the knee the next morning. The swelling persisted for about two weeks, during which time he noticed that the knee hurt him on the inner aspect while he was lying in bed, and he was unable to flex the knee past an angle of 30 degrees. Most of the pain was noted to he present following motion, however. Internal and external rotation were particularly painful. He ran for about two weeks working out on the track, and then he noticed that the knee got stiffer after running a play and became worse.

The first roentgenogram was made about three weeks after the initial injury and revealed beginning calcification. There was a sensitive area on the medial aspect of the knee for about six weeks. He was treated at Hermann Hospital with about twelve hours of ice packs, elevation, and pressure to the knee followed by whirlpool, diathermy, and seven courses of roentgen-ray therapy, which were completed about November 6. The symptoms gradually subsided, and the patient was able to return to football and entered the Cotton Bowl game on January 1, 1954. However, the knee was still sore and painful, particularly on flexion, at that time. At present he lacks about a 5 degree angle of having complete extension and has a palpable mass 1.50 cm. in diameter over the medial aspect of the knee. However, he is able to continue all of his normal activities and feels that he is able to go at full speed in football.

CASE 2.—R. E., a 24 year old white baseball player, received his injury the second week of March, 1952, at which time his left leg was externally rotated and flexed. This man, a left-handed pitcher, caught his heel as he was winding up to pitch. At that time he was aware of crepitation in his knee and had immediate pain in it, followed by swelling shortly thereafter. For six to seven weeks he had a sensitive area on the medial aspect of the knee and had pain at the extremes of motion. Flexion and extension were both limited. His treatment included ice packs, diathermy, whirlpool, and exercise, which consisted of running up and down the stands and around the track. Now he has some crepitus present in his knee. He has a full range of motion, and his only symptom is that the injury sometimes causes an ache in the knee.

CASE 3.—E. D., a 22 year old white man, was injured in the second week of July, 1953, when he was playing softball and slid into second base. At that time he had pain which eased up some, and later that night swelling developed. This was a flexion and external rotation type of injury which caused in addition to the pain and swelling some limitation

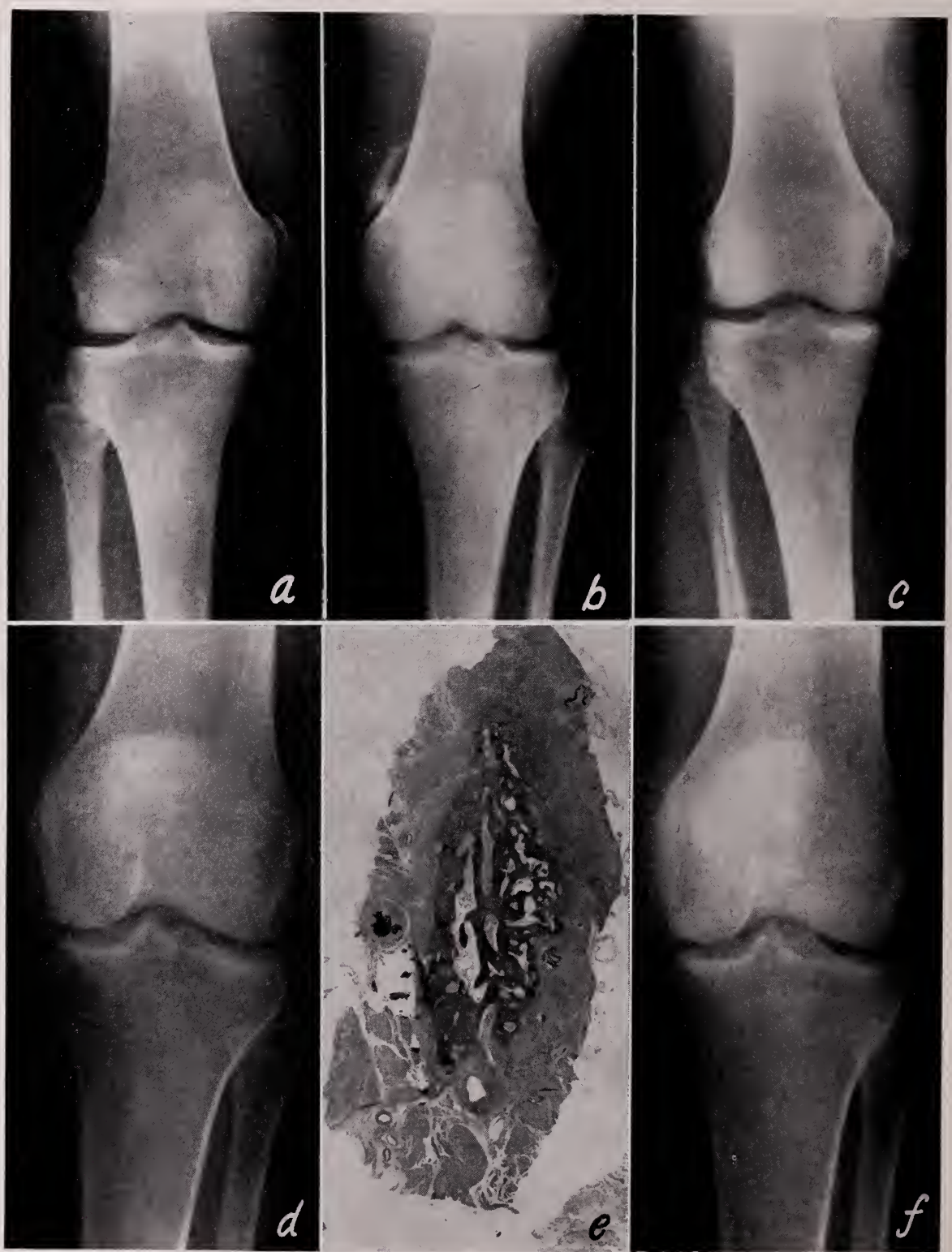

FIG. 1a. Case 1. Roentgenogram showing crescent shaped calcification capping the epicondyle.

b. Case 2. Extensive calcification of the tibial collateral ligament is revealed in the roentgenogram.

c. Case 3. Roentgenogram of compact, circumscribed area of calcification.

d. Case 4. An area of calcification closely adjacent to the condyle is seen in the roentgenogram.

e. Case 4. Photomicrograph of pathologic specimen reveals actual ossification in the center of the tibial collateral ligament. x 54.

f. Case 6. Faint, indistinct area of calcification adjacent to the medial condyle is shown in the roentgenogram.

of flexion. He was on crutches for two days at that time, and then he started motion. Swelling persisted for one week, and the pain persisted for two months. There was no special area of increased sensitivity, and he was unable to palpate a mass. He noticed that the knee loosened up some after walking but was stiff after periods of immobility. His first roentgenogram was made two weeks after the initial injury and showed calcification. Another roentgen ray film made about six weeks after the initial injury showed approximately the same amount of calcification. He was treated with a hot pad early, and two weeks after the initial injury when the first roentgenograms were made diathermy was instituted and continued for three to four weeks after the injury. At present the patient has a full range of motion and notices only that the knee is somewhat sore and stiff after playing ball and when he is walking upstairs.

CASE 4.—J. C. W., a 45 year old white man from Brenham, who was unemployed at the time he was seen, gave a history of having injured his right knee in approximately April, 1951, at which time he slipped in a hole and twisted his leg. Since that time he had gradually increasing severe pain in the knee and a feeling of tightness of the skin over the knee. The knee had never locked, but there was limitation of motion which was recorded as slight, and the knee gradually loosened up with rest and again became stiff with immobility. He had slight limitation of motion at the extremes of flexion and extension at the time he was seen and no other positive findings according to the examiner. Roentgen ray revealed calcification over the medial tibial collateral ligament, and the patient was taken to surgery on February 27, 1952, at which time a plaque of bone over the medial femoral condyle of the right knee was excised by sharp dissection. And, after this plaque was removed, it was necessary to remove the base of the ossified lesion with an osteotome. The patient had an uneventful postoperative course; he was up on the first postoperative day and discharged from the hospital on the fifth day with no complaints at that time.

The pathologic specimen revealed actual ossification of the ligament with cancellous bone present in the center of the ligament (fig 1e).

CASE 5:—G. B., a 46 year old Negro longshoreman, was injured February 15, 1946, by a 140 pound sack of flour which was thrown and hit the patient on the lateral side of his left knee. At that time he was seen by a physician and a roentgenogram was made, but he was not admitted to the hospital. Heat treatments were applied to his knee every day or so until May 17, when he was dismissed and told he could return to work. However, he continued to have pain in his knee, and although he walked on the leg, he did not return to work because of the pain. There was no history of other injury to the knee. At the time he was seen, he had pain in the knee and stiffness in it after walking. He was unable to flex the knee, and the knee was painful. He stated that a knot which appeared after the sack hit him gradually decreased in size, but it was still noticeable at the time he was seen. He had a full range of extension, but flexion was limited. He was brought into the hospital and operated on June 25, at which time an incision was made over the medial collateral ligament, and a small disklike mass was removed by sharp dissection. On August 28, he had a complete range of motion of the knee although there was still some tenderness in the skin. We believed that he had reached his maximum recovery, and he was considered as having a 5 per cent permanent disability as applied to the knee.

CASE 6.—B. L., a 37 year old Negro laborer, was injured about June 1, 1951, at which time the man struck the inner aspect of his left knee on a four wheel truck. This area became painful, but he was able to continue his work. He was seen by a physician on June 22, at which time examination revealed enlargement of the left medial femoral condyle. There was a complete range of motion, but tenderness was present over the condyle. No swelling was present. He continued his normal activities and was seen again on August 31, still complaining of some discomfort on the medial side of the left knee. No specific treatment was recommended. He was estimated to have 10 per cent permanent disability as applied to his left knee.

SUMMARY

Pellegrini-Stieda's disease is rarely reported but apparently occurs more frequently than the literature indicates. In these 6 cases trauma preceded the onset of the disease and is considered to be the cause. All 6 cases occurred in males, which would emphasize trauma as a precipitating factor. The treatment of these cases varied from no treatment to surgical excision. We believe that all patients should receive physical therapy, particularly diathermy. The residual disability of all cases was minimal.

We would like to acknowledge the assistance of Mr. Eddie Wojecki, athletic trainer of Rice Institute, Houston, in securing some of the clinical material for this article.

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Hermann Hospital.

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Clinical Evaluation and Management of the Painful Joint

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THE general practitioner of medicine is frequently confronted by patients whose chief complaint is joint pain. This may be a manifestation of arthritis, trauma, systemic disease, or neoplasm. In many instances, there may be symptoms arising from the nonarticular structures, namely, the muscles, ligaments, tendons, fascia, and periosteum. The evaluation and significance of joint pain can be understood better if attention is given to the anatomic and physiologic factors involved.

The joint is composed of articular cartilage, a synovial cavity, a synovial membrane, and a surrounding fibrous capsule. The synovium is a specialized connective tissue membrane lining the joint cavity. A similar structure lines the tendon sheaths and bursae. In that articular cartilage and bone are devoid of nerve tissue, all pain must arise from the synovial membrane, periosteum, or fibrous capsule. The nerve fibers reach their end-organs by following along the course of the vascular system. These nerves may end as free nerve-endings or with special end-organs called the pacinian corpuscles. These bodies can be found in synovial tissue removed from the joints of patients suffering from rheumatoid arthritis. The most sensitive portion of a joint is along the junction of the periosteum with the articular cartilage, fibrous capsule, and synovial membrane.

Joint pain is poorly localized, and frequently is referred to areas away from the joint. Many times pain from the knee is referred to the medial upper third of the tibia. Patients with painful shoulders frequently complain of discomfort in the midbiceps area. Hip conditions are associated with pain above the knee. Trauma and inflammation may cause tenderness and spasm of the adjacent muscles. Joint pain may be induced by stretching, pinching, or tearing of the supportive articular tissues or by the development of abnormal conditions, such as neoplastic or inflammatory disease. A diagnosis may be suggested by giving special attention to the character of the joint pain.

The following discussion will be devoted to a few types of joint disease most commonly seen in a physician's office.

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FREQUENCY OF TYPES OF ARTHRITIS

The relative frequency of various types of arthritis and rheumatic disease can be seen in table 1. It is evident that the frequency of arthritis is essentially the same, regardless of whether the patients are seen as consecutive admissions to special hospitals, at clinics, or in an office practice. A further examination of this table reveals that osteoarthritis, rheumatoid arthritis, fibrositis, and gouty arthritis make up from 61 to 68 per cent of the patients admitted to special rheumatic disease hospitals. This group constitutes approximately 75 per cent of those seen in private practice. This difference is due to the large number of soldiers under treatment for psychiatric disturbances labeled "psychogenic rheumatism." The group made up from 16 to 20 per cent of the total admissions in Army rheumatism centers. In private practice one rarely sees this group of patients, with the exception of the compensation cases.

Specific infectious arthritis, "septic," is rare. This difficult problem has been solved by the introduction of antibiotics. For the same reason, gonorrheal arthritis, formerly responsible for 2 to 3 per cent of this group, is almost nonexistent.

It is apparent from table 1 that the majority of patients complaining of joint symptoms will suffer from one of four conditions: osteoarthritis, rheumatoid arthritis, fibrositis, or gouty arthritis.

OSTEOARTHRITIS

Osteoarthritis, a degenerative process, results from the gradual "wearing out" of the articular cartilage during a lifetime. Articular cartilage has a limited ability to regenerate or repair; thus defects caused by trauma remain a lifetime. Examination of the articular cartilage of persons 40 years of age and above will

show roughened and fissured areas. This loss of articular cartilage continues until large areas of the joint surface become denuded. This process may be entirely painless until the poor alignment of the joint bearing surfaces causes additional stress upon the ligamentous marginal structures. This unaccustomed strain is responsible for pain and tenderness. Eventually, there is bone proliferation along the junction of the fibrous capsule and the articular cartilage. These structures are frequently called osteophytes or spurs because of their roentgenologic appearance. Many times this new bone forms a ridge along the joint margin. Histologic examination of the synovial membrane and synovial fluid shows little evidence of inflammation. There is no evidence that infection plays any role in the etiology of degenerative joint disease (osteoarthritis).

The disease is most frequently seen in middle-aged obese women. It occurs in the large weight-bearing joints, especially the knees, hips, lumbar spine, and terminal phalangeal joints of the hands. Laboratory examinations are normal. Roentgenologic examination may show narrowing of the joint space indicating a thinning or loss of cartilage, proliferation of the bone along the joint margins, and an increased density of the bone in the subchondral area.

A word should be said about the occurrence of Heberden's nodes on the terminal phalangeal joints of the fingers. In many instances, patients fear that this is the first manifestation of a generalized crippling arthritis. At first, these small nodules may be acute and painful. Later, the pain subsides, leaving a firm hard nodule or ridge. The joints become asymptomatic, except for varying degrees of deformity of the terminal phalangeal joints. Stecher has found a definite increase in the familial incidence in a study of 7,000 persons.[9] He did not find a greater incidence of arthritis in the other joints of these people.

Treatment of osteoarthritis is directed towards the correction of mechanical factors to prevent further joint trauma.[1] Obese patients should be put on reducing diets with a limitation of weight-bearing activities. Frequently, patients may remain asymptomatic if they are not permitted to climb stairs. Many other measures are helpful, especially physiotherapy with the applications of heat twice a day at home using simple methods of heat application. The regular use of salicylates, in daily doses of 3 to 4 Gm., is recommended. Phenylbutazone may be used for short periods of time. This drug has definite limitations because of its toxicity. Skin rash, hematemesis, purpura, hematuria, agranulocytosis, and anemia are the most significant complications. These hazards may be minimized by keeping the daily dosage at 400 mg.

The articular injection of 30 to 50 mg. of hydrocortisone gives prompt and lasting benefit. The usual period of benefit is from ten days to two weeks. A few patients may be relieved for several months.

Reconstructive surgery of the hip is helpful unless contraindicated by a poor physical condition. This may be accomplished by inserting a Vitallium cup or by a replacement prosthesis of the femoral head and neck.

TABLE 1.—*Relative Frequency of Various Rheumatic Diseases in Consecutive Admissions.*

Diagnosis	Hospital			Clinic		Office
	A 1,000 Patients %	B 800 Patients %	C 200 Patients %	D %	E %	F 200 Patients %
Osteoarthritis	13.6	26.7	40.0	25-30	30.0	31.5
Rheumatoid Arthritis	33.1	38.3	32.0	30-40	25.0	27.5
Fibrositis	13.4	2.2	17.0	10-20	20.0	23.0
Gouty Arthritis	1.0	0.6	1.5	3- 5	1.0	4.5
Psychogenic Rheumatism	20.0	16.1	...	....	...	2.0
Traumatic Arthritis	...	...	...	7-10	10	4.0
Specific Infectious Arthritis	1.3	1.6	0.5	2.0	3.0	...
Acute Rheumatic Fever	...	...	...	2.0	5.0	0.5
Other	17.6	14.5	9.0	....	6.0	7.0

A: U. S. Army Rheumatism Center, Army and Navy General Hospital.[7]
B: U. S. Army Rheumatism Center, Ashburn General Hospital.[7]
C: U. S. Army General Hospital.[7]
D: P. S. Hench, Mayo Clinic, Rochester, Minn.[4]
E: M. H. Dawson, Presbyterian Hospital Clinic, New York.[8]
F: H. C. Coggeshall, Dallas.

RHEUMATOID ARTHRITIS

Rheumatoid arthritis presents the most difficult problems in diagnosis and treatment. In many instances, the disease has an atypical onset which delays the making of a definite diagnosis. A careful history is important to bring out the constitutional symptoms that precede the arthritic involvement. The usual complaints are fatigue, loss of weight, anorexia, insomnia, depression, and irritability. Joint pain is worse in the morning, after periods of rest, and with weather change. Relief is obtained by exercise, heat application, and salicylates. The joint involvement is symmetrical with a predilection to the interphalangeal joints. This tendency for the interphalangeal involvement gives the fingers a spindle-shaped appearance. The swelling results from the inflammation in the synovium and joint effusion.

In addition to the joint deformities, there may be generalized lymphadenopathy, enlarged spleen, cold clammy hands and feet, pigmentation of the skin, hyperkeratosis of the skin and nails, and atrophy of the skin and muscles. Psoriasis and subcutaneous nodules are seen in about 5 per cent of this group. Pericarditis is rare; I have seen 3 cases.

The success of treatment depends upon a satisfactory physician-patient relationship. It is important for the physician to assume an optimistic attitude concerning the prognosis. Such an opinion is justified by the reports of results of untreated patients followed for a five-year period: approximately 25 per cent became asymptomatic, 50 per cent had good functional joints, and only 25 per cent showed progressive crippling. Every attempt should be made to get the patient's attention away from the day-to-day progress to the months ahead. Treatment of arthritis should be directed to obtain an active participation by the patient. It is important to explain the nature of the disease and instruct him in the use of simple physiotherapy procedures and analgesics.

Rest is important, but complete bed rest is to be avoided. This, of course, does not apply for short periods of time under hospital supervision. All bed patients should be taught a routine of nonweight-bearing exercises. Bed rest may encourage invalidism and promote loss of joint motion. Improper attitudes with pillows cause permanent flexion contractures. Bed splints are helpful in correcting and maintaining the arms and legs in good position.

A definite program of graduated nonweight-bearing exercises should be carried out for the affected joints. Excessive exercises causing an increase of the joint pain on the following day should be avoided.

There is no evidence that diet has any etiologic significance in arthritis. In general, the diet should include the daily vitamins, calcium, iron, and caloric requirements. Special high caloric diets should be given to combat anorexia, weight loss, and anemia. Vitamins should include the daily requirements only.

Salicylates, acetysalicylic acid, or sodium salicylate in doses of 3 to 5 Gm. daily are the analgesic drugs of choice. Other drugs less desirable because of toxicity, together with the conditions they may aggravate, are (1) phenylbutazone (Butazolidin), which in doses of 400 to 600 mg. daily gives marked analgesia but is of limited use because of its toxic qualities (agranulocytosis, hematemesis, anemia, salt retention); (2) aminopyrine (agranulocytosis); and (3) cinchophen (acute hepatitis).

The use of gold salts (sodium thiosulfate, sodium thiomalate, or thioglucose) is advisable in a limited number of patients with progressive resistant arthritis. The chief objection to its use is the toxic reactions. These reactions are of two types: (1) the acute allergic reaction to the initial small doses of 5 to 10 mg., including fever, rash, leukopenia, enteritis, and nephritis, and (2) the late reactions including usually a skin rash, leukopenia, or purpura. The acute reactions can be minimized by giving doses of 5 to 10 mg. weekly for a month and then gradually increasing the dose to not more than 25 mg. per week. The intervals of administration should be lengthened to three or four weeks as soon as there is improvement in the arthritis or a decrease in the sedimentation rate. Toxic reactions can be controlled by giving BAL (British anti-Lewisite), ACTH, or cortisone.

Roentgen therapy is recommended for rheumatoid spondylitis, but not for peripheral joints.

Cortisone should not be used routinely. It should be limited to those patients who get satisfactory relief from taking 75 mg. or less per day. This small dose rarely causes hypercortisonism. If ACTH is used for long periods, the dose should not exceed 20 mg. daily. In some instances patients may respond to 5 mg. per day. The continued use of ACTH over a long period, twelve months or more, may be accompanied by an increase in drug tolerance. In one instance, this tolerance was seen to develop over a period of twelve months to the point that as much as 180 units daily offered no relief of symptoms or joint swelling. Many patients with mild or moderate joint symptoms will receive marked benefit from 20 mg. of ACTH once weekly. This weekly schedule of treatment is helpful in combating fatigue and depression.

The results of treatment of rheumatoid arthritis with hydrocortisone duplicate those obtained by the use of cortisone and ACTH. When administered by mouth, the daily dose required is slightly less, 40 to 60 mg., and it is beneficial when injected into the joints, tendon sheaths, or bursae. The usual dose required is from 25 to 50 mg.

Testosterone, 25 to 50 mg. per week, improves nutrition and combats fatigability. The antirheumatic effect does not result if methyl testosterone is used. The reason for this difference may be due to the failure of the body to metabolize methyl testosterone as evidenced by its excretion unaltered in the urine. Testosterone is metabolized, which may account for its effectiveness.

The use of large doses of pregnenolone fails to give any benefit in the treatment of rheumatoid arthritis, except for occasional improvement in the sense of well-being.

Pregnenolone methyl ether, made by Max Huffman in 1949, differs from pregnenolone because of its marked sedative-like action. Three of my patients having rheumatoid arthritis in 1949 received pregnenolone methyl ether. There was no objective change

in the degree of joint involvement or the sedimentation rate, but there was a marked subjective improvement in their well-being, ability to relax, and ability to sleep without sedation. Since that time, 12 patients have been given pregnenolone methyl ether with the same results. There is no evidence of any abnormality in the salt, water, or carbohydrate metabolism. One patient took 300 mg. daily for two years without disturbance of the menstrual cycle. The use of pregnenolone methyl ether is useful in combating the tension and depression associated with rheumatoid arthritis and frequently acts as a mild sedative. Patients with fibrositis and premenstrual tension benefit from its use.

FIBROSITIS SYNDROME

There are a large number of patients who complain of generalized skeletal "aches and pains" of the muscles and joints. The lack of objective signs of arthritis in the physical and laboratory examinations has necessitated a separate classification of this group. The term fibrositis has been used for many years as a diagnosis of convenience and permits the physician to tell his patients, "You don't have arthritis." There is considerable controversy concerning the justification of this diagnosis, because it suggests an inflammatory process as yet unproved. Fibrositis may be either primary, without any apparent cause or signs of systemic disease, or secondary, a manifestation of another disease such as unrecognized rheumatoid arthritis, rheumatic fever, trauma, or infections.

Primary fibrositis is almost always associated with nervous tension and fatigue. The victim is not considered "nervous," but "high strung" and unable to relax. The person might be described as being "a perfectionist," "a finicky housekeeper," or an "emotional" misfit in office or home. Women with fibrositis give histories of prolonged periods of tension resulting from problems at home—difficult children or husbands, nursing care of an elderly parent. Except for fatigue, there may be no complaints. The lack of multiple complaints of other systems sets fibrositis apart from psychoneurosis.

The treatment of fibrositis is directed toward correcting the causes of the tension state. The symptoms can be relieved by salicylates, sedatives, rest, and psychiatric advice. It should be emphasized to the patient that the symptoms are "not imagined." The physiologic muscular stiffness that follows unaccustomed exercise may be used as an example in the explanation of what happens following the constant fatigue of emotional tension. The increased muscular tension causes chronic fatigue, constant pain, and stiffness. The patient should be told that the treatment is symptomatic until the tension state can be corrected.

GOUTY ARTHRITIS

During the past few years considerable progress has been made in the treatment and understanding of gouty arthritis.[2, 3, 5, 6, 8, 10] There are two types, primary gout, an inherited metabolic defect, and secondary gout, associated with other diseases such as polycythemia, myeloid metaplasia, chronic leukemia, Cooley's anemia, and lymphoma. Measurements of the miscible uric acid pool of the body have been estimated by using isotropes. It is possible to determine the uric acid content of the body by measuring the percentage of isotropic uric acid in the urine following the injection of N^{15} uric acid. A normal subject will have a total body uric acid content of approximately 1.2 Gm. while a gouty subject may have 3 to 30 Gm.

The important feature of gout is the hyperuricemia with a blood serum level of uric acid in excess of 6.0 Gm. per 100 cc. The stable solubility of uric acid in serum is about 6.5 mg. per 100 cc. A concentration above this level is supersaturated and subject to sudden precipitation. For this reason large amounts of sodium urate accumulate in tophi. The problem in gout is (1) an overproduction of uric acid and (2) an inefficient renal mechanism for uric acid disposal. In man, the collecting tubules of the kidney reabsorb about 90 per cent of the uric acid from the glomerular filtrate.

Treatment should be directed toward restriction of food rich in purines, the alleviation of the acute attack, and the use of uricosuric agents between episodes of joint pain. The acute attack can be brought under control by giving colchicine 1/100 grain (0.6 mg.) every hour until diarrhea or remission of joint pain. The response to colchicine therapy requires about twenty-four to forty-eight hours. When the attack is severe, 20 units of ACTH gel may be given once daily for three successive days. Colchicine should be used in conjunction with the ACTH to prevent a rebound attack. Phenylbutazone alone or in combination with colchicine and ACTH is effective in arresting the attack.

After the acute attack subsides, the patient should be started on probenecid (p-[dinpropylsulfamyl]-benzoic acid) in doses of 1 to 2 Gm. daily. This acts as a uricosuric agent by blocking tubular resorption of uric acid. When probenecid (Benemid) is first administered, it may induce an acute attack. For this reason, small doses, 0.5 Gm. daily, are recommended for several weeks. Colchicine given three or four times daily is also recommended during the initial probenecid therapy. The long time use of probenecid is not toxic and will reduce the frequency of attacks and the size of sodium urate tophi. The uricosuric action of probenecid is completely blocked by salicylates. Patients receiving probenecid should not be

given aspirin or other forms of salicylates. The maintenance dose of probenecid is from 0.5 to 2.0 Gm. daily and may be established by following the blood serum uric acid levels.

SUMMARY

A diagnosis of osteoarthritis, rheumatoid arthritis, fibrositis, or gouty arthritis can be made in at least 75 per cent of the patients suffering from joint pain seeking medical care. In the light of recent advances, the majority of these patients should expect to have a proper diagnosis and a satisfactory regimen of therapy.

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Basic Orthopedic Principles in Rheumatoid Arthritis

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RHEUMATOID arthritis is a systemic disease that belongs in the realm of internal medicine or rheumatology. The orthopedic surgeon is strictly a consultant. He would indeed be an unusual surgeon who by training or temperament could take on the total care of one of these patients, either early or late. In order that the patient may receive the best medical care possible, more teamwork is required in this disease than in any other.

BIOPSY

The orthopedic surgeon can be helpful in establishing an early diagnosis in rheumatoid arthritis. It has been my observation that patients who have had a considerable delay in diagnosis have been critical of their medical treatment. They often go from doctor to doctor, and it is often difficult to establish confidence in these patients. On the other hand, of course, it is a serious mistake to brand a person a rheumatoid arthritic if he is not one.

The classical joint for biopsy is the knee. Biopsy is a benign procedure, and having done many biopsies, I can truthfully say that I have seen no untoward results. To help the pathologist most in the interpretation of the synovial tissue, the synovial membrane must be obtained consistently at the same site, preferably just medial to the midthird of the patella. The synovial membrane and subsynovial tissue will differ in thickness about the knee. A generous section of synovial membrane should be taken in such a way that the synovial membrane can be closed but at the same time in such a way that the forceps will not crush the biopsy substance. The synovial membrane is then placed on a piece of filter paper which is moistened with saline solution and immediately placed in the fixative. Wide exploration of the joint and extensive trauma to the joint are unnecessary and add little to the final diagnosis.

NONSURGICAL TREATMENT

I shall not enter into a dissertation as to whether it is necessary for an individual patient to have a psychiatrist and a social worker to help the rheumatologist. It is well known, however, that these patients universally have psychiatric difficulty. It has been my observation that most rheumatologists are also excellent psychiatrists.

The role played by social service is important, whether the part is taken by a physician or by a trained lay-worker. One person must help these patients plan their home life, their financial obligations, and their subsequent rehabilitation.

Physical medicine is an ancillary service in the treatment of rheumatoid arthritis. There is nothing more annoying than to have a patient tell me in the hospital that he has been down to "Physio" or "PT" for thirty minutes today. The remaining twenty-three

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and one-half hours he remained in bed idle. Where a patient gets the idea that he can spend a half hour doing some particular exercises and do nothing for the rest of the day, with great benefit, is beyond me. Exercise and stretching should be carried out frequently by the patient himself. It should be started early in the disease. The persons who outline this program must have a basic understanding of the disease and the types of deformities most likely to develop. Early, it should be a program of preventing deformity. The rheumatologist is most likely in the acute stage to insist on the patient's going slowly while the orthopedist is more likely to deviate too far toward the other extreme of too rapid activity. There is certainly a middle ground here, and this should be reached early in the disease and in the outline of the treatment.

Pain and Muscle Spasm

The etiology of muscle spasm is of course unknown as is the specific treatment of muscle spasm. It is assumed, however, that muscle spasm is on a basis of inflammatory reaction in the subsynovial tissue, in the muscle septums, and muscle bundles themselves. Muscle spasm is usually thought of in medicine as a protective mechanism. It has been interesting to me to see that under general anesthesia in a patient with acute rheumatoid arthritis, with particular reference to the hip, it is necessary to anesthetize the patient very deeply with ether, even past the plane of surgical anesthesia, before the muscle spasm will relax. As soon as the patient awakens from the general anesthetic, even before he is completely awake, this muscle spasm will recur and be just as severe as it was prior to anesthesia. So there is little wonder that we have no specific drug for severe muscle spasm. Early treatment or treatment during an exacerbation is directed primarily to the relief of pain and indirectly to the treatment of muscle spasm.

It goes without saying that during the acute phase of an exacerbation, when the sedimentation rate is high and the joints are hot and swollen, the patient should be in bed at complete rest as in any other acute systemic disease. It is important, however, that the positioning of the extremities in bed be watched carefully. For instance, it is desirable not to have the knees brought up to 90 degrees all the time. A program could be scheduled in such a way that the knees could be flexed up for comfort for a definite period and then extended as far as possible for a definite period. Moist heat is by far the most relaxing type of local application still in use; it is used by orthopedists in all types of muscle spasm whether it be traumatic in origin, as following a back injury, or following acute poliomyelitis. Traction is particularly applicable to the lower extremities where it is used intermittently in the form of Russell traction; it is the same form of preliminary traction used for broken hips and fractured femoral shafts. Traction apparatus does not work as well in the upper extremities.

I believe it is safe to say that circular plaster or a solid cast has little place in the treatment of rheumatoid arthritis. Circular plasters are placed on the upper or lower extremities and then bivalved into the two halves. These plasters are then relined with sheet wadding and stockinet and are then put together with webbing strap and buckles. If made right, they are comfortable and are best used at night. The orthopedist tends to take as much correction as he can obtain and remake the cast in three to six weeks. As a gain is made from the standpoint of a contracture or as muscle spasm tends to subside, one must try not to lose correction while the patient is asleep. Splints and braces are much more expensive and are not nearly so effective as a well molded plaster cast that has been bivalved. These bivalved casts can also be hinged to give a wedging effect.

Drugs certainly have a part to play in pain and muscle spasm. I shall not go into a discussion of the value of cortisone. It may be well to mention hydrocortisone, which I had an opportunity to use through the courtesy of Merck and Company. This drug was used intra-articularly under my direction for a variety of joint disabilities, one of which was rheumatoid arthritis. In the small series in which I used it, the results were inconsistent and unpredictable. It has a place in treatment and may be useful in the early mono-articular arthritic. The long-acting curare drugs have been of no help in muscle spasm generally in orthopedics and have had no effect on muscle spasm once the effect has worn off. Tolserol has been disappointing as a muscle relaxing agent; it has been of no help to me either orally or intravenously. Intravenous procaine has had its advocates and may be worth while in an occasional case. Aspirin is still an excellent drug.

When the patient first becomes ambulatory, it is often wise to begin using a walker. Crutches are used from an orthopedic standpoint primarily to protect the joints of the lower extremities. Patients allowed to bear unsupported weight on flexed joints distended with fluid will have rapid deterioration of the joints whether the underlying cause is rheumatoid arthritis or some other condition. A wheel chair is a dangerous instrument in a rheumatoid arthritic, particularly a young person, as these patients for some reason become very attached to wheel chairs. If possible, I should avoid the use of wheel chairs entirely

in rheumatoid arthritis. Either the patient should be in bed or on crutches.

The use of braces in rheumatoid arthritis is limited almost entirely to the hands and to the back. Functional hand splints are helpful in maintaining position, particularly at night, and for exercising the small joints of the fingers, which tend to subluxate. Back braces are used primarily for comfort and should be light. They play little part in the prevention of the kyphous deformity in rheumatoid spondylitis. There is no mechanical arrangement that will prevent the forward flexing of the spine in rheumatoid spondylitis. Braces for the lower extremities made out of the new lighter metals are still heavy and have little corrective influence. They are rarely used in rheumatoid arthritis. Good orthopedic oxfords with anterior metatarsal bar or longitudinal arch supports will make the patient much more comfortable when he is on his feet. Ace bandages for the knees are helpful and should be used when the patient is ambulatory if he has a hydroarthrosis of the knees.

Contractures

With long continued muscle spasm and because of the inherent strength of the flexor muscle groups, which is much greater than that of the extensor muscle groups, the patient tends to develop flexion contractures at the major joints. The attitude of flexion at the major joints is more comfortable for the patient because most joints tend to hold more fluid in a flexed position than in a completely extended position. Other contributing factors to fixed joints in flexion are muscle atrophy and fibrosis of the muscles themselves and of the capsule about the joint. Position is an extremely important factor in the development of flexion contractures. For instance, a patient lies recumbent in bed with about two pillows beneath his head, the Gatch bed in flexion, hips and knees both flexed. If he is allowed in a wheel chair again, he assumes the position of flexion throughout.

Methods of treatment in soft tissue contracture include (1) positioning to get help from gravity; (2) specific muscle exercise of extensor groups; (3) more vigorous stretching; (4) traction, intermittent and continued; (5) wedging of bivalved casts; (6) functional elastic hand splints; and (7) surgery.

Bony Deformity

Bony deformities which may develop include subluxation or dislocation, fibrous ankylosis, and bony ankylosis.

Destruction of cartilage by pannous formation, fixed soft tissue contracture, unsupported weight bearing on joints with fixed contracture, lack of muscle power, and prolonged hydro-arthrosis are factors which may produce bony deformity.

As we see, the early findings in a rheumatoid joint are acute inflammation, fluid, and pannous formation. The clinical signs are muscle spasm, soft tissue contracture, and finally bony deformity. This chain of events may be rapidly progressive or may be characterized by remissions and exacerbations over a period of many years.

SURGERY

Indications for surgery may include pain, ankylosis in nonfunctioning positions, a need to make or keep the patient ambulatory, or an effort to enable the patient to take care of personal needs.

By pain is meant the pain that usually occurs with fibrous ankylosis. Ankylosis in the nonfunctioning position, such as the elbow, interferes with the use of crutches; ankylosis of the spine in acute flexion makes it impossible to see straight ahead; and ankylosis of the knees and the hips in flexion prevents assumption of the upright position. Soft tissue surgery in the early rheumatoid arthritic may be useful where the knees are acutely flexed. This type of surgery is a capsulotomy performed before there is any bony deformity. It may be necessary to make the patient ambulatory. Every effort should be made to try to keep the patient as independent as possible. For instance, it is essential in taking care of patients with rheumatoid arthritis that they be able to take care of their own toilet, brush their teeth, comb their hair, and feed themselves. Surgery is often the only way to maintain these basic requirements.

The best surgical result will be obtained in patients with so-called "burned out" rheumatoid arthritis, if there is such a thing. Certainly an active rheumatoid arthritic is not a good candidate for best surgical results. On the other hand, why wait until the patient has been a chronic invalid for years in a wheel chair with marked muscle atrophy, bone atrophy, and complete lack of interest in rehabilitation? With active rheumatoid arthritis there is, of course, the inflammatory reaction of the fibrous tissue with gluing down of the muscle bundles themselves and subsequent atrophy. Timing in rheumatoid surgery is extremely important, but I do not believe that it is desirable to wait until the sedimentation rate is normal before undertaking a reconstructive surgical procedure.

In any type of reconstructive surgery the mental attitude of the patient is so important that a physician may do equally as good technical surgery on 2 patients and get opposite results. This is particularly true in arthroplasty type of surgery. A surgeon can make the joint movable, but the patient must have the will, endurance, and fortitude to keep it moving.

Again, the rheumatologist is the most important factor in this mental attitude. If the rheumatologist is convinced in his own mind that a surgical procedure is indicated, he immediately lays the groundwork for a successful operative procedure. Evaluating the end results of rheumatoid surgery is extremely difficult. For instance, the surgeon may do an arthroplasty of the hip on a patient enabling him to continue at his job, or a housewife to resume doing her work, but in the analysis of the range of hip motion, it has improved little. Here the simple factor of relief of pain may outweigh an increase in range of motion.

Cortisone should be continued right through the preoperative and postoperative phase. It has not been my experience that cortisone has anything to do with the blood clotting mechanism, and I have noted no difference in the amount of bleeding either operatively or postoperatively. The difficulty that I have encountered with cortisone is that there is considerable delay in discovering wound infections because of lack of pain and of systemic reaction.

A variety of surgical procedures have proved their value in arthritis.

A painful subluxed wrist will interfere with the entire use of the hand. There will be a tendency to exaggerate the deformities of the small joints of the fingers. By fusing the wrist in a functional position, the patient will be enabled to use his hand.

Arthroplasty of the elbow is necessary often to enable the patient to use crutches and, most important, to allow the patient to comb his hair, feed himself, and so forth. Acromioplasty is simple excision of the outer end of the acromium to allow more abduction at the shoulder.

The excision of painful rheumatoid nodules from the dorsal aspect of the elbow and upper forearm is a beneficial and simple procedure. It can be performed under local anesthesia. The patients are greatly relieved as this area is so repeatedly touched during a normal day's activity. Occasional excision of a single nodule from a finger is helpful.

Arthroplasty of the temperomandibular joint is often a necessary procedure to maintain bodily nutrition and to maintain normal oral hygiene. It is an effective procedure.

There are cases of rheumatoid involvement of the spine in which it would seem impossible to prevent the severe flexion of the spine. The result is a pitiful person who can neither sit, lie, nor stand with any semblance of normality. It is possible by osteotomy in the lower lumbar area to gain sufficient correction to enable the patient to lie comfortably and to look straight ahead when either sitting or standing. Postoperatively, these patients are perhaps the most grateful that one encounters.

Reconstructive surgery of the hip is a procedure that one undertakes for intractable pain or bilateral involvement with severe deformity. Many procedures have been attempted. At the present time both mold arthroplasty and femoral head replacements are in common use. The basis for this type of surgery is elimination of pain, a stable hip, and motion, as many cases are bilateral. Surgery of the hips is often the only way possible to keep the patient ambulatory.

Arthroplasty of the knee is seldom necessary in unilateral involvement. It has not generally gained favor as the results have not proved eminently satisfactory. In selected cases, carefully individualized, it is a worth-while procedure.

Triple arthrodesis of the midtarsal joints of the feet is a useful procedure when pain in this area is prolonged and spontaneous fusion is delayed.

Deformity of the forefoot is common in rheumatoid arthritis. Prevention in the progressive case is not possible. There is bunion formation with clawing of the toes and prominent callosities on the plantar aspect of the feet. Correction of the bunion with excision of metatarsal heads and proximal phalanges gives relief of pain and enables the patient to wear shoes.

RELIEF FROM SEVERE PAIN

Five Illinois doctors reported a new drug, already shown to be effective in controlling nausea, now promising to relieve pain in patients who no longer get adequate help from large doses of narcotics in the June 12 *Journal of the American Medical Association*. The physicians said that 22 of 28 patients treated with chlorpromazine in addition to narcotics or sedatives which had not helped alone were given "satisfactory relief" from severe abdominal, bone, and nerve pain. The study made by these doctors confirms earlier reports that the drug relieves nausea and vomiting.

It was reported by two Canadian doctors earlier this year that the drug had been used successfully in quieting severely excited patients without making them confused or otherwise inaccessible to psychotherapy.

Some patients whose pain was not actually changed "seemed to be more relaxed and less reactive to their pain," Drs. Max S. Sadove, Myron J. Levin, Raymond F. Rose, Lester Schwartz, and Frederick W. Witt, Chicago, stated. Side effects other than drowsiness were "minimal."

Urology Award

An annual award of three prizes totaling $1,000 for essays on the result of some clinical or laboratory research in urology has been announced by the American Urological Association. Competition is limited to urologists who have been graduated not more than ten years and to those who are in training to become urologists. Additional information may be obtained from the executive secretary, William P. Didusch, 1120 North Charles Street, Baltimore.

CASE REPORTS

HUMAN RABIES CAUSED BY BAT BITE

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RABIES was first discovered in the vampire bat (Desmodus rotundus murinus Wagner) in the state of Santa Catarina in southern Brazil during investigations of an epizootic paralytic disease of cattle and other livestock called mal de caderas. Carini[2] in 1911 demonstrated Negri bodies in the brains of cattle dying of this paralytic disease and suggested that vampire bats which had been seen biting livestock might be transmitting the disease to cattle. Following the isolation of the rabies virus from the brain of a bat a few years later, Haupt and Rehaag[6] also concluded that the repeated epizootics of a paralytic disease that had occurred among livestock in southern Brazil were due to rabies transmitted by vampire bats. The livestock disease continued to spread until by 1930 it was found in many South American countries as far north as Venezuela.

In 1925 a paralytic disease of livestock occurred in the area of Port of Spain, Trinidad, B.W.I., killing several thousand animals. During the course of this epidemic, which was also traced to the bite of the vampire bat, 55 human cases of rabies were reported.[4, 7, 10] In 1944, in the Pacific Coast states of Mexico, a paralytic disease of livestock called derriengue also was proved to be rabies with the source demonstrated to be vampire bats.[8] Similar observations have been made in Honduras[12] and Venezuela.[1]

Other than the human cases of rabies reported in the Trinidad outbreak, there has been no record of human infection from bat bite. Venters and his associates[13] recently reported an experience in Florida in which a child was bitten by a lactating female Florida yellow bat (Dasypterus floridanus) from which an agent identified as rabies virus by neutralization and complement fixation tests was recovered. Pasteur treatment prevented the development of the disease in this child. Witte[14] tells of a woman in Pennsylvania bitten by a hoary bat (Lasiurus cinereus) which was proved to be rabid. In this instance, also, antirabies therapy was effective. More recently, Grimes and his associates[5] demonstrated Negri bodies in the brain of a free-tailed bat (Tadarida mexicana) which had bitten a 9 year old boy in Austin, Texas, on May 19, 1954. The child received Pasteur treatment.

From the Departments of Microbiology and Internal Medicine, Southwestern Medical School of the University of Texas.

Because of these experiences, together with the current interest in bats and bat rabies in certain areas in the United States,[3, 5, 9, 11, 13] it seems desirable to report a fatal human case of rabies which presumably resulted from the bite of a bat. To our knowledge, this is the first human case of rabies resulting from a bat bite in the United States.

CASE REPORT

In October, 1951, a 43 year old white housewife was admitted to the Parkland City-County Hospital in a comatose state with a diagnosis of bulbar poliomyelitis. Three weeks prior to admission and sixteen days prior to the onset of her illness, the patient had stopped to investigate what was apparently a dead bat on the roadside. The animal, however, was not dead, and on investigating at close range the patient was bitten on the left forearm. Unfortunately, the bat was not made available to us for identification and further study.

The patient continued to feel well until five days prior to admission when she complained of aching in her left arm and had a temperature of 103 F. The following day the fever continued; she had nausea, vomiting, and generalized aching and was unable to move her left arm. She was treated for influenza but became progressively more ill and on October 29 was admitted to a hospital in West Texas. It is reported that at this time she had high fever and inability to move her left arm. She was given intravenous fluids and on the following day was observed to have inability to swallow the secretions. A lumbar puncture revealed a total cell count of 24 and a protein of 74 mg. per 100 cc. At this time the patient was tranferred to Dallas. The patient was considered to have bulbar poliomyelitis, although the possibility of rabies could not be excluded. She remained comatose to semicomatose throughout her hospital stay and did not attempt to speak at any time. On the fourth hospital day the blood pressure slowly fell to the unobtainable level, mottled cyanosis appeared, and the patient died quietly about three hours after onset of hypotension and cyanosis.

A post-mortem examination was done by Dr. George H. Wahle, Jr. The primary pathologic diagnoses follow: "encephalomyelitis with demonstrable Negri bodies in central motor neurons compatible with rabies" and "perivascular lymphocytic infiltration of regional capillaries and motor neuron area, with destruction of anterior motor neurons and neuronophagia; also meningeal perivascular infiltration with endarteritis." The history together with the histopathologic findings strongly suggests that the bat bite was the source of the rabies infection.

SUMMARY

A fatal case of human rabies due to bat bite is reported. This experience suggests that the extent of rabies in bats in certain areas of the United States

should be explored thoroughly in order to establish the significance of the bat in the ecology of this disease in the United States.

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NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, Fort Worth, April 25-27, 1955. Dr. F. J. L. Blasingame, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, Miami, Fla., Nov. 30-Dec. 3, 1954. Dr. Walter B. Martin, Norfolk, Va., Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice, Los Angeles, March 28-31, 1955. Dr. W. B. Hildebrand, Menasha, Wis., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. Bayard Carter, Durham, N. C., Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Atlantic City, N. J., April 24-26, 1955. Dr. Edward S. Welles, Saranac Lake, N. Y., Pres.; Dr. Paul C. Samson, 3959 Happy Valley Rd., Lafayette, Calif., Secy.

American Association of Genito-Urinary Surgeons, Monterey, Calif., May 22-25, 1955. Dr. Fletcher H. Colby, Boston, Pres.; Dr. John A. Taylor, 2 E. 45th St., New York 22, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 9-11, 1954. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Chicago, April 25-30, 1955. Dr. Homer Prince, Houston, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, Atlantic City, N. J., June 2-5, 1955. Dr. William A. Hudson, Detroit, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Philadelphia, April 25-29, 1955. Dr. C. C. Sturgis, Ann Arbor, Mich., Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 4, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-18, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress on Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chairman.

American Congress of Physical Medicine and Rehabilitation, Washington, D. C., Sept. 6-11, 1954. Dr. William B. Snow, New York, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Belleair, Fla., April 17-21, 1955. Dr. Richard S. Weiss, St. Louis, Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, Atlantic City, N. J., June 4-5, 1955. Dr. Dwight L. Wilbur, San Francisco, Pres.; Dr. H. Marvin Pollard, University Hosp., Ann Arbor, Mich., Secy.

American Gynecological Society, Quebec, Canada, May 23-25, 1955. Dr. Philip F. Williams, Philadelphia, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, New Orleans, Oct. 26-30, 1955. Dr. E. Cowles Andrus, Baltimore, Pres.; Mr. Irving Hexter, 44 E. 23rd St., New York 10, Secy.

American Hospital Association, Chicago, Sept. 13-16, 1954. Mr. Ritz E. Heerman, Los Angeles, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Hollywood, Fla., March 15-17, 1955. Dr. Kenneth M. Day, Pittsburgh, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Chicago, June 13-15, 1955. Dr. Percival Bailey, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, W. Sulphur Springs, W. Va., June 2-4, 1955. Dr. Everett L. Goar, Houston, Tex., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, W. Sulphur Springs, W. Va., June 19-22, 1955. Dr. J. Warren White, Honolulu, Hawaii, Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Quebec, Canada, June 13-17, 1955. Dr. Alfred H. Washburn, Denver, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, New York, June 1-4, 1955. Dr. A. W. Martin Marino, Brooklyn, N. Y., Pres.; Dr. Karl Zimmerman, 3500 Fifth Ave., Pittsburgh 13, Secy.

American Psychiatric Association, Atlantic City, N. J., May, 1955. Dr. Alfred P. Noyes, Norristown, Pa., Pres.; Dr. William Malamud, 80 E. Concord St., Boston 18, Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Cincinnati, Oct. 25-30, 1954. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Washington, D. C., Sept. 6, 1954. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Philadelphia, April 27-29, 1955. Dr. John H. Gibbon, Jr., Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, Los Angeles, May 16-19, 1955. Dr. W. Joseph McMartin, Omaha, Neb., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Delegates Interim Meeting, Chicago, Oct. 1-2, 1954. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1954. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Milwaukee, May 23-27, 1955. Dr. John H. Skavlem, Cincinnati, Pres.; Mrs. Morrell DeReign, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas. Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nashville, Pres.; Dr. George Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, Oct. 21, 1954. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, Nov. 17-19, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Oklahoma City, Sept. 20-22, 1954. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secy.

Tri-State Medical Assembly, Fall, 1954. Dr. Joe D. Nichols, Atlanta, Pres.; Dr. Broox C. Garrett, 940 Margaret Pl., Shreveport, La., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice, Galveston, Sept. 9-11, 1954. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris, 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 11-12, 1954. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association. Dr. J. S. Minnett, Dallas, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians. Dr. Howard E. Smith, Austin, Pres.; Dr. John Wiggins, 1707 Medical Arts Bldg., Fort Worth, Secy.

Texas Club of Internists. Victor E. Schulze, San Angelo, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, Fort Worth, April 24-25, 1955. Dr. Paul H. Power, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, Fort Worth, April, 1955. Dr. George M. Jones, Dallas, Pres.; Dr. Hugo Engelhardt, P. O. Box 2180, Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Geriatric Society, Fall, 1954. Dr. Henry H. Niehuss, Longview, Pres.; Dr. Frank V. Mondrik, 214 Bramlette Bldg., Longview, Secy.

Texas Heart Association. Dr. George R. Herrmann, Galveston, Pres.; Mr. Edgar M. Brown, Jesse H. Jones Library Bldg., 1133 M. D. Anderson Blvd., Houston, Executive Director.

Texas Hospital Association, Houston, April 12-14, 1955. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, Galveston, Fall, 1955. Dr. Edgar S. Ezell, Fort Worth, Pres.; Dr. Bruce H. Beard, 1519 Pennsylvania, Fort Worth, Secy.

Texas Orthopedic Association, Fort Worth, April, 1955. Dr. Brandon Carrell, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, Oct. 22-23, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society. Dr. Jack Kerr, Dallas, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 13-16, 1955. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Fort Worth, April, 1955. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, Fort Worth, April, 1955. Dr. Raleigh White, Temple, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred W. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Mineral Wells, 1955. Dr. Charles N. Burrows, San Antonio, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 3, Executive Secy.

Texas Society of Anesthesiologists, Fort Worth, April, 1955. Dr. Frank O. Barrett, El Paso, Pres.; Dr. Milton M. Rosenzweig, 200 Wildwood Dr. E., San Antonio, Secy.

Texas Society of Gastroenterologists and Proctologists, Fort Worth, April, 1955. Dr. Charles Hardwicke, Austin, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, Dallas, Jan. 30, 1955. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Galveston, April 15-16, 1955. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Corpus Christi, 1954. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg., Corpus Christi, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society. Dr. John R. Mast, Midland, Pres.; Dr. M. J. Loring, 304 North N St., Temple, Secy.

Third District Society, Borger, April, 1955. Dr. M. C. Overton, Jr., Pampa, Pres.; Dr. William Klingensmith, 215 Fisk Bldg., Amarillo, Secy.

Fourth District Society, San Angelo, Oct. 21, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society. Dr. Y. C. Smith, Sr., Corpus Christi, Pres.; Dr. E. Jackson Giles, 705 Medical-Professional Bldg., Corpus Christi, Secy.

Seventh District Society. Dr. William McLean, Austin, Pres.; Dr. John Rainey, 1709 San Antonio, Austin, Secy.

Eighth District Society, Victoria, September 23, 1954. Dr. Howard Z. Fretz, Wharton, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society. Dr. Thomas H. Giddings, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. John M. White, Port Arthur, Pres.; Dr. Rider Stockdale, Jasper, Secy.

Eleventh District Society, Jacksonville, Fall, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society. Dr. Neil Buie, Marlin, Pres.; Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society. Dr. Mal Rumph, Fort Worth, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society. Dr. J. David Thomas, Denton, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Mount Pleasant, 1955. Dr. R. L. Johnson, Mount Pleasant, Pres.; Dr. R. L. Hardman, Mount Pleasant, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 14-17, 1955. Dr. Lawrence B. Sheldon, Dallas, Pres.; Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco. Dr. Ross Shipp, Waco, Pres.; Dr. Milton Spark, 3805 Herwal, Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 7-10, 1955. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Sept. 22, 1954. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.
Postgraduate Medical Assembly of South Texas. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.
State Tumor Conference, Wichita Falls, April, 1955. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.
Texas State Board of Medical Examiners, Fort Worth, Dec. 2-4, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

FOUR POSTGRADUATE COURSES

The University of Texas Postgraduate School of Medicine, Houston, will sponsor a fourteen-week course on functional neurology, to be held each Thursday evening, September 9 through December 16. This is the second in a series of courses designed by the Department of Medical Psychology of the M. D. Anderson Hospital and the Tumor Institute for those interested in medical psychology. Twenty-eight credit hours will be given. The tuition fee is $15, with no fee charged to residents or trainees. Instructors will be Dr. George J. Ehni, Dr. Edmund M. Fountain, Dr. J. B. Trunnell, Dr. William S. Fields, and Dr. Abe Hauser.

Early in October will be begun a course of twenty-four one-hour lectures once a week on radiologic physics. The course is designed for trainees and residents in radiology and physicians interested in the use of radiation as applied to the treatment of malignant disease.

A course in industrial medicine will be given each Tuesday evening from October 12 through November 16 with Dr. V. C. Baird in charge. After each scientific presentation will be a question and answer period.

Practical electrocardiology will be the topic of a course to be presented in Houston by Dr. Demetrio Sodi-Pallares, chief of the Department of Electrocardiology of the National Institute of Cardiology of Mexico City. The lectures will be given each evening, December 6-10, under the auspices of the University of Texas Postgraduate School of Medicine, Baylor University College of Medicine, and the Houston Heart Association. Emphasis will be on tracings commonly encountered in practice. Individualized instruction interpretation of specific tracings will be given.

Details about all courses may be obtained from the postgraduate school, Texas Medical Center, 1400 Outer Belt Drive, Houston 25.

GERIATRICS SOCIETY TO MEET

The Texas Geriatrics Society will meet on September 4 at the Texas Medical Association headquarters building, Austin. Business on the agenda for this meeting according to Dr. Henry H. Niehuss, Longview, president, includes the selection of an official journal for the society, preparation of an outline for the fall scientific meeting, and adoption of the constitution and by-laws.

The committee which drew up the constitution and by-laws is composed of Dr. Martin S. Buehler, Dallas, chairman; Dr. Don G. Kilgore, Dallas; Dr. W. S. Horn, Fort Worth; Dr. V. R. Hurst, Longview; Dr. B. E. Pickett, Sr., Carrizo Springs; Dr. S. W. Thorn, Houston; Dr. Hugh P. Reveley, San Antonio; Dr. Charles T. Stone, Galveston; and officers of the society.

Prior to the business meeting, speakers will be Dr. Stone, University of Texas School of Medicine, and Dr. Buehler, president of the Texas Academy of Internal Medicine, who will have recently returned from the International Academy of Gerontology in London.

Applications for membership may be addressed to the Texas Geriatrics Society, Longview.

PERSONALS

Dr. H. Jaworski, Waco, described the Waco plan for mass civilian casualties before the Industrial Medical Association in Chicago in April.

Dr. Daniel E. Jenkins, Houston, was elected vice-president of the American Trudeau Society at the meeting of the group in Atlantic City, May 18.

Dr. John A. Trautman, Bethesda, Md., has been appointed officer in charge of the Public Health Service Hospital, Fort Worth.

Dr. Albert W. Hartman, Jr., San Antonio, returned to his office in July after serving for several months in Europe as a civilian surgical consultant to the United States Army.

Dr. Henry A. Cromwell, Houston, has been appointed to the board of directors of Texas Industrial Trust, Inc.

Dr. E. R. Cox, Dallas, has been chosen recently as a board member of the Lakewood State Bank.

Dr. Francis T. N. Hood, Jr., Sweetwater, and Miss Patsy Louise Wofford, Cleburne, were married June 6, in Cleburne.

The wife of *Dr. Ralph E. Donnell,* Plainview, died on June 5. Mrs. Donnell was a member-at-large of the Third District Auxiliary.

The wife of *Dr. Arnett D. Ladd* died on June 8 in a Fort Worth hospital after a long illness. Mrs. Ladd was a member of the Tarrant County Woman's Auxiliary.

The wife of *Dr. Robert W. Holton, Sr.* died June 4 at their home in Terrell.

WORLD CARDIOLOGY CONGRESS

The Second World Congress of Cardiology will be held September 12-17 in Washington, D. C. The scientific sessions, which last for five days, will include formal papers, panel discussions, clinical pathologic conferences, and visits to several medical centers in Washington and Bethesda, Md.

The congress will include banquets, sight-seeing tours, and post-congressional visits and conferences at some of the leading cardiac clinics in the United States and Canada.

The registration fee will be $25 for members and $15 for associate members (wives and children). Additional information may be obtained from the secretary-general, Dr. L. W. Gorham, 44 East 23rd Street, New York 10.

LSU ALUMNI ASSOCIATION

The Louisiana State University Medical Alumni Association of Texas was organized at a May 3 meeting in San Antonio. Dr. Mildred Ward, San Antonio, presiding officer, introduced a special guest, Dr. B. H. Beard, Fort Worth, former professor of biochemistry at the medical school. It was decided to meet annually at the time of the convention of the Texas Medical Association, and the following officers were elected: Dr. Sam F. Hartman, Beaumont, president; Dr. A. A. Tisdale, Austin, vice-president; Dr. J. R. Dupre, San Antonio, secretary; and Dr. Ward, treasurer.

Regional Rehabilitation Meeting

At the Southwest Regional Conference of the National Rehabilitation Association held in Fort Worth May 31-June 2, three members of the Texas Medical Association were speakers. Addressing the group on "Dynamics of Counseling" was Dr. David Wade, Austin. Dr. Robert H. Mitchell, Fort Worth, was moderator of a panel discussion "Cardiac in Industry," and Dr. Joseph F. McVeigh, Fort Worth, participated on the panel as the physician member.

In addition to Texans on the program, there were representatives from Louisiana, New Mexico, and Oklahoma and guest speakers from Washington, D. C.

Southwestern Surgical Congress

The Southwestern Surgical Congress will hold its sixth annual meeting September 20-22 at Oklahoma City. The program will include scientific papers, panel discussions, round table luncheons, and entertainment.

Guest speakers include Dr. John M. Waugh, Rochester, Minn.; Dr. W. Alton Ochsner, New Orleans; and Dr. Zeph J. R. Hollenbeck, Columbus, Ohio. In addition, Dr. Michael E. DeBakey, Dr. Denton A. Cooley, and Dr. Oscar Creech, all of the Baylor University School of Medicine, Houston, will present a paper on "Surgical Considerations of Disease of the Aorta." "Effects of Various Shock States and Their Treatment on: Pulmonary Function; Hepatic Function; Renal Function" will be the topic of Dr. Ben J. Wilson, Dr. Morris J. Fogelman, and Dr. Jerry A. Stirman, Southwestern Medical School of the University of Texas, Dallas. Dr. F. M. Lingenfelter, Dr. Ernst Lachmann, Dr. Frank E. Darrow, and Dr. Ray H. Lindsey, University of Oklahoma School of Medicine, Oklahoma City, will present "Inguinal Hernia—Anatomical Considerations, Statistical Analysis and Surgical Technique."

Entertainment will include a barbecue, a dinner and dance, and special entertainment for the ladies.

Further information may be had from the congress, 207 Plaza Court Building, Oklahoma City 3.

PHYSICAL MEDICINE AND REHABILITATION

The thirty-second annual session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11 in Washington, D. C. Scientific and clinical sessions will be given beginning on September 7, and all sessions are open to doctors who are members of the American Medical Association. Annual instruction seminars will be held also. These lectures will be open to physicians and therapists who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Additional information may be obtained from the executive offices, 30 North Michigan Avenue, Chicago 2.

NORTH TEXAS-SOUTHERN OKLAHOMA CLINIC

The North Texas-Southern Oklahoma Fall Clinical Conference will be held in Wichita Falls on September 22. The scientific program will include Dr. Edward L. Pratt, Dallas, "Management of Meningitis in Children"; Dr. Elmer L. Sevringhaus, Jersey City, N. J., "Use of Sex Steroids in General Practice" and "Prescribing of Adequate Nutrition in General Practice"; Robert L. Faulkner, Cleveland, Ohio, "Ectopic Pregnancy" and "Early Diagnosis of Cancer of Cervix and Corpus"; and Robert Sparkman, Dallas, "Common Fallacies in Gallbladder Disease."

William Alan Richardson, Rutherford, N. J., editor of *Medical Economics,* will speak on "How to Liquidate Your Poor Relations" at the evening dinner. The registration fee of $8 for doctors includes meals and a cocktail party; a fee of $4 for the ladies covers the evening meal and cocktail party.

Heart Symposium

The Red River Valley District Heart Association presented on June 6 in Sherman a one day symposium on "Diseases of the Heart and Circulation" under the auspices of Southwestern Medical School of the University of Texas in cooperation with the Fort Worth Laboratory for Surgical Research. Participants in the program were Dr. Albert M. Goggans, Dr. Clive Johnson, Dr. John Marietta, Dr. Robert H. Mitchell, and Dr. O. J. Wollenman, Fort Worth; and Dr. Alfred Harris, Dr. John A. Osborne, Dr. Howard Heyer, and Dr. Maurice Scurry, Dallas. In addition to the scientific papers, three panel discussions were presented at he meeting.

World Medical Association

The World Medical Association will convene in Rome, Italy, for its eighth general assembly from September 26 through October 2. Information about the meeting may be obtained from the secretary-general, Dr. Louis H. Bauer, 345 46th Street, New York 17.

LIBRARY SECTION

SNAKES OF TODAY

There are more than 2,000 kinds of snakes, ranging in size from the 30 foot python to the midget of only 6 inches. Fortunately a large majority of snakes are nonvenomous. Only one-eighth of all known venomous species have highly developed poison-conducting fangs, and of this number not more than 60 per cent are deadly to man. According to Ditmars, in the United States there are over 100 kinds of nonvenomous snakes, and close to 20 poisonous species. At least 40 varieties of the poisonous snakes are found in the Southwest.

Rattlesnakes are found only in the New World, being most abundant in the southwestern United States, where more than a dozen kinds occur. Texas rattlesnakes range in size from the 18 inch western ground rattlesnake to the 7 foot diamondback rattlesnake, one of the most dangerous snakes in North America.

Snakes found in Texas have been the topic of many interesting papers, and the various species collected in the state are to be found in many museums throughout the world. As early as 1853 Dr. Benno Matthes, a Silesian physician, went to Galveston to collect naturalia for the cabinet in Dresden. From the published works of Dr. Matthes it is found that he made a study of the coral snakes. He noted that the Elaps had immovable fangs, were poisonous, and could open their jaws wide enough to swallow other snakes as large as themselves. He noted also that snakes frequently devour their own species.

Although there are few deaths annually from snake bites in the United States, it is well known among snake bite authorities that more people die from snake bites in Texas than in any other state. The problem of a bite from a poisonous snake can be complicated still further by the fact that distances are great between towns, and since frequently the patient is far from help when he is bitten, considerable time may elapse before treatment is available.

The Memorial Library of the Texas Medical Association has available the following publications on the subject of snakes:

Apology to Texas, J. Pediat. *43:*120 (July) 1953.

Bulger, J. J., and Northrop, A. K., Jr.: Perforated Duodenal Ulcer Following Snakebite, J.A.M.A. *147:*1134-1135 (Nov. 17) 1951.

Chotkowski, L. A.: Treatment of Snake-Bite Poisoning, New England J. Med. *241:*600-603 (Oct. 20) 1949.

Crimmins, M. L.: Facts About Texas Snakes and Their Poison, Texas State J. Med. *23:*198-202 (July) 1927.

Dawson, Everett T.: Western Diamond-Backed Rattlesnake, Austin, Texas Game and Fish Commission, Leaflet No. 16C.

Ditmars, Raymond L.: Snakes of World, New York, MacMillan Company, 1952.

Fillmore, R. S.: Early Local Treatment of Snake Bite, Texas State J. Med. *37:*311-313 (Aug.) 1941.

Gowdy, John M.: Treatment of Snakebite with Cortisone; Report of Four Cases, Am. Pract. & Digest Treat. *5:*569-572 (July) 1954.

Hoback, William W., and Green, Thomas W.: Treatment of Snake Venom Poisoning with Cortisone and Corticotropin, J.A.M.A. *152:*236-237 (May 16) 1953.

Jackson, Dudley: First Aid Treatment for Snake Bite, Texas State J. Med. *23:*203-209 (July) 1927.

Ortenburger, A. I.: Treatment of Snake Bite, J. Oklahoma State M. A. *45:*211-215 (June) 1952.

Shannon, Frederick A.: Comments on Treatment of Reptile Poisoning in Southwest, Southwestern Med. *34:*367-373 (Oct.) 1953.

Snake Bites, J. Pediat. *42:*643-644 (May) 1953.

Stahnke, Herbert L.: L-C Treatment of Venomous Bites or Stings, Am. J. Trop. Med. *2:*142-143 (Jan.) 1953.

Werler, John E.: Poisonous Snakes of Texas and First Aid Treatment of Their Bites, Austin, Texas Game and Fish Commission, Bulletin No. 31, February, 1953.

MEDICAL LIBRARY ASSOCIATION

At the fifty-third annual meeting of the Medical Library Association in Washington, D. C., in June, Miss Pauline Duffield, Librarian, Texas Medical Association, was elected treasurer. Other officers elected were Miss Wilma Troxel, Chicago, president; Mr. Wesley Draper, Brooklyn, vice-president (president-elect); Dr. E. H. Cushing, Washington, D. C., honorary vice-president; Miss Esther Judkins, New York, secretary; and Miss Clara S. Manson, San Francisco, and Mr. Robert T. Lentz, Philadelphia, members of the board of directors. The next meeting of the group will be at Marquette University School of Medicine, Milwaukee, in June, 1955.

BOOKS RECEIVED IN JULY

Ackerman, L. V.: Cancer, Diagnosis, Treatment and Prognosis, ed. 2, St. Louis, C. V. Mosby, 1954.

Advances in Internal Medicine, vol. 6, New York, Interscience Press, 1954.

American Medical Association: New and Non-Official Remedies, 1954, Chicago, 1954.

American Medical Association Council of Pharmacy and Chemistry: Fundamentals of Anesthesia, ed. 3, Philadelphia, W. B. Saunders, 1954.

Dubuisson, M.: Muscular Contraction, Springfield, Ill., Charles C Thomas, 1954.

Escamilla, Roberto F.: Laboratory Aids in Endocrine Diagnosis, Springfield, Ill., Charles C Thomas, 1954.

Fine, Jacob: Bacterial Factor in Traumatic Shock, Springfield, Ill., Charles C Thomas, 1954.

Hill, Fontaine S.: Practical Fluid Therapy in Pediatrics, Philadelphia, W. B. Saunders, 1954.

Iowa State Medical Society: Handbook of Resources Available to Physicians, Iowa State Medical Society, 1954.

Kant, Fritz: Treatment of Alcoholic, Springfield, Ill., Charles C Thomas, 1954.

Katz, Louis N., and Stamler, Jeremiah: Experimental Atherosclerosis, Springfield, Ill., Charles C Thomas, 1953.

Krantz, John C.: Pharmacologic Principles of Medical Practice, ed. 3, Baltimore, Williams and Wilkins, 1954.

MacKenna, R. M. B.: Modern Trends in Dermatology, series 2, New York, Paul B. Hoeber, Inc., 1954.

National Foundation for Infantile Paralysis: Collected Reprints, vol. 14, parts 1 and 2, New York, 1954.

Roskam, Jacques: Arrest of Bleeding, Springfield, Ill., Charles C Thomas, 1954.

Rothman, Stephen: Physiology and Biochemistry of Skin, Chicago, University of Chicago Press, 1954.

Wolstenholme, G. E. W.: Peripheral Circulation in Man, Ciba Foundation Symposium, Boston, Little, Brown and Company, 1954.

CONTRIBUTIONS TO THE LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library for the following recent gifts:

Bexar County Woman's Auxiliary, San Antonio, 10 volumes of Transactions of the Texas Medical Association.

Dr. G. E. Brandes, Austin, 97 journals.

Dr. S. N. Key, Jr., Austin, 32 journals.

Dr. L. H. Reeves, Fort Worth, 4 journals.

Dr. W. D. Roberts, Austin, 36 journals.

Dr. N. L. Schiller, Austin, 27 journals, 7 pamphlets.

MOTION PICTURES FOR LOAN

Surgical Treatment for Splenic Flexure Carcinoma with Solitary Liver Metastasis

16 mm., silent, color, 40 minutes. By Dr. Philip Thorek, Chicago.

Part one contains an exceptionally good illustration of the McBurney incision and will be of interest to any physician who might use this incision. An excellent illustration of the method of doing a cecostomy is included. Part two deals with the resection of the carcinoma in the splenic flexure. It is superb for the surgeon who has occasion to perform colon resections. Part three follows the pattern of reel two and contains the closure of the cecostomy. Remarkable hemostasis is noted throughout the three reels. The color is excellent.

Surgical Treatment for Coarctation of the Aorta

16 mm., silent, color, 30 minutes. By Dr. Philip Thorek, Chicago.

This film is beautifully done and well edited, with remarkable true color rendition. It is of interest to cardiologists and those interested in cardiac conditions amenable to surgery. It is highly specialized and only of academic interest to most physicians.

Hemicolectomy for Carcinoma of Right Side of Colon

16 mm., silent, color, 22 minutes. By Dr. Philip Thorek, Chicago.

This is an excellent color rendition, with the material well organized. The film presents a good demonstration of the technique of ileocolostomy and is recommended for any physician who might encounter the necessity of this procedure. The film will be of most interest to surgeons.

BOOK NOTICES

Speech Problems of School Children

A symposium co-sponsored by the Divisions of School Psychologists and of Educational Psychology of the American Psychological Association, the American Speech and Hearing Association, and the National Society for Crippled Children and Adults, Inc. 61 pages. $1.25. Chicago, National Society for Crippled Children and Adults, 1953.

[1]Basic Principles of Cancer Practice

ANDERSON NETTLESHIP, M. D., *Professor of Pathology, University of Arkansas, Fayetteville, Ark. 397 pages. $7. Williams and Wilkins, Baltimore, 1952.*

This volume was prepared for the general practitioner and the medical student. In an introductory exposition of his purpose and reasons for writing the book the author states the need for a text to deal broadly with the subjects of diagnosis, prognosis, and treatment of cancer in humans. Most of the book's nineteen chapters are so divided and in that order. The larger divisions of the subject are made according to the part of the body in which the neoplasms occur rather than by tumor classification. There are additional materials of interest on the subjects of occupational cancer, trauma, biochemistry, medicolegal aspects, and psychological implications. Dr. Nettleship gives seven principles of treatment, and his approach to the whole theme is instructive, as noncontroversial as the nature of the subject permits, and practical.

An attractive feature of this volume is the illustrative matter included. There are 109 photographs, drawings, and charts (not separately indexed), and case histories are cited in some detail. The bibliographies are at the ends of the chapters and are both up-to-date and full. From the literature the author has selected well over 300 bibliographic items for recommended further reading. Another favorable factor for quick reference usage is his practice of summarization of each chapter at its conclusion.

[2]Practical Management of Diabetes

EDWARD TOLSTOI, M. D., *Associate Professor of Clinical Medicine, Cornell University Medical College; Attending Physician and Chief, Diabetic Hospital, New York Hospital, New York. 93 pages. $3.25. Springfield, Ill., Charles C Thomas, 1953.*

This ninety-three page manual consists of nine chapters on various aspects of the management of diabetes—some new, some old. As many reviewers have noted, it is "a defense of glycosuria," and one of the newer points is the author's opinion that glycosuria and hyperglycemia are harmless as long as the patient is symptomless and without acetonuria. This undoubtedly will be strongly challenged in many areas since the generally accepted aim in treatment of the diabetic is to keep the blood sugar approximately normal and the urine relatively sugar free.

From a critical standpoint, there is no mention of diet calibration nor are there any food tables except in weight reduction. Desired weight gain is regulated by insulin dosage rather than food intake and this deviates considerably from accepted practice.

Favorable points are that the arrangement and typography are good. In general, however, this book serves only to present one point of view which will provoke many arguments.

[3]Handbook on Diseases of Children

BRUCE WILLIAMSON, M. D. *(Edin.)*, F.R.C.P. *(London), Physician, Children's Department, Royal Northern Hospital, London, and Lecturer, North London Post-Graduate Institute. Seventh edition. 467 pages. $5. Edinburgh and London, E. & S. Livingstone, 1953. Distributed by Williams and Wilkins, Baltimore.*

This handbook gives a detailed and comprehensive description of the signs and symptoms of diseases of children and the underlying physiology. It is a book designed for the general practitioner and busy pediatrician as a quick ready reference for clinical information that can be utilized in making a diagnosis without an exorbitant expenditure of the patient's funds on costly laboratory procedures.

The author discusses pathognomonic as well as groups of significant symptom complexes and signs helpful to an immediate bedside diagnosis. No great emphasis is made on laboratory findings or specialized diagnostic procedures.

Description of the course of each disease is illuminating and interestingly simple. It is easy to follow the author's viewpoint in his vivid portrayal of the child with the disease.

It is a handy reference for medical students, busy practitioners, and pediatricians. The disease entity is presented in an orderly manner with a brief discussion of the pertinent diagnostic tests and modes of treatment of practical value. This handbook is a valuable addition to any practitioner's set of reference books and to that of allied specialists.

[4]Experimental Atherosclerosis

LOUIS N. KATZ, M. D., *Director Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago, and* JEREMIAH STAMLER, M. D., *Research Associate, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago. 375 pages. $10.50. Springfield, Ill., Charles C Thomas, 1953.*

This monograph presents a study of human atherosclerosis and a review of the vast and sometimes conflicting experimental work in this field. The authors define atherosclerosis as intimal arteriosclerosis or amorphous lipid accumulation in the intima.

The effect of world dietary habits upon the incidence of atherosclerosis and elevated cholesterol plasma levels is noted as is the decreased incidence of atherosclerosis on an enforced low fat diet, demonstrated during World War II. Diabetes mellitus, nephrosis, chronic nephritis, hypothyroidism, biliary obstruction, hypertension, hyperadrenocorticism and familial hypercholesterolemia are accompanied by an increased incidence of atherosclerosis.

The relationship of the plasma lipoprotein colloidal complex (the state of aggregation of cholesterol in plasma) is considered the most important single factor in atherosclerosis.

The final chapter reviews experimental animal work particularly with chickens. The authors conclude that "altered cholesterol metabolism plays a key role in human atherogenesis."

The monograph is a good review of experimental atherosclerosis. Because of the insertion of many references in the text and inclusion of conflicting evidence, the work is necessarily rather cumbersome as regards readability.

[5]Salmonellae and Shigellae; Laboratory Diagnosis Correlated with Clinical Manifestations and Epidemiology

ALFRED J. WEIL, M. D., *Department of Bacteriology, Bronx Hospital, New York, and* IVAN SAPHRA, M. D., *Department of Bacteriology, Beth Israel Hospital, New York. 247 pages. $7.75. Springfield, Ill., Charles C Thomas, 1953.*

The purpose of this book, as quoted by the authors in the preface, is to assemble, conveniently, the information necessary for handling the laboratory aspects of Salmonellae and Shigellae infections. Furthermore, it was written to supply the link for adequate cooperation between bacteriologist, clinician, and epidemiologist in controlling these diseases (typhoid fever, paratyphoid fever, and bacillary dysentery).

[1]*Clifton D. Howe, M. D., Houston.*
[2]*H. C. Powell, M. D., Austin.*
[3]*Joe C. Rude, M. D., and Pura Santiago, M.D ., Austin.*
[4]*Gretchen Runge, M D., Austin.*
[5]*H. C. Powell, M. D., Austin.*

The book is divided into fifteen chapters which deal with the various aspects of Salmonellae and Shigellae from laboratory, clinical, and therapeutic standpoints. There are fourteen illustrations, all of which are good except figure 14, which does not demonstrate clearly the testing for antibiotic sensitivity of the disk method.

The best chapters on the laboratory procedures and evaluation are the ones dealing with properties, methods of isolation, cultural methods, and the Widal test. Clinical viewpoints are best expressed in the chapters on clinical features and epidemiology, natural and immune resistance, bacteriophages for diagnosis and treatment, and, again, cultural methods. Treatment is summarized and emphasized well in the chapter on sulfonamides and antibiotics. Epidemiology is thoroughly brought out, both in the localized and the generalized form of the diseases.

This book serves as a handy review of the Salmonellae and Shigellae infections and is food for thought when unexplained fevers and diarrheas need explaining.

[6]The Psychiatrist, His Training and Development

Report of the 1952 Conference on Psychiatric Education held at Cornell University, Ithaca, New York, June 19-25, 1952, organized and conducted by the American Psychiatric Association and the Association of American Medical Colleges. 214 pages. Baltimore, Lord Baltimore Press, 1953.

This report is focused primarily on training and development of career psychiatrists, so the discussion begins with the development of residency training. There is much succeeding discussion, pro and con, of the contents of the ideal residency training program.

The report of the special commission on psychodynamic principles is given verbatim, and the conference as a whole apparently preferred to accept the report.

Considerable detail in the discussion is given on the ideals and practices in the training of residents, recruitment and selection of residents, and the resident's personal problems.

The chapter on training centers discusses the approved training program and lists the approved residencies in psychiatry for one, two, and three years. The roles of psychoanalysis and of child psychiatry in residency training were discussed thoroughly.

The chapter on some special fields includes memoranda submitted to the conference on special fields or subspecialties for which hospital residency training provides scanty orientation. Psychiatry in the training for other specialties, such as pediatrics, internal medicine, surgery, and public health, was discussed at the conference.

The statements on psychiatry and the nation's health are good and reveal to a great extent the need for psychiatrists and allied psychiatric personnel throughout the nation. There is also a realization of the need for the residency programs to prepare the psychiatrist to grasp the opportunities for preventive psychiatry and to make the most of them in the rapidly expanding field of promoting mental health.

This report has made an excellent book, and it should be recommended for many individuals. Some parts of the book are somewhat difficult reading for individuals not familiar with psychiatry, but, in general, this book is recommended and specially for psychiatrists and physicians who are interested in becoming psychiatrists.

[6]*J. C. Strong, M. D., Dallas.*

ORGANIZATION SECTION

TEXAS MEDICAL ASSOCIATION

EXECUTIVE COUNCIL TO MEET

Meetings on September 3 and 4 of councils and committees of the Texas Medical Association will precede the fall Executive Council meeting September 5 at the headquarters building in Austin. Dr. A. L. Thomas, Ennis, is to be presented with the plaque for the General Practitioner of the Year of Texas, and reports of the various councils and committees of the Association will be accepted at the September 5 meeting.

The Board of Trustees will meet Friday evening, September 3, and again the next day. Friday at 8 p. m. there will be a meeting of the Committee on Infringements of Medical Practice. Meetings scheduled for Saturday, September 4, include the following: Advisory Committee to the President at 8:30 a. m.; Committee on Blood Banks, 1 p. m.; Committee on Rural Health and Doctor Distribution, 1 p. m.; Council on Medical Education and Hospitals, 1 p. m.; Committee on Library Endowment, 2 p. m.; Council on Medical Defense, 4 p. m.; Council on Medical Economics, 4 p. m.; Council on Medical Jurisprudence, 7 p. m.; Council on Scientific Work, 7 p. m.; and Committee on Mental Health, 8:30 p. m. Other meetings may be scheduled at a later date.

Sunday morning, September 5, at 8 a. m. the Council on Scientific Work will meet jointly with the officers of the scientific sections for the 1955 annual session and representatives of various specialty societies, and the Executive Council will be called to order at 9 a. m. at the Texas Medical Association headquarters building.

The Executive Council, ex-officio, is composed of the President as chairman, the President-Elect, Vice-President, Secretary, Executive Secretary, Treasurer, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, Board of Trustees, Board of Councilors, Texas Delegates to the American Medical Association, chairmen of all councils, members of the Council on Medical Jurisprudence, and chairman of the Committee on Public Relations.

Officers, Councils, and Committees

Following are the officers, councils, and committees of the Texas Medical Association for the year 1954-1955 with the year in which their terms of office expire indicated in parentheses:

OFFICERS

F. J. L. Blasingame, Wharton, President.
J. Layton Cochran, San Antonio, President-Elect.
J. C. Terrell, Stephenville, Vice-President.
J. M. Travis, Jacksonville, Secretary (1956).
N. C. Forrester, Austin, Executive Secretary.
T. H. Thomason, Fort Worth, Treasurer (1956).
Hobart O. Deaton, Fort Worth, Speaker of the House of Delegates.
Charles P. Hardwicke, Austin, Vice-Speaker of the House of Delegates.

BOARD OF TRUSTEES

R. W. Kimbro, Cleburne, Chairman (1957).
G. V. Brindley, Temple, Vice-Chairman (1955).

Troy A. Shafer, Harlingen, Secretary (1959).
Denton Kerr, Houston (1958).
Sam N. Key, Austin (1956).

Board of Councilors

First District, J. Leighton Green, El Paso (1955); C. E. Oswalt, Jr., Fort Stockton, Vice-Councilor.
Second District, R. B. G. Cowper, Big Spring (1957); Chester U. Callan, Rotan, Vice-Councilor.
Third District, Frank B. Malone, Lubbock (1956); H. H. Latson, Amarillo, Vice-Councilor.
Fourth District, H. L. Locker, Brownwood (1955); O. H. Chandler, Ballinger, Vice-Councilor.
Fifth District, J. J. Hinchey, San Antonio (1956); D. E. Packard, Kerrville, Vice-Councilor.
Sixth District, Franklin W. Yeager, Corpus Christi (1956); Stanley W. Bohmfalk, Weslaco, Vice-Councilor.
Seventh District, David Wade, Austin (1957); Vacancy, Vice-Councilor.
Eighth District, James H. Wooten, Jr., Columbus (1957); John L. Otto, Galveston, Vice-Councilor.
Ninth District, J. T. Billups, Houston, Secretary (1957); A. M. Dashiell, Houston, Vice-Councilor.
Tenth District, L. C. Heare, Port Arthur (1957); Stephen B. Tucker, Nacogdoches, Vice-Councilor.
Eleventh District, C. E. Willingham, Tyler (1955); Lynn Hilbun, Henderson, Vice-Councilor.
Twelfth District, J. Wilson David, Corsicana (1956); Howard O. Smith, Marlin, Vice-Councilor.
Thirteenth District, R. G. Baker, Fort Worth, Chairman (1955); L. J. Webster, Abilene, Vice-Councilor.
Fourteenth District, Mayo Tenery, Waxahachie (1955); L. W. Johnston, Terrell, Vice-Councilor.
Fifteenth District, H. O. Padgett, Marshall (1956); Vacancy, Vice-Councilor.

Delegates to the American Medical Association

A. C. Scott, Jr., Temple (1956).
John K. Glen, Houston (1956).
Robert B. Homan, Jr., El Paso (1956).[1]
T. C. Terrell, Fort Worth (1955).
M. O. Rouse, Dallas (1955).
J. B. Copeland, San Antonio (1955).
Delegate Designate, James H. Wooten, Jr., Columbus (1956).

Alternate Delegates to the American Medical Association

John L. Otto, Galveston (1956).
Robert W. Kimbro, Cleburne (1956).
L. C. Heare, Port Arthur (1956).
J. C. Terrell, Stephenville (1955).
Troy Shafer, Harlingen (1955).
George Turner, El Paso (1955).
Alternate Delegate Designate, L. H. Reeves, Fort Worth (1956).

Executive Council

Ex-officio, President (Chairman), President-Elect, Vice-President, Secretary, Executive Secretary, Treasurer, Speaker of the House of Delegates, Vice-Speaker of the House of Delegates, Board of Trustees, Board of Councilors, Texas Delegates to the American Medical Association, Chairmen of all Councils, Members of the Council on Medical Jurisprudence, and Chairman of the Committee on Public Relations.

[1]*Appointed May 10, 1954, to fill the vacancy created by the resignation of Dr. E. A. Rowley, Amarillo, on May 7, 1954.*

Council on Medical Defense

Charles L. McGehee, San Antonio, Chairman (1955).
John H. Wootters, Houston (1959).
Joe Nichols, Atlanta (1958).
P. M. Kuykendall, Ranger (1957).
Harold M. Williams, Austin (1956).
F. J. L. Blasingame, Wharton (ex-officio).
N. C. Forrester, Austin (ex-officio).

Council on Medical Jurisprudence

J. B. Copeland, San Antonio, Chairman (1957).
G. W. Cleveland, Austin (1959).[2]
J. W. Rainer, Odessa (1958).
Robert D. Moreton, Fort Worth (1956).
John K. Glen, Houston (1955).
F. J. L. Blasingame, Wharton (ex-officio).
N. C. Forrester, Austin (ex-officio).

Council on Scientific Work

May Owen, Fort Worth, Chairman (1957).
John C. Kennedy, Houston (1959).[3]
Clyde A. Stevenson, Temple (1958).
L. Bonham Jones, San Antonio (1956).
Kleberg Eckhardt, Corpus Christi (1955).
F. J. L. Blasingame, Wharton (ex-officio).
N. C. Forrester, Austin (ex-officio).

Council on Medical Economics

Harvey Renger, Hallettsville, Chairman (1957).
Gail Medford, Lufkin (1959).
E. W. Jones, Wellington (1958).
A. G. Barsh, Lubbock (1956).
Raleigh R. Ross, Austin (1955).
F. J. L. Blasingame, Wharton (ex-officio).
N. C. Forrester, Austin (ex-officio).

Council on Medical Education and Hospitals

John L. Matthews, San Antonio, Chairman (1957).[4]
S. W. Thorn, Houston (1959).
G. N. Aagaard, Dallas (1958).[5]
Truman G. Blocker, Jr., Galveston (1956).
W. S. Barcus, Fort Worth (1955).
F. J. L. Blasingame, Wharton (ex-officio).
N. C. Forrester, Austin (ex-officio).

War Council

Ex-officio, President (Chairman), President-Elect, Vice-President, Secretary, Executive Secretary, Treasurer, Speaker of the House of Delegates, Board of Trustees, Board of Councilors, Chairmen of all Councils, and Chairman of the Committee on Public Relations.

Committee on Cancer

Porter Brown, Fort Worth, Chairman (1958).
Charles Phillips, Temple (1959).
C. T. Ashworth, Fort Worth (1957).
R. E. Windham, San Angelo (1956).
R. Lee Clark, Jr., Houston (1955).

Committee on Medical History

Tate Miller, Dallas, Chairman (1958).
Felix P. Miller, El Paso (1959).

[2]*Appointed July 26, 1954, to fill the vacancy created by the resignation of Dr. Sam N. Key, Jr., Austin, on June 8, 1954.*

[3]*Appointed May 13, 1954, to fill the vacancy created by the resignation of Dr. Charles D. Reece, Houston, on May 11, 1954.*

[4]*Appointed chairman May 4, 1954, to fill the vacancy created by the resignation of Dr. M. O. Rouse, Dallas, on May 4, 1954.*

[5]*Appointed May 13, 1954, to fill the vacancy created by the resignation of Dr. John S. Chapman, Dallas, who was appointed to fill the unexpired term of Dr. Rouse.*

W. E. Whigham, McAllen (1957).
L. H. Reeves, Fort Worth (1956).
A. A. Ross, Sr., Lockhart (1955).

COMMITTEE ON PUBLIC RELATIONS

William M. Crawford, Fort Worth, Chairman.
A. F. Clark, Jr., San Antonio.
Glenn D. Carlson, Dallas.
Raleigh R. Curtis, Temple.
H. M. Anderson, San Angelo.
Van D. Goodall, Clifton.

COMMITTEE ON TUBERCULOSIS

W. D. Anderson, San Angelo, Chairman (1956).
William D. Seybold, Houston (1959).
Orville E. Egbert, El Paso (1958).
John A. Wiggins, Fort Worth (1957).
Ralph E. Gray, Lake Jackson (1955).

COMMITTEE ON LIBRARY ENDOWMENT

B. E. Pickett, Carrizo Springs, Chairman (1957).[6]
Jack G. Kerr, Dallas (1959).
Joe T. Gilbert, Austin (1958).
V. R. Hurst, Longview (1956).
R. D. Little, Wharton (1955).

COMMITTEE ON MENTAL HEALTH

Hamilton Ford, Galveston, Chairman (1958).
Andrew S. Tomb, Victoria (1959).
Dorothy Wyvell, Midland (1957).[7]
A. B. Cooper, El Paso (1956).
Abe Hauser, Houston (1955).

COMMITTEE ON PUBLIC HEALTH

Hugh Welsh, Houston, Chairman (1956).
M. O. Rouse, Dallas (1959).
H. H. Latson, Amarillo (1959).
T. A. Fears, Beaumont (1958).
William E. Lockhart, Jr., Alpine (1958).
John F. Pilcher, Corpus Christi (1957).
Arthur G. Schoch, Dallas (1957).
H. D. Gilliam, McAllen (1956).
Thomas H. Diseker, San Antonio (1955).
H. K. Brask, San Angelo (1955).

COMMITTEE ON BLOOD BANKS

E. E. Muirhead, Dallas, Chairman (1956).
D. A. Todd, San Antonio (1959).
W. J. Emerson, Laredo (1958).
O. J. Wollenman, Jr., Fort Worth (1957).
T. M. Oliver, Waco (1955).

Committee on General Arrangements for the 1955 Annual Session (all of Fort Worth).—William M. Crawford, Chairman; James D. Murphy; Robert D. Moreton; Dolphus E. Compere; R. V. Brasher.

Committee on Memorial Services.—L. H. Reeves, Fort Worth, Chairman; R. G. Baker, Fort Worth, Vice-Chairman; Irving W. Moody, Houston; Herbert Donnell, Waxahachie; E. H. Lindsey, Beaumont; A. C. Bennett, Marlin.

Committee on Scientific Exhibits.—E. T. Smith, Houston, Chairman; J. W. Birdwell, Tyler; S. S. Evans, McAllen; Olin B. Gober, Temple; S. L. Witcher, Clifton.

Advisory Board to Texas Society of Medical Technologists.—W. O. Russell, Houston, Chairman; J. H. Childers, Galveston; M. S. Hart, El Paso.

Committee on Rural Health and Doctor Distribution.—C. U. Callan, Rotan, Chairman; C. E. Oswalt, Jr., Fort Stockton; Stephen B. Tucker, Nacogdoches; J. H. Harris, Marshall; George Bruce, Baytown; G. V. Edgar, Levelland.

Committee on Revision of the Constitution and By-Laws.—John F. Thomas, Austin, Chairman; Robert B. Homan, Jr., El Paso; Hobart O. Deaton, Fort Worth; J. J. Hinchey, San Antonio; J. Charles Dickson, Houston.

Committee on Nursing Care.—A. C. Scott, Jr., Temple, Chairman; R. D. Holt, Meridian; R. A. Neblett, Canyon; G. E. Brereton, Dallas; Joseph F. McVeigh, Fort Worth.

Committee on Negro Medical Facilities.—W. L. Marr, Galveston, Chairman; L. C. Powell, Beaumont; G. V. Pazdral, Somerville; J. A. Neely, Bellville; R. D. Little, Wharton.

State Council on National Emergency Medical Service.—R. E. Gray, Lake Jackson, Chairman; W. H. Hamrick, Houston; Henry A. Holle, Austin; J. W. Hill, Dallas; A. W. Hartman, Jr., San Antonio.

Advisers to Texas Chapters of the Student American Medical Association.—W. L. Marr, Galveston; William D. Seybold, Houston; J. P. McNeill, Dallas.

Committee on Liaison with State Bar of Texas.—John E. Skogland, Houston, Chairman; Earl Gaston, Kingsville, Vice-Chairman; James W. Rainer, Odessa; J. B. Copeland, San Antonio; R. W. Kimbro, Cleburne; R. G. Carpenter, Dallas; David M. Cameron, El Paso.

State Committee for American Medical Education Foundation.—S. W. Thorn, Houston, Chairman; V. R. Hurst, Longview; F. L. Butte, Dallas; J. A. Little, Wichita Falls; Raleigh R. Curtis, Temple; Stephen B. Tucker, Nacogdoches; S. D. Coleman, Navasota; M. A. Forbes, Jr., Austin; S. W. Bohmfalk, Weslaco; O. H. Chandler, Ballinger; Joe R. Donaldson, Pampa; T. D. Young, Sweetwater; Charles E. Oswalt, Jr., Fort Stockton; Harold M. Northington, Wharton.

Telephone Postgraduate Broadcast Committee (Special Committee of Council on Medical Education and Hospitals).—Joe Kopecky, San Antonio, Chairman; C. T. Stone, Galveston; Henry M. Winans, Dallas; Mavis P. Kelsey, Houston; James D. Murphy, Fort Worth; Raleigh R. Ross, Austin; Asher R. McComb, San Antonio.

Joint Committee on Health Costs.—M. C. Overton, Jr., Pampa, Chairman; Tom B. Bond, Fort Worth; J. H. Wootters, Houston; James W. Rainer, Odessa.

Committee for Liaison with Workmen's Compensation Insurance Companies.—Sam N. Key, Jr., Austin, Chairman; Frederick C. Rehfeldt, Fort Worth; R. G. Carpenter, Dallas; M. H. Morris, San Antonio; Wendell H. Hamrick, Houston.

Appointees to Cooperate with the Board of Nurse Examiners.—A. C. Scott, Jr., Temple; G. E. Brereton, Dallas.

Committee on Infringements of Medical Practice.—J. T. Billups, Houston, Chairman; Neil D. Buie, Marlin; Franklin W. Yeager, Corpus Christi; E. A. Rowley, Amarillo; Mal Rumph, Fort Worth.

Texas Joint Commission for Improvement of Care of the Patient.—A. C. Scott, Jr., Temple; Joseph F. McVeigh, Fort Worth; Truman G. Blocker, Jr., Galveston; G. E. Brereton, Dallas; F. J. L. Blasingame, Wharton (ex-officio); N. C. Forrester, Austin (ex-officio).

Committee on Maternal Mortality.—Garth L. Jarvis, Galveston, Chairman; A. L. Dipple, Houston; G. F. Goff, Dallas; D. M. Gready, Houston; F. P. Helm, Austin; E. K. Blewett, Austin; W. H. Jondahl, Harlingen; R. E. Moon, San Angelo; William F. Mengert, Dallas.

Advisory Committee to the President.—President-Elect, Vice-President, Speaker of the House of Delegates, Chairman of the Board of Trustees, Chairmen of all Councils, Chairman and Secretary of the Board of Councilors, Chairman of the Texas Delegates to the American Medical Asso-

[6] *Appointed chairman April 20, 1954, to fill the vacancy created by the resignation of Dr. J. M. Travis, Jacksonville, on April 1. 1954.*
[7] *Appointed May 14, 1954, to fill the vacancy created by the resignation of Dr. David Wade, Austin, on May 13, 1954.*

ciation, Chairman of the Committee on Public Relations, and President of the Woman's Auxiliary.

SPECIAL DELEGATES

Texas Hospital Association.—Neil D. Buie, Marlin.

Texas State Nutrition Council.—Dolph L. Curb, Houston.

State Rural Health Council.—Chester U. Callan, Rotan.

Lone Star State Medical Association.—R. D. Little, Wharton.

Louisiana State Medical Association.—L. C. Heare, Port Arthur.

Arkansas Medical Society.—H. O. Padgett, Marshall.

Texas State Dental Society.—Herbert Donnell, Waxahachie.

New Mexico Medical Society.—C. E. Webb, El Paso; G. H. Jordan, El Paso, Alternate.

Texas Polio Planning Committee.—J. Edward Johnson, Austin.

Private Clinics and Hospitals Association of Texas.—J. C. Terrell, Stephenville.

OFFICERS OF SCIENTIFIC SECTIONS

SECTION ON GENERAL PRACTICE

Van D. Goodall, Clifton, Chairman.
John M. Smith, San Antonio, Secretary.

SECTION ON INTERNAL MEDICINE

John R. Winston, Temple, Chairman.
Mavis P. Kelsey, Houston, Secretary.

SECTION ON SURGERY

Robert F. Short, Jr., Dallas, Chairman.
Norman Duren, Beaumont, Secretary.

SECTION ON OBSTETRICS AND GYNECOLOGY

S. Foster Moore, San Antonio, Chairman.
Dennis M. Voulgaris, Wharton, Secretary.

SECTION ON EYE, EAR, NOSE, AND THROAT

Oliver W. Suehs, Austin, Chairman.
Robert Marion Johnson, Houston, Secretary.

SECTION ON RADIOLOGY

Delphin Von Briesen, El Paso, Chairman.
David H. Allen, Wichita Falls, Secretary.

SECTION ON PUBLIC HEALTH

Austin E. Hill, Houston, Chairman.
L. P. Walter, Austin, Secretary.

SECTION ON CLINICAL PATHOLOGY

J. L. Goforth, Dallas, Chairman.
John H. Childers, Galveston, Secretary.

SECTION ON PEDIATRICS

Robert A. Gardner, Houston, Chairman.
B. H. Williams, Temple, Secretary.

LOCAL COMMITTEES

Alumni and Fraternity.—J. H. Grammer, Chairman; John W. Garnett; T. L. Lauderdale; George Y. Siddons; Walter B. Petta; W. F. Armstrong; J. W. Tottenham, Jr.; J. R. Cochran; Cuvier P. Lipscomb; Charles H. McCollum, Jr.; L. H. Reeves.

Halls and Lanterns.—William E. Flood, Chairman; J. T. Tucker, Jr.; Cyrus L. Worrall; Richard V. Price; Joe B. Ellis.

Hotels.—R. V. Brasher, Chairman; Robert C. Barker; M. H. Crabb.

Information.—James F. Campbell, Chairman; Frank J. Daugherty; I. L. Van Zandt; Leo N. Roan.

Memorial Services.—L. H. Reeves, Chairman; R. G. Baker, Vice-Chairman; Truman C. Terrell; C. P. Schenck; L. O. Godley; Nelson Dunn; Webb Walker; Mrs. Tom B. Bond.

Publicity.—Joseph F. McVeigh, Chairman; Hersel F. Willis; Thomas J. Coleman.

Scientific and Technical Exhibits.—James D. Murphy, Chairman; Thomas L. Shields; W. S. Lorimer, Jr.; John H. Richards.

Social.—James O. McBride, Chairman; Robert D. Bickel; James W. Short; J. A. Hallmark; H. T. Jackson; Adolph F. Kauffmann.

Sports.—Dolphus E. Compere, Chairman; Randall D. Nyman; Harold D. Shelley; Drue O. D. Ware; James H. Hook; Fred B. Aurin.

Transportation and Finance.—W. D. Marrs, Chairman; Robert C. Stow, Jr.; James B. Boone; Robert H. Mitchell.

Public Lectures.—Robert D. Moreton, Chairman; Mal Rumph; James N. Walker; Ernest D. Rogers; J. H. Steger.

Local Tours and Sightseeing Trips.—Rex Z. Howard.

VISITATIONS FOR SEPTEMBER

Visitations have been scheduled to seven county medical societies for September. Those groups to be visited are Hopkins-Franklin Counties, September 2; Ellis County, September 8; Falls County, September 13; Grayson County, September 14; Angelina County, September 16; La Salle-Frio-Dimmit Counties, September 21; and Kleberg-Kenedy Counties, September 21.

Officers and staff representatives participating in the programs for September are Dr. F. J. L. Blasingame, Wharton, President of the Texas Medical Association; Dr. J. L. Cochran, San Antonio, President-Elect; Dr. Robert W. Kimbro, Cleburne, chairman of the Board of Trustees; Dr. R. G. Baker, Fort Worth, chairman of the Board of Councilors; Dr. Harvey Renger, Hallettsville, chairman of the Council on Medical Economics; and C. Lincoln Williston, Austin, assistant executive secretary.

AMERICAN MEDICAL ASSOCIATION

AMA SCIENTIFIC EXHIBIT AWARDS

Texans won three scientific exhibit awards at the convention of the American Medical Association in San Francisco. The highest scientific exhibit award given by the AMA, the Hektoen award, comprising three gold, silver, and bronze medals, was awarded to a Texas group.

For an exhibit on "Aneurysms and Thrombo-Obliterative Disease of the Aorta: Surgical Considerations," Dr. Michael E. DeBakey, Dr. Denton A. Cooley, and Dr. Oscar Creech, Jr., Houston, received a Hektoen gold medal.

A certificate of merit for diseases of the chest went to Dr. G. V. Brindley, Jr., Temple, for his exhibit on "Bronchogenic Carcinoma Simulating Benign Pulmonary Diseases." Winning a certificate of merit for laryngology, otology, and rhinology were Dr. J. Dudley Singleton, Dr. Louis E. Adin, Jr., Dr. Ralph S. Clayton, Lewis B. Waters, and Patricia O'Neill, Dallas. This exhibit was on "The Temporal Bone—An Anatomic and Clinical Study."

COUNTY SOCIETIES

Armstrong-Donley-Childress-Collingsworth-Hall Counties Society

May 19, 1954

(Reported by Carter Holcomb, Secretary)

Obstructive Diseases of Children—William Pickett, Dallas.

Armstrong-Donley-Childress-Collingsworth-Hall Counties Medical Society met with the woman's auxiliary on May 19

for a dinner in Wellington. E. W. Jones, Wellington, gave a report on the recent meeting of the Texas Medical Association, which he attended as delegate.

The scientific part of the program was given as outlined above with an open discussion from the floor following the presentation by Dr. Pickett.

Bee-Live Oak-McMullen Counties Society

April 26, 1954

Condition of Hip—J. E. Upshaw, Corpus Christi.

The Bee-Live Oak-McMullen Counties Medical Society met on April 26 at Beeville for a short business meeting. Dr. Upshaw gave the above paper, showing slides with the presentation.

Bell County Society

June 9, 1954

(Reported by F. M. Hammond, Secretary)

Diagnosis and Treatment of More Common Malformations of Heart—Dan G. McNamara, Houston.

At the June 9 meeting of the Bell County Medical Society in Temple, I. D. Ellis, Troy, and J. G. Jenkins, Temple, were elected honorary members of the society. The following committee was appointed to study the feasibility of establishing a permanent roentgen-ray unit for Bell County: Harry Frey, Belton, chairman, and W. O. Arnold, E. E. Seedorf, James Wilson, Joel H. Johnson, and James Moore, all of Temple.

The scientific program as outlined above was presented.

Brazoria County Society

May 27, 1954

(Reported by Carlos E. Fuste, Jr., Secretary)

Vaginal Pruritus—Karl John Karnaky, Houston.

Brazoria County Medical Society met May 27 at Freeport for dinner and to hear the scientific program as presented above. The next meeting of the group will be in September.

Cameron-Willacy Counties Society

May 17, 1954

(Reported by Harry A. Miller, Executive Secretary)

Diagnosis and Treatment of Gastric Ulcer—F. C. Pannill, Houston.

The Cameron-Willacy Counties Medical Society met in Harlingen on May 17 for dinner with the woman's auxiliary. After the dinner and a short business meeting in which James Clarke, Harlingen, was named medical director for the Southwest Blood Bank, the above scientific program was heard. Dr. Pannill showed slides with his paper.

Cass-Marion Counties Society

May 13, 1954

Diseases of Thyroid Gland—Henry Carney, Texarkana.

Cass-Marion Counties Medical Society met with its woman's auxiliary on May 13 for dinner at Texarkana. Following the dinner Dr. Carney addressed the society on the above subject.

Dallas County Society

May 11, 1954

(Reported by Glenn D. Carlson, Secretary)

Changing Concepts in Management of Pulmonary Tuberculosis—D. O. Shields, McKinney.

Nephropathy Following Medical Treatment of Peptic Ulcer—Joseph C. Ogle, McKinney.

The Dallas County Medical Society met at the Baylor Hospital Auditorium in Dallas on May 11. After hearing medical economics news, the above outlined scientific program was presented by Dr. Shields and Dr. Ogle, members of the staff of the Veterans Administration Hospital, McKinney. Doctors newly elected to membership in the society are Kenneth W. LaRue, Dallas; Marvin H. Bartlett, Garland; Robert A. McCall, Dallas; Warren E. Hancock, Dallas; Stanley L. Gilbert, Dallas; Ward George Dixon, Dallas; and James R. Phillips, Grand Prairie.

June 8, 1954

(Reported by Glenn D. Carlson, Secretary)

Panel Discussion: Concurrent Disease in Pregnancy

Diabetes Mellitus—William F. Mengert, moderator, George M. Jones, Howard K. Crutcher, and Douglas M. Haynes, Dallas.

Rubella—Don G. Harrel, moderator, Stewart A. Fish, Jack H. Kamholz, and Joe V. Moody, Dallas.

Dallas County Medical Society met on June 8 at the Methodist Hospital, Dallas, with members as dinner guests of the medical staff of the hospital. The above outlined scientific program was presented after medical economics news and announcement of the following new society members: James E. Ensey, Robert George Budd, Alexander B. Humes, Milam B. Pharo, Glendon A. Hoffman, Marion Jack Williams, and Irene Marie Stayer.

East Harris County Society

May 4, 1954

Diseases of the Ear, Nose, and Throat—John H. Barrett, Houston.

East Harris County Chapter of the Harris County Medical Society met on May 4 in Houston. An open discussion of the Salk poliomyelitis vaccine was held before the presentation of the above program.

Eastland-Callahan-Stephens-Shackelford-Throckmorton Counties Society

May 18, 1954

Surgical Conditions of Chest—Roy T. Lester, Abilene.

Medical Conditions of Chest—M. C. Bessire, Abilene.

Eastland - Callahan - Stephens - Shackelford - Throckmorton Counties Medical Society met on May 18 in Breckenridge for dinner with the woman's auxiliary. After a business meeting, the above scientific program was heard.

Hale-Floyd-Briscoe-Swisher Counties Society

May 11, 1954

(Reported by John C. Long, Jr., Secretary)

Hale-Floyd-Briscoe-Swisher Counties Medical Society met in Amarillo on May 11. "Coarctation of the Aorta," a motion picture, was shown and discussed by a member of the surgical service of Plainview Hospital and Clinic.

Nueces County Society

May 11, 1954

(Reported by G. S. Ahern, Secretary)

Recent Advances in Vascular Surgery—Denton Cooley, Houston.

Nueces County Medical Society held a joint meeting with the medical officers of the United States Naval Air Station on May 11 at the Naval Air Station hospital auditorium, Corpus Christi. The combined group heard the above scientific program.

Tarrant County Society

May 20, 1954

(Reported by S. W. Wilson, Secretary)

Present Status of Artificial Insemination—Robert P. McDonald, Fort Worth.

Tarrant County Medical Society met in Fort Worth on

May 20 to hear the above scientific program and a report from the delegates to the Texas Medical Association on the recent convention.

During the meeting tribute was paid to E. H. Bursey, Fort Worth, who died on May 11.

Tom Green-Eight County Society

May 10, 1954

(Reported by Joe L. Cornelison, Secretary)

Common Sense in Peripheral Vascular Disease—William J. Block, San Antonio.

Tom Green-Eight County Medical Society met in San Angelo on May 10 and heard the above scientific program. Prior to the presentation of the program a business meeting was held. John E. Ballard, San Angelo, was elected chairman of the military affairs committee. A permanent disaster committee composed of Robert A. Morse, chairman; Lacey Smith, Gus F. Eckhardt, Harry F. Round, William H. McCaw, Sam Gainer, and Edward Sattenspiel, was appointed.

The Tom Green County Crippled Children's Society requested the medical society to invite the Crippled Children's Division of the State Health Department to hold a clinic in San Angelo this fall, and the society voted to do so.

Wharton-Jackson-Matagorda-Fort Bend Counties Society

May 11, 1954

(Reported by S. E. Thompson, Secretary)

Wharton-Jackson-Matagorda-Fort Bend Counties Medical Society met May 11 at New Gulf with thirty-six members and the woman's auxiliary present. They heard Mr. Williams, federal narcotics agent, speak on narcotics and its problems as related to the physician.

DISTRICT SOCIETIES

Seventh District Society

June 18, 1954

(Reported by William F. McLean, Secretary)

William F. McLean, Austin, was elected president of the Seventh District Medical Society at its June 18 meeting at Green Shores on Lake Austin. Roy H. Morris, Jr., Elgin, was elected vice-president, and John Rainey, Austin, was elected secretary-treasurer. The doctors and their wives had a boat ride on the Riverboat Commodore for their annual summer meeting.

Fourteenth District Society

June 1, 1954

(Reported by L. W. Johnston, Secretary)

Feeding Problems of Infancy and Childhood—Logan U. Mewhinney, Dallas.
Treatment of Common Dermatoses in General Practice and in Pediatrics—J. B. Howell, Dallas.
Amenorrhea—C. F. Hamilton, Dallas.
Carcinoma of Endometrium—J. B. Griffin, Dallas.
Disorders of Back—Paul C. Williams, Dallas.
Carcinoma of Tongue—Charles L. Martin, Dallas.

The Fourteenth District Medical Society met on June 1 in Denton to hear the above program which was sponsored by Southwestern Medical School of the University of Texas, Dallas. Speakers at a noon meeting with the auxiliary were F. J. L. Blasingame, Wharton, President of the Texas Medical Association, and Mrs. Mark H. Latimer, Houston, President of the Woman's Auxiliary to the Texas Medical Association.

Newly elected officers of the district are J. David Thomas, Denton, president, and D. W. Freeman, Denison, vice-president. L. W. Johnston, Terrell, was reelected secretary-treasurer.

AUXILIARY SECTION

COUNTY AUXILIARIES

The *Galveston County Auxiliary* had a program for future nurses on April 20, which was designated by the president, Mrs. Andrew J. Magliolo, Dickinson, as "Career in Nursing Day" in Galveston County. Future nurses were models for a style show "Cavalcade of Nursing Stars," and honor guests were mothers of the girls.

Cass-Marion Counties Auxiliary met in Hughes Springs on March 10 and heard Mrs. Eva Robitaile, American Red Cross nurse, speak on "Home Nursing."

Ellis County Auxiliary heard Mrs. E. W. Coyle, San Antonio, President of the Woman's Auxiliary, at the March 16 meeting. Mrs. B. C. Wallace, Jr., and Mrs. Herbert Donnell, both of Waxahachie, were elected delegates to the state convention; Mrs. W. P. McCall, Ennis, and Mrs. Mayo Tenery, Waxahachie, were elected alternates. Mrs. Coyle also spoke to the *Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Auxiliary* at a meeting in Eagle Pass on March 12. Mrs. L. M. Cartall, Del Rio, was installed as president.

Travis County Auxiliary heard a program on "Know Your Community" at the March 16 meeting in Austin. Representatives of the Vocational Rehabilitation Division of the Texas Education Agency, the YWCA, and two hospital auxiliaries explained the work of their organizations in helping those in distress.

Cherokee County Auxiliary honored the society with a dinner on March 23 for Doctor's Day. Dr. Hardy Kemp, Baylor University College of Medicine, Houston, spoke on "Education for Professional Responsibility." *Andrews-Ector-Midland Counties Auxiliary* met with the society on March 18 for dinner, and each doctor was presented a boutonniere in observance of Doctor's Day. New president of the auxiliary is Mrs. M. J. Loring, Midland. Another group honoring the society for Doctor's Day was the *Jasper-Newton Counties Auxiliary,* which had a dinner at the home of Dr. and Mrs. A. J. Richardson, Sr., Jasper, on March 17. Mr. Ward Markley, county attorney, spoke to the group about phases of juvenile delinquency.

April 2 guest speaker for *Grayson County Auxiliary* was Dr. Edgar S. Ezell, Fort Worth, who spoke on "Juvenile Delinquency."

The Port Arthur unit of the *Jefferson County Auxiliary* was honored on March 16 by members of the Otwitanda

Officers of the Woman's Auxiliary to the Texas Medical Association: President, Mrs. E. W. Coyle, San Antonio; President-Elect, Mrs. Mark H. Latimer, Houston; First Vice-President (Organization), Mrs. John D. Gleckler, Denison; Second Vice-President (Physical Examinations), Mrs. Cecil O. Patterson, Dallas; Third Vice-President (Today's Health), Mrs. Ralph B. Payne, Amarillo; Fourth Vice-President (Program), Mrs. Guy Knolle, Houston; Recording Secretary, Mrs. Paul Brindley, Galveston; Corresponding Secretary, Mrs. Charles L. McGehee, San Antonio; Treasurer, Mrs. Oscar M. Marchman, Jr., Dallas; Publicity Secretary, Mrs. Allen H. Neighbors, Jr., Austin; Parliamentarian, Mrs. H. S. Renshaw, Fort Worth.

Campfire Girls. This group sponsors the Campfire Girls in Port Arthur.

Tarrant County Auxiliary met on May 14 in Fort Worth for a demonstration of corsage making and installation of officers.

The *Navarro County Auxiliary* met in the home of Dr. and Mrs. S. J. Barron, Corsicana, on May 7 to hear Mrs. Paul H. Mitchell and Mrs. C. L. Gary, Jr., report on the convention in San Antonio. The auxiliary met in the home of Dr. and Mrs. William Miller, Corsicana, June 4. Included in the business session was a discussion of the coming Twelfth District meeting, which will be in Corsicana, and a legislative report. It was reported that fifty-three men in homes for the aged would be remembered by the auxiliary on Father's Day. Mrs. Ben Griffin, Frost, gave two Louis Bromfield readings for the entertainment portion of the program.

At the April 20 meeting of the *Kleberg-Kenedy Auxiliary* held in the home of Dr. and Mrs. W. A. Ewert, Kingsville, Mrs. Ewert was elected president. Mrs. F. B. Higgins, Kingsville, was elected secretary and Mrs. L. E. Ramey, Kingsville, was elected treasurer.

McLennan County Auxiliary heard J. A. Moore, executive assistant in physical medicine rehabilitation service at the Veterans Administration Hospital, Waco, speak at the April 28 meeting in Waco. Mr. Moore outlined the modern pattern of treatment of mentally disturbed persons. Mrs. Eldon Fine, Waco, was named delegate and Mrs. J. C. Dunlap, Waco, alternate delegate.

Mrs. Haskell D. Hatfield was installed as president of the *El Paso County Auxiliary* at the May 10 meeting in El Paso.

The May 11 Temple meeting of the *Bell County Auxiliary* featured Judge J. K. Evetts, Belton, as guest speaker. Judge Evetts' talk, which was on juvenile delinquency, stressed the obligations of parents to provide their children not only with material necessities, but with the giving of time, companionship, and understanding.

Kerr-Kendall-Gillespie-Bandera Counties Auxiliary has chosen Mrs. Russell Guill, Kerrville, as president for the coming year.

Hutchison County Auxiliary honored the graduating seniors of the Future Nurses Clubs of their county on May 23 with a tea.

The *Bexar County Auxiliary* met at the Medical Library, San Antonio, on April 9, and had over one hundred guests for its annual guest day. Presidents of local civic organizations and presidents of auxiliaries of the surrounding counties were invited. Judge Raymond Gerhardt spoke to the group on "Juvenile Delinquency." Bexar County Auxiliary met on May 21 in San Antonio for installation of officers.

Potter County Auxiliary hosted the District 3 Auxiliary when it met in Amarillo on April 14. Mrs. W. C. Barksdale, Borger, was elected district council woman.

Cooke County Auxiliary celebrated Doctor's Day on March 30 with a buffet dinner in honor of the Cooke County Medical Society in the home of Dr. and Mrs. Vincent C. Cirone, Gainesville.

Dawson-Lynn-Terry-Gaines-Yoakum Counties Auxiliary held a business meeting after the April 7 dinner with the society in Brownfield. Mrs. C. Skiles Thomas, Tahoka, was elected president.

Angelina County Auxiliary honored the society with a dinner on April 14 in Lufkin.

EXECUTIVE BOARD AND WORKSHOP

The fall Executive Board meeting and Workshop for County Presidents will be held in Austin at the Texas Medical Association headquarters building, September 22-23. On September 22, state committee meetings are scheduled for the morning, and the Executive Board meeting is scheduled for that afternoon, with county presidents invited to attend.

The Workshop for County Presidents will be given the morning of September 23, and a luncheon and showing of films will be at noon. Round-table discussions will be held that afternoon.

A ten mile ride up Lake Austin on the Riverboat Commodore with dinner at the Green Shores picnic grounds is planned for the evening of September 22.

Everyone planning to attend is asked to make hotel or motel reservations as early as possible.

DEATHS

H. G. GARRETT

Dr. Henry Grady Garrett, Dallas, Texas, died at his home on June 28, 1954, of myocardial infarction.

The son of J. O. and Elizabeth Garrett, Dr. Garrett was born August 18, 1890, in Kosse. He attended Trinity University, then at Waxahachie, and was graduated in 1919 from Baylor University College of Medicine, then in Dallas. Dr. Garrett interned at Parkland Hospital, Dallas, and did postgraduate work at Polyclinic, Chicago, in 1921, and Charity Hospital of Louisiana, New Orleans, in 1936. He practiced in Pilot Point from 1920 until 1922, when he moved to Dallas. He was a general practitioner, specializing in pediatrics and obstetrics.

A member of the Texas and American Medical Associations through Denton County and Dallas County Medical Societies continuously throughout his career, Dr. Garrett was also a member of the American Academy of General Practice and Dallas Southern Clinical Society. He was a member of the Masonic Lodge, being a Shriner, and the Kiwanis Club. Dr. Garrett was an elder in the St. Andrew's Presbyterian Church. He received the 1954 Alumni Service Award from Trinity University of San Antonio.

Dr. Garrett and the former Miss Bernice Ewing were married on October 2, 1919, in Dallas. She survives, as do a daughter, Mrs. J. Averett Waller, Dallas; a sister, Mrs. J. L. Parks, Amarillo; five brothers, Leonard Garrett, Guy Garrett, and Sanford Garrett, of Marlin, R. L. Garrett of Irving, and Ross E. Garrett of Lubbock; and two grandsons.

W. DEATHERAGE

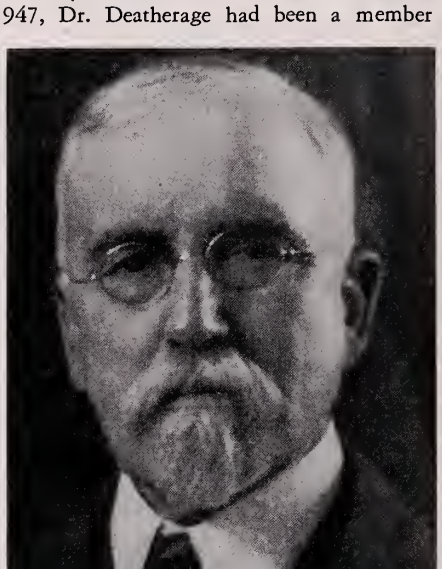
Dr. William Deatherage, Dallas, Texas, died June 10, 1954, in a local hospital after a two-year illness.

Born in Grayson County, near Bonham, on August 8, 1860, Dr. Deatherage was the son of John English and Hannah (Campbell) Deatherage, who had come to Texas from Tennessee in a covered wagon in 1852. In the days when a man became a doctor by studying as an apprentice,

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

Dr. Deatherage began his study of medicine and later attended the old Eclectic Medical College, Cincinnati, Ohio, from which he was graduated in 1886. After practicing for several years in Bells, where he made most of his calls on horseback, Dr. Deatherage returned to school and was graduated in 1895 from the Marion-Sims College of Medicine, which later became the St. Louis University School of Medicine. He then moved to Dallas and practiced there until 1950, when he went into semiretirement. He had a stroke in 1952 and had been bedridden since that time.

An honorary member of the Texas Medical Association since 1947, Dr. Deatherage had been a member of the



Dr. William Deatherage

Texas and American Medical Associations through Dallas County Medical Society almost continuously since 1907. He was a member of the Methodist Church. The saddlebags which Dr. Deatherage used in his early career were on display at the Texas Centennial at Dallas in 1936.

Dr. Deatherage and the former Miss May W. Cole were married in 1893 in Dallas. Mrs. Deatherage died ten days after the death of her husband. Surviving are a daughter, Mrs. Paul Taylor, Dallas; a son, Dr. W. R. Deatherage, Lubbock; three grandsons; and two great-grandchildren.

G. W. SCOTT

Dr. George Warren Scott, Irving, Texas, died of bronchogenic carcinoma on April 1, 1954, in that city.

Born in Indianola, Iowa, on December 25, 1911, Dr. Scott was the son of Mr. and Mrs. John Scott. He attended Morningside College, Sioux City, Iowa, and the State University of Iowa, Iowa City. He attended the State University of Iowa College of Medicine, Iowa City, and the University of South Dakota School of Medical Sciences, Vermillion, and was graduated from the University of Arkansas School of Medicine, Little Rock, in 1937. Dr. Scott interned at the Charity Hospital, Shreveport, La. He practiced in Waxahachie and Hamilton for a short time before moving in January, 1939, to Tishomingo, Okla. While in the United States Army Medical Corps in Honolulu, Dr. Scott served a residency in surgery in 1943.

Dr. Scott was a captain in the United States Army Medical Corps from 1941 to 1946, serving in the Pacific area for forty-four months during World War II. He was battalion surgeon and assistant chief of surgery with the Twenty-Fourth Division at Oahu and served as battalion surgeon with the Fortieth Division. Dr. Scott was awarded the bronze star, medical combat badge, Philippine liberation ribbon with one bronze star, Asiatic-Pacific ribbon with three battle stars, bronze arrowhead for three assault landings, American defense ribbon, victory ribbon, and seven overseas bars for his service during World War II.

Dr. Scott returned to Tishomingo in 1946 and moved to Irving in 1952. He was a member of the Texas and American Medical Associations through the Dallas County Medical Society while practicing in Texas. Dr. Scott was a member of Phi Gamma Delta fraternity, the Masonic Lodge, and the Presbyterian Church.

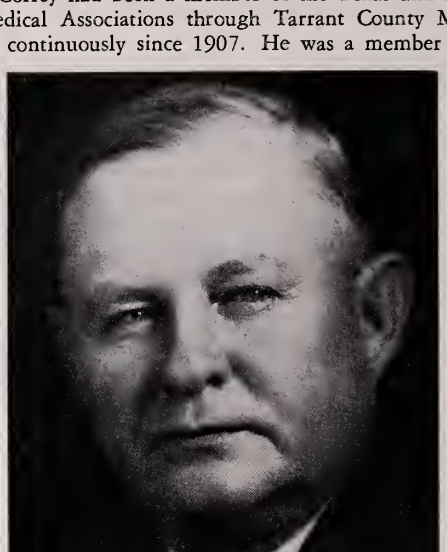
Dr. Scott and Mrs. Elizabeth Broyles were married April 22, 1938, in Shreveport, La. He is survived by his wife; a daughter, Mrs. Frank W. Cole, Conroe; and a brother, Clark I. Scott, Southbury, Conn.

A. COFFEY

Dr. Alden Coffey, Fort Worth, Texas, died at his home of a heart attack on May 26, 1954.

Born in Farmersville on February 16, 1884, Dr. Coffey was the son of William H. and Annice (Cooper) Coffey. He attended the old Fort Worth Medical School and was graduated from Vanderbilt University School of Medicine, Nashville, in 1906. He did postgraduate work in Paris in 1925.

Dr. Coffey had been a member of the Texas and American Medical Associations through Tarrant County Medical Society continuously since 1907. He was a member of the



Dr. Alden Coffey

Thirteenth District Medical Society and the Fort Worth Academy of Medicine. He was a fellow of the American College of Surgeons, and a member of Phi Beta Pi medical fraternity and the Congregational Church. Dr. Coffey organized the Coffey Clinic in 1924. He had been district surgeon for the Texas and Pacific Railway, Pullman Company, and Fort Worth Transit Company. He was senior surgeon emeritus at St. Joseph's Hospital. Dr. Coffey, an active golfer until 1940 when he suffered a heart attack, is considered the "father of Fort Worth golf." He was instru-

mental in bringing the National Open Golf Tournament to Fort Worth in 1941, and he had been president of the Fort Worth Golf Association for three years. He was past president of River Crest Country Club and a member of the Fort Worth Club, Exchange Club, and Colonial Country Club.

On June 12, 1906, Dr. Coffey and the former Miss Maud Polly were married in Wichita, Kan. He is survived by his wife; two sons, William R. Coffey, Weatherford, and Alden Coffey, Jr., Palos Verdes, Calif.; a sister, Mrs. W. E. Bush, Harlingen; and a brother, W. Herman Coffey, Orange.

C. A. AULT, JR.

Dr. Charles Aaron Ault, Jr., Dallas, Texas, died in a local hospital of a heart attack on April 1, 1954.

The son of Mr. and Mrs. Charles A. Ault, Sr., Dr. Ault was born in Houston on October 30, 1913. He attended Rice Institute and was graduated from Baylor University College of Medicine, Dallas, in 1937. He interned and took his residency in medicine at Baylor Hospital, Dallas, after which he practiced in Dallas for one year prior to entering the Army Medical Corps in 1941. He served as a lieutenant colonel in the South Pacific during World War II and returned to Dallas in 1946, practicing there until the time of his death.

Dr. Ault had been a member of the American and Texas Medical Associations through Dallas County Medical Society since 1940. He was a member of Alpha Omega Alpha

DR. CHARLES A. AULT, JR.

honorary medical fraternity, Phi Alpha Sigma medical fraternity, and the Christian Church.

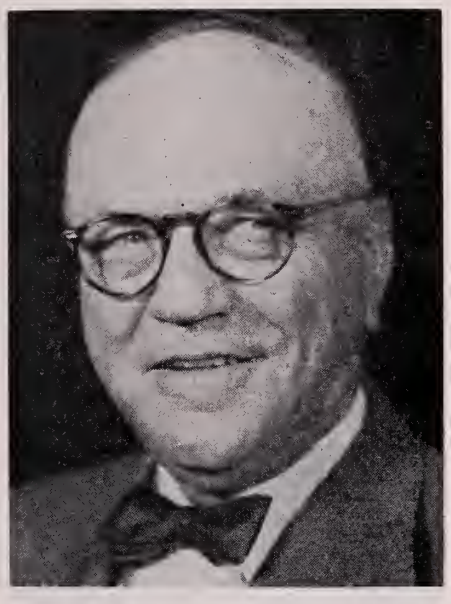
Dr. Ault and the former Miss Lenora Robertson, a graduate of Baylor University School of Nursing, were married on June 20, 1939. Dr. Ault is survived by his wife and a son, Charles Aaron Ault, III, Dallas, and his parents, Houston.

C. C. NASH

Dr. Cleveland Crumby Nash, Dallas, Texas, died on June 14, 1954, in Dallas of a ventricular fibrillation.

Born on April 14, 1884, in Limestone County, Dr. Nash was the son of Thomas Monroe and Nancy (Pearce) Nash. He attended Sam Houston State Teachers College, Huntsville, and was graduated from the Washington University School of Medicine, St. Louis, in 1907. He interned at the Barnard Free Skin and Cancer and St. Louis City Hospitals for two years and began his practice in Palestine in 1909. Dr. Nash had practiced in Dallas since 1922.

A member of the Texas and American Medical Associations almost continuously since 1904, Dr. Nash had belonged to the Jefferson, Anderson, and Dallas Counties Medical Societies and served as councilor of the Eleventh District in 1915 and the Fourteenth District from 1941



DR. C. C. NASH

through 1948. He was a member of the American Academy of Neurology and the Texas Surgical Society. He belonged to the Masonic Lodge, Knights Templar, and Shrine, and was a member of the Baptist Church. He was a charter member of the Dallas Athletic Club.

He and the former Miss Jewell Middlebrook were married on February 9, 1911, at Hope, Ark. She survives, as do two sons, Cleve C. Nash, Jr., Ph. D., Syracuse, N. Y., and Dr. Tom Nash, Dallas; two daughters, Mrs. Joe Belden, Dallas, and Dr. Jane Nash Higbee, Austin; two brothers, H. E. Nash, Austin, and Jeff D. Nash, San Antonio; two sisters, Mrs. S. W. Puckett, Dallas, and Mrs. W. E. Pitts, San Antonio; and ten grandchildren.

J. C. THOMAS

Dr. John Calhoun Thomas, Austin, Texas, died at his home of hepatic insufficiency on May 17, 1954.

Dr. Thomas was born June 26, 1884, in Rogers, the son of James E. and Annie (Berry) Thomas. He attended Rogers public schools and was graduated from the University of Texas School of Medicine, Galveston, in 1908. He practiced at Temple from then until 1914, when he moved to Taylor, where he built and operated the Taylor Sanatorium until 1917. Dr. Thomas was a captain in the Army Medical Corps from 1917 to 1919, serving with a base hospital in France. In 1919 he entered private practice in Austin.

Dr. Thomas had been a member of the Texas and American Medical Associations almost continuously throughout his career. He was elected an honorary member of the state organization in 1953. A charter member of the present

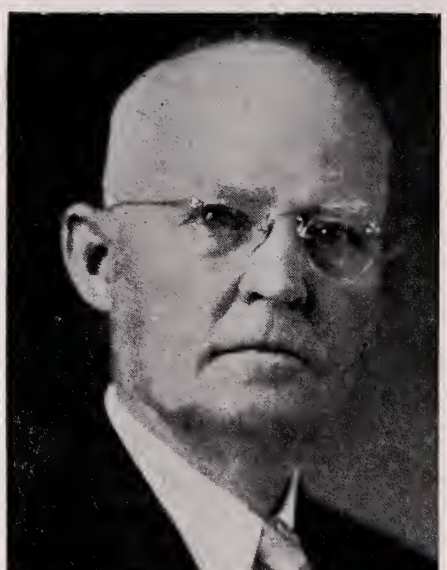
Travis County Medical Society, he was secretary in 1921-1922 and president in 1943. He also belonged to the Seventh District Medical Society. He was a former fellow of the American College of Surgeons. He was a member of Alpha Omega Alpha honorary medical fraternity. Dr. Thomas was an avid supporter of and worker for the new St. David's Hospital in Austin, which is now under construction.

He is survived by his wife, the former Miss Mary Fulton, whom he married in Temple on November 5, 1911. Also surviving are a daughter, Mrs. Brown Booth, Houston; a son, Dr. John F. Thomas, Austin; his mother, Rogers; a sister, Mrs. Byron Hammersmith, Belton; a brother, Mike Thomas, Temple; and nine grandchildren.

D. PRICE

Dr. Don Price, Athens, Texas, died on April 20, 1954, at his home of cancer.

The son of William P. and Martha (Rouse) Price, Dr. Price was born on October 12, 1875, at Kosse. He attended the Limestone County schools and entered the old Trinity University, Fort Worth, in 1894. He was graduated from the Baylor University College of Medicine, then in Waco, in 1904, later taking special courses in eye, ear, nose, and throat at Tulane University of Louisiana School of Medicine, New Orleans. Beginning his practice in Centerville, he practiced in Concord, Seale and San Antonio before moving in 1919 to Athens, where he practiced until the time of his death.



DR. DON PRICE

A member of the Texas and American Medical Associations since 1905 with the exception of a few years, Dr. Price was the secretary of Henderson County Medical Society from 1936 until 1952, when he served as president. He had been city health officer of Athens for ten years, Henderson County health officer for fifteen years, chairman of the local American Red Cross for several years, and examining physician of the Selective Service board in Henderson County. For this he received four certificates of appreciation from the President of the United States and one medal from Congress. A member of the Masonic Order, Knights Templar, and Shrine, he was past commander of the Taylor Commandery. He was a member of the Baptist Church.

Dr. Price is survived by his wife, Mrs. Rena (Matthews) Price; one son, Myrl Price, Athens; two daughters, Mrs. Kirk Willingham, Austin, and Mrs. Emrys Jones, Dallas; one brother, J. R. Price, Dallas; and one sister, Mrs. Howard Ruland, Dallas.

E. H. BURSEY

Dr. Ernest Harmon Bursey, Fort Worth, Texas, died there May 14, 1954, of rheumatic heart disease with acute pneumonia.

Dr. Bursey was the son of William Allen and Amanda Bursey and was born August 27, 1887, in Fort Worth. He went to the old Polytechnic College there, attended the University of Texas, Austin, and was graduated from the University of Texas School of Medicine, Galveston, in 1914. Dr. Bursey did postgraduate work at Harvard Medical School,

DR. E. H. BURSEY

Boston, and the Mayo Clinic, Rochester, Minn. He began his medical career in 1914 in Weatherford, where he was city health officer one year, and moved in 1916 to Fort Worth, where he practiced until the time of his death.

Affiliated with the Texas and American Medical Association through Tarrant County Medical Society continuously since 1916, Dr. Bursey was a member of the Thirteenth District Medical Society and Southern Medical Association also. He was a fellow of the American College of Surgeons, a member of the Fort Worth Academy of Medicine, and on the staffs of Harris and St. Joseph's Hospitals. He belonged to the Phi Chi medical fraternity, Masonic Lodge, Knights of Pythias, and Presbyterian Church. Dr. Bursey was a golfing enthusiast, being a charter member of the Colonial Country Club in Fort Worth. He felt close to the soil because of his boyhood on a farm and owned cattle ranches first near Springtown and then near Keller, where he bred registered Herefords. He was especially interested in soil and water conservation.

Dr. Bursey and the former Miss Florence McDonald Blunt were married on June 1, 1914, in Galveston. She survives; as do three children, Mrs. W. Kent Mitchell, Ernest Harmon Bursey, Jr., and William Fred Bursey; five grandchildren; and two brothers, J. W. Bursey, and A. P. Bursey, all of whom live in Fort Worth.

President's Page

FINANCING MEDICAL EDUCATION

The financing of medical education is an issue of major importance to our Association and to each of us as an individual physician.

The growth in modern scientific medicine has been phenomenal; teaching and research have required an increase in manpower and physical facilities. To bring about this needed increase, more than $100 million in 1954 will be spent in capital investments for the nation's medical schools.

At the national level, the Council on Medical Education and Hospitals has the largest budget of any council or bureau of the American Medical Association. In our State Association we have a similar council which studies the problems of education and hospitals as related to medical teaching and practice in Texas.

A modern medical school is considered to be needed for each 2 to 2½ million people, and we are fortunate to have three medical schools in Texas. Baylor University College of Medicine is supported totally by philanthropy and tuition, whereas the two state schools are supported by taxation and income from public lands, gifts, and tuition. It is my understanding that approximately 50 per cent of the plant investment and expenditures of the University of Texas is given over to medical and allied facilities.

The three medical schools in Texas had an enrollment of undergraduate students of 1,354 last year. Each of our medical schools is about as large as is usually considered appropriate for the best teacher-student relationship. If our state population continues to increase, as we have reason to expect, consideration in the not distant future will have to be given to the establishment of another medical school in Texas.

The National Fund for Medical Education recently estimated the average cost per student per year in the larger medical schools to be $3,339. The average cost in the three Texas schools is about $3,500, according to information recently furnished.

It is estimated that currently $16 million additional funds annually are necessary to assist the medical schools to meet reasonable needs in teaching and research.

To help meet this need, the American Medical Education Foundation was organized by the AMA in 1951 to contact the medical profession for funds. These have been added to funds gathered from business and industry by the National Fund for Medical Education, which was incorporated by the last Congress and given the prestige of a charter similar to the American Red Cross. Since the formation of these organizations three years ago, approximately $7 million has been disbursed to the medical schools of our country, including grants in Texas totaling $270,540. These funds, not restricted like tax monies, are available for immediate purchase of audiovisual equipment and other special purposes at the two state medical institutions, and Baylor has found its grant equal to the amount necessary to operate its library for the year.

If funds are not forthcoming to help meet needed expenses, federal funds may be sought for support. Thus, another item will be added to the federal tax load, coupled with the possibility of governmental controls and regulation.

It is disappointing to learn that physicians of Texas are not contributing their proportionate share toward the support of medical education. In 1953 Texas physicians donated $21,411 by contributing $8,930 to the AMEF and $12,481 directly to the nation's medical schools, according to the AMEF annual report. Less than 10 per cent of the physicians of Texas supported medical education by contributions in 1953; in contrast 22.5 per cent of the physician population of the United States contributed.

I believe that Texas physicians will want to give their fair share when the facts are better understood. Each physician owes a debt to society for his training, and he should express for it his gratitude by contributing personally to the financing of medical educational facilities. I should like to suggest that you consider a contribution to the American Medical Education Foundation. The gift is tax deductible and can be earmarked for the medical school of your choice or for the Foundation's general fund.

T. J. L. Blasingame, M.D.

Give to the American Medical Education Foundation

TPR diagnotes

REPORT OF COMMITTEE ON PUBLIC RELATIONS: During Executive Council meeting, Austin, September 3 through 5, the Committee on Public Relations met and saluted new chairman, Dr. William M. Crawford of Fort Worth. Dr. Crawford succeeds Dr. Troy A. Shafer, Harlingen, who became member of Board of Trustees during annual session last May.

The committee, including Drs. Van D. Goodall, Clifton, and H. M. Anderson, San Angelo, welcomes the following new members: Dr. A. Fletcher Clark, Jr., San Antonio; Dr. Glenn D. Carlson, Dallas; and Dr. Raleigh R. Curtis, Temple.

Interesting sidelight of Executive Council week end was Friday night meeting of inter-professional representatives, including key officials of the Texas Dental Association, the Texas Pharmaceutical Association, the State Department of Health, the Texas Graduate Nurses Association, the Texas League for Nursing, the Chiropodists Society of Texas, Inc., the Texas State Veterinary Medicine Association, the Group Hospital Service, the Texas Public Health Association, and the Texas Joint Commission for the Improvement of the Care of the Patient. The group heard Dr. F. J. L. Blasingame, host-association President, and other officers and members of the Texas Medical Association express the desire and belief that such meetings could do much to strengthen inter-professional relationships between all members of the health profession in the state of Texas. Recommended areas which might be explored for cooperative action included legislation, inter-professional grievance procedures, the exchange of information, and programs designed to improve the care of the patient.

Highlighting the Council meeting was the presentation to Dr. A. L. Thomas, Ennis, of one of the highest honors that Texas doctors can bestow upon a fellow member of their profession. Dr. Mayo Tenery, Councilor of

District 14, presented Dr. Thomas with the plaque naming him Texas' General Practitioner of the Year.

Now available from the central office are two sets of drop-card presentations which illustrate and form outline for members of the Speakers' Bureau. The presentation, entitled "Expanded Services for You," is a complete resume of the Association, its facets and services to societies and to the individual doctor.

In addition to the Speakers' Bureau, the central office can provide Audio-Digest tapes, select scientific films, and telephone broadcasts to implement the programs of county societies. List of available topics sent upon request.

FROM OVER THE STATE: The Smith County Medical Society sponsored a thirteen week radio series during the summer called "June, July, and August." The public information program spotlighted emergency measures to take during the summer months when injury and accidents so frequently occur--explained treatments for insect bites, fever, and summer diseases.

Success inspired another sequence entitled, "Tea for Three." This AMA radio series contains thirteen question and answer programs of public interest. Topics discussed include nail biting, allergies, the common cold, overweight, and graying hair.

Soon to celebrate its one hundred and first anniversary, the Travis County Medical Society is launching a vigorous public relations program. Eight monthly television programs will feature panel discussions covering every phase of medicine and will acknowledge allied professions with representatives as guest panelists.

Public health forums to be launched in late October bid for keen lay interest with such titles as "Why Do People Die in Austin?" Initial forum will set off health fair, open house, and anniversary special newspaper section.

TIP OF THE MONTH

Psychologically, there's a jagged break in the ideal doctor-patient relationship when a patient with a minor ailment is dispatched with a prescription after one visit to the doctor. "How can the doctor tell whether the medicine helped me or not?" wonders the patient. Many doctors solve this problem by handing such patients self-addressed post cards, asking them to report on their condition in a day or two. It's a friendly "let me hear from you" gesture.

TEXAS State Journal of Medicine

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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NURSES TO BE HONORED

Although the total number of active nurses and students enrolled in schools of nursing is greater than ever before in history, there remains a shortage of nursing personnel.

To help meet a major problem facing an increasingly health-conscious America, that of bringing the supply of nursing personnel into better balance with the demands for nursing service, a resolution designating October 11-16 as National Nurse Week passed both houses of Congress and was signed by President Eisenhower on August 23.

As a means to interpret nursing more fully, serve as a basis for a wide variety of community projects throughout the nation, stimulate student nurse recruitment, and dramatize the service which nurses are performing in all types of health and hospital programs, the observance will honor the professional nurses of America on the one hundredth anniversary of Florence Nightingale's historic service to the sick and wounded in the Crimea.

Emphasis will follow the positive approach, pointing out the contributions nursing personnel is making to the nation's health, welfare, and defense, but the week affords an excellent opportunity to spearhead recruitment. Activities in connection with the annual affair will be coordinated by a committee composed of representatives of the sponsoring organizations, American Medical Association, American Nurses Association, National League for Nursing, American Hospital Association, and the United States Department of Defense, Department of Health, Education, and Welfare, and Veterans Administration.

What can the individual physician do to help the nursing situation? The Committee on Careers of the National League for Nursing recommends that physicians keep at hand up-to-date information about the opportunities for nurses, the types of educational programs, and other important facts so that they may counsel patients or the sons and daughters of patients who turn to their doctors for advice about entering nursing. Also, having available nursing career materials in the patients' waiting room

is an effective aid to recruitment. Members of women's auxiliaries have similar responsibilities in disseminating nursing information and in recruitment.

Even though the nursing supply of the nation has been increasing steadily each year, it is estimated that between 50,000 and 65,000 professional nurses are needed immediately to meet essential demands for nursing service.

In the five years from 1948 to 1953, the number of professional nurses in hospitals and schools of nursing increased 12 per cent, and with an increase of 46 per cent in the number of practical nurses and auxiliary workers, there were approximately 30 per cent more nursing personnel caring for hospitalized patients in 1953 than in 1948. However, physicians are well aware of the effect on the nursing situation created by the increase in the population of the United States, the greater number of persons who go to hospitals, the more rapid turnover of patients, the expansion of hospital facilities, the increased number of physicians in the nation, the extension of public health service, the requirements of military services and other government agencies, the shorter working hours for nurses, and the like.

The need for more and better nursing care in our hospitals and health agencies is acute, and it is a problem touching every person who uses nursing service, whether directly or indirectly. The first National Nurse Week not only will focus attention on the achievements of nurses but also will spotlight the desirability of adding qualified persons to that profession.

BETTER TO SERVE YOUR COMMUNITY

Many people feel that members of the medical profession have held themselves aloof from civic organizations. Some are very active, but the doctors who do not participate in service groups have given the impression that doctors as a whole are interested only in persons providing a means of income or those sharing their profession.

Although a doctor is one of the busiest professional men, there are those who find time to enter wholeheartedly into civic, church, and service fields without hurting their practice. Belonging to these organizations is not only beneficial public relations–wise, but the doctor can find that rather than draw him away from his family, joining certain groups can actually help strengthen family ties. Boy Scouts, school boards, alumni associations, YMCA, and YWCA are a few which can help the professional man keep up with interests which he and his children can and should share.

Finding time not only to join groups but to participate enthusiastically and accept positions as officers is a challenge to some. Still others make such good officers of local groups that they are elected to official jobs in statewide organizations. There are members of the Texas Medical Association who have served and are serving as mayors of their cities. In almost any city or town, regardless of size, there is one large entertainment program each year, whether it is a parade, a livestock show, a cotton or strawberry festival, or something else. A few physicians head committees or help organize and back the shows on these occasions.

By sharing common interests with persons who are unable to discuss professional experiences, a hobby club can provide a means of activity in which a doctor can make new friends.

Veterans organizations feel that members of the medical profession who share their background of service to their country have not accepted their responsibility in the organization and formulation of policy of veterans' associations. Doctors have failed to realize that, by taking no part in the management and membership of a group, they cannot expect it to be run the way they feel it should be. Because of the doctor's educational background and responsibility as a citizen, he should strive to help guide others about health needs and problems.

A large number of physicians are members

and officers of lay bodies of their chosen churches. In most instances this affords an excellent opportunity for the doctor and his wife to work together.

Of course, a doctor cannot join a lot of organizations and expect to keep up with his practice and medical societies. It is better for him to be an active member of two groups than to be an inactive member of five. To be a member of a group and not attend meetings and participate in the activities can be worse public relations than not being on the roll of any. Holding an active interest in not only the medical world but also in the civic, religious, and service world can assure the layman that the doctor has accepted his responsibility to his community as both a physician and a citizen.

TIME FOR GIVING

Autumn brings united community drives for funds to operate certain services which deserve general support. As has been pointed out, community chests and united funds are safeguards against too much governmental control; they provide means to take care of ourselves and our neighbors without looking to government for help. If this independent and localized solution to health, welfare, and character building problems is to suffice, however, each person must feel some responsibility to share in it.

The budgets for united campaigns are arrived at after careful study not only by the benefiting agencies but also by volunteer civic leaders familiar with community needs and resources.

For those who choose to handle their philanthropy individually, the community fund drive is a reminder that they have a responsibility and privilege to share in charitable activities and that they should reach some decision as to what contributions they wish to make during the year. For most, the community fund itself is a welcome answer to much of the question because of the care that has marked its budgeting, the reduction of overhead expense possible through a single campaign, and the saving of time otherwise lost in a multiplicity of solicitations.

PROGRAM HELPS AVAILABLE

County medical society presidents and secretaries this month are receiving a brochure outlining some of the specific program aids which the Texas Medical Association is prepared to offer, including speakers, recordings of scientific material, and motion pictures.

Many county medical societies of medium or small membership recently have indicated that they would welcome assistance in the development of good programs, and the brochure is an effort to meet this expressed need. Although most of the facilities listed in the brochure have been available for some time, special committees have reviewed them and have chosen topics and materials of special current interest for consideration by program committees in the county societies.

The first section of the brochure calls attention to a speakers bureau operated by the Texas Medical Association in cooperation with the larger county medical societies and the University of Texas Postgraduate School of Medicine. A speaker on almost any scientific or socio-economic topic related to medicine as well as on any phase of medical organization can be obtained on thirty days' notice.

A series of tape recordings of lectures prepared by the Audio-Digest Foundation of California have been added to the collection of the Memorial Library of the Texas Medical Association, and additional tapes will be obtained as they become available. Nonillustrated lectures require only a standard tape player accommodating twin-track material at 3.75 inches per

second. Some of the recordings are accompanied by 2-by-2-inch illustrative slides.

Recordings of nine postgraduate broadcasts transmitted by telephone in 1952, 1953, and 1954 under auspices of the Council on Medical Education and Hospitals of the Texas Medical Association and two additional discussions arranged by the council also are available, either on tapes as described in the preceding paragraph or on disks playing at 33⅓ r.p.m.

Fifty-six select motion pictures chosen by a special committee of Travis County Medical Society from the collection of the Memorial Library are recommended in the program brochure. These and other 16 mm. films, silent or sound, black and white or color, may be borrowed by county medical societies or individual members.

The only expense to county societies taking advantage of the Texas Medical Association program helps is the payment of shipping charges one way on recordings and motion pictures.

Recognition by county medical society officers of the program facilities available to their groups from the state organization and fullest use of these facilities may help solve some problems. Requests for further information will be answered promptly by the central office staff.

CURRENT EDITORIAL COMMENT

THE DOCTOR AND ACCIDENT AND HEALTH INSURANCE

What kind of accident and health insurance protection is most suitable for a doctor?

A doctor's earning span starts later, is therefore shorter, and is more intensified than that of most other persons. At middle age a doctor is working harder and usually under more strain than persons in most other pursuits. Likely it will take him several years longer than the reasonably successful business man to reach an economic peak.

People in active productive life face three principal dangers: premature death or dying too soon; economic death, which may result from living too long; and disability due to accident or sickness.

Inevitable death and taxes can be prudently provided for through life insurance and sound financial planning. But, just as a birth certificate means an eventual death certificate, for most people a life span also includes the uncertainties of accident or illness.

At a time when the doctor is increasingly productive and his personal responsibilities mount at a rapid rate, he often is too heavily burdened with work and too lightly thoughtful in regard to security. A physician in this position, if he should be stricken by accident or illness that curtails his practice, usually stands in much graver economic jeopardy than a patient who is a corporation official and whose ulcers may be said to be an occupational hazard.

Chances are, the business executive has a salary continuation plan where he works or an individual income protection policy with an insurance company. Or if he's incapacitated, his business may continue to pay him a monthly return. But could the average doctor face his own occupational hazard with the same financial equanimity?

Statistics indicate how much a physician is worth in earning power. The American Medical Association's Bureau of Medical Economic Research says the average net income from medical practice for doctors amounted to $11,058 in 1949, or just under $1,000 per month. Being laid up for two years would mean a loss of income of nearly $24,000. Even being disabled

This department of the JOURNAL *presents editorial comments on current items pertaining to the science, art, and practice of medicine, contributed by members of the Texas Medical Association and others closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the Texas Medical Association to submit such discussions for this department. The discussions preferably should be between 300 and 500 words in length.*

for two months would mean a $2,000 earning loss.

Assuming complete recovery, chances are, savings or investments would be substantially dipped into—if there were no income protection present.

A doctor doesn't stumble on an insurance program by accident. It is carefully tailored to fit him. Some doctors develop their own programs, buying a number of policies that will give adequate protection when put together. Others prefer to put the programming in the hands of a competent insurance man or broker.

With either approach there are some basic facts about disability insurance a physician should know.

Many professional medical organizations have group accident and health plans in which the doctor may participate. This form of group accident and health insurance has the fewest restrictions and the lowest premiums. Chances are, however, the physician will want and need some additional tailor-made protection.

If this is the case, there are noncancellable and cancellable individual income protection policies on the market. A noncancellable policy costs more, but it is guaranteed renewable up to 60 or 65 years of age. As long as the premiums are paid, the company can neither cancel nor refuse to renew.

Both the noncancellable and cancellable are good policies. In addition to loss of income benefits, both types usually pay lump sums for accidental death or dismemberment. Monthly or weekly benefits for sickness are usually paid for from two to five years—in some cases longer—and for lifetime when an accident is the cause of total disablement.

So that insurance is not, in effect, written on a "burning house," exclusions are necessary for a person with an ailment existing at the time the policy is taken out. There is sometimes a waiting period, in the case of illness, before the beginning of benefit payments. Mental disease is often excluded. In many policies distinction is made between total and partial disability, the benefits being greater if disability is total. In partial disability a further distinction is made regarding the ability of a person to perform in his own occupation or any gainful occupation. There is often a difference in benefit payment depending on whether the disability is confining or nonconfining.

With a few noncancellable policies, a medical examination is necessary. All answers on the application generally become a part of the contract, and, of course, falsification regarding the status of the applicant's health may lead to cancellation. After an accident or during an illness, proof of disability statements must be sent to the insurance company.

Overinsurance is as undesirable as underinsurance. Usually, 75 per cent of net income is considered optimum. Some companies will attempt to determine this on the application form, and if an individual is overinsured or would tend to make a profit on a disability, the company will not issue the policy or will limit it. Since benefits are not taxable, up to 75 per cent of net income will enable the physician's family to maintain the essentials of its living standard.

These facts and principles, with a few exceptions, apply as well to many other forms of health insurance with cash benefits—hospitalization, surgical benefits, medical payments, major medical expense, and accident policies.

The theory of such insurance is simple. The elements are a risk; a group of people, either individually or collectively, who want security; and an organization to collect, safeguard, and disburse the premiums. Insurance, or security in action, means a steady flow of money to pay bills and maintain a standard of living.

HEALTH INSURANCE COUNCIL,
Chicago, Illinois.
208 South LaSalle Street.

This is the first of a series of three articles prepared at the request of the Hospital-Insurance-Physicians Joint Advisory Committee of Texas. Other forms of health insurance of interest to patients and to doctors for their families will be discussed in the ensuing articles.

ORIGINAL ARTICLES

Acute Diseases of the Liver

JOHN R. KELSEY,* M.D., Houston, Texas

VARIOUS acute diseases of the liver and their treatment are discussed in this paper.

VIRAL HEPATITIS

Viral hepatitis is the most frequent form of acute liver disease. Of these viral agents, the most common is that of infectious hepatitis. This disease is recorded as occurring in epidemic form during almost every military engagement in history. It is spread by fecal contamination of food. The disease is endemic in certain areas and occurs in epidemic form in as high as 50 to 75 per cent of the personnel when troops are moved into endemic areas.

Homologous serum jaundice occurs as a result of parenteral transmission of virus through either whole blood or pooled serum. Unsterilized or poorly cleansed syringes can inadvertently transmit the infection. Sborov,[6] in a study conducted in the Korean hostilities, found that serum hepatitis occurred in more than 20 per cent of the wounded soldiers receiving blood and plasma. Neefe,[5] in a recent study of blood donors who had no known history of hepatitis, demonstrated asymptomatic blood carrier state in 5 persons. The proof of the carrier state of serum hepatitis in blood donors indicates the great need for careful screening of donors, as well as the need for new screening methods.

TABLE 1.—*Differences Between Infectious and Serum Hepatitis.*

	Infectious	Serum
Fever	+	Rare
Incubation period	20-45 days	45-150 days
Transmission by ingested feces	+	—
Parenteral transmission	+	+
Homologous immunity	+ (1 yr. +)	+ (18 mo. +)
Heterologous immunity	—	—
Gamma globulin protection	+	—
Carrier state	+	++
Mortality rate	0.01-0.20	0.2-20.0%

Adapted from Snell, A. M.: Viral Hepatitis and Public Health, California Med. 67:69-77 (Aug.) 1947.

The difference between infectious and serum hepatitis is outlined in table 1.

Infectious mononucleosis is thought to be a virus infection. The hepatitis which occurs in this disease is seldom of primary importance. Of these patients 20 to 40 per cent develop abnormal liver function, and 5 to 10 per cent develop physical signs of hepatitis.

Yellow fever is a virus infection which is now extinct in this country. Hepatitis associated with this disease accounted for a high mortality rate in epidemics of the past.

Clinical Forms

As it is impractical to identify the offending viral agent causing hepatitis, the diagnosis is made on the basis of clinical manifestations and nonspecific liver function tests.

Without respect to the causative agent, several clinical patterns of acute viral hepatitis are seen. The typical form has an onset similar to influenza, lasting a few days to two weeks before the appearance of jaundice. Anorexia, malaise, generalized aching, and right upper quadrant discomfort are the characteristic early symptoms. The development of dark urine, light stools, and jaundice brings the patient to the doctor. Low grade fever and generalized pruritus are occasional symptoms. Physical examination often reveals an enlarged, tender liver. In about 20 per cent of the patients there is a palpable spleen and in some cases ascites can be demonstrated. The white blood cell count ranges from 3,000 to 10,000 per cubic millimeter. The Bromsulphalein excretion test is the first liver function test to become abnormal. Bilirubinemia develops; then the thymol turbidity and cephalin flocculation tests become positive. The disease usually lasts from two weeks to two months with recovery in almost every case.

Anicteric hepatitis is another form of acute viral hepatitis. The clinical manifestations are similar to the previous form except clinical jaundice is absent. Detection is dependent upon laboratory tests. The flocculation tests are abnormal, but the serum bilirubin is only slightly elevated. This form is benign and is commonly seen in children and young adults.

Cholangiolitic hepatitis is another form of viral hepatitis which usually runs a more chronic course. The laboratory findings are similar to those of extrahepatic obstruction with elevation of serum alkaline phosphatase and decreased fecal urobilinogen. The flocculation tests which are positive in hepatocellular disease are commonly normal in this form. For this

Presented before the Texas Society of Gastroenterologists and Proctologists, San Antonio, May 3, 1954.

*Clinical Assistant Professor of Medicine, Baylor University College of Medicine.

reason, the diagnosis is often confused with extrahepatic biliary obstruction, and surgery may be erroneously prescribed.

Rarely viral hepatitis may progress rapidly to death in a few days. This form, which was described previously as acute yellow atrophy, probably represents a fulminating form of acute viral hepatitis.

BACTERIAL DISEASES

Bacterial infections of the liver occur secondary to intra-abdominal infections. Suppurative hepatitis is a septic disease, and the manifestations of liver disease are of secondary importance. With the advent of antibiotic drugs, these conditions are seen frequently.

SPIROCHETAL DISEASES

Leptospiral infections have become increasingly important as causative agents in liver disease. Leptospira icterohaemorrhagiae (Weil's disease), Leptospira canicola (canicola fever), Leptospira pomona (swineherd's disease), and other strains have been identified in the United States.[9] Rodents, dogs, swine, cattle, and horses are animal carriers of the Leptospira. Water, food, and moist soil contaminated by urine from infected carriers may contain pathogenic Leptospirae after a period of several weeks. The infection occurs through mucous membranes, cuts, or skin abrasions. The digestive action of gastric juice or pasteurization destroys Leptospirae. This disease is an occupational hazard of dock workers, veterinarians, butchers, and sewer workers. Epidemics have occurred in swimmers bathing in contaminated water.

The classical type of Weil's disease has an incubation period of eight days with early clinical features of malaise, fever, and influenza-like syndrome. Darkfield demonstration of the spirochete in the blood will establish the diagnosis. Later, hepatomegaly and jaundice develop and the blood agglutinations become positive. The mortality of the disease is 15 to 20 per cent in the icteric cases. In milder forms of the disease, 50 per cent are anicteric. Some show neurologic, cutaneous, or pneumonic features.

Leptospirosis is frequently missed as the diagnosis is made by laboratory means. Gochenour[2] described the difficulty encountered in laboratoty tests and pointed out that too few laboratories in the United States offer these facilities. These diseases are more common in this country than is generally believed. I have had occasion to see 3 leptospiral infections in the Veterans Administration Hospital in Houston during last year.

PARASITIC INFESTATIONS

Amoebic hepatitis occurs in approximately 5 per cent of the cases of amoebiasis. Onset is sudden with severe pain and tenderness in the liver area. A septic course with fever to 104 F. with a leukocytosis up to 30,000 leukocytes per cubic millimeter is common. Frequently there is a history of amoebic infection of the bowel. These patients characteristically respond to emetine or chloroquine therapy.

Amoebic abscesses of the liver differ from amoebic hepatitis in their clinical symptoms. These abscesses may be single or multiple. The onset is often vague with poorly localized physical signs. Pain in the liver area may be dull or sharp with characteristic percussion tenderness. There is elevation and immobilization of the diaphragm radiologically. Jaundice or other signs of liver failure are unusual, as there is only focal involvement of the liver rather than a diffuse hepatic cellular damage. About one-third of patients with amoebic abscesses may present themselves for diagnosis after the abscess has extended to the pleura or pericardium or to an adjacent abdominal viscus. The diagnosis of amoebic abscesses of the liver is often difficult. Complement fixation tests for amoebiasis are difficult to obtain and unreliable. A therapeutic test with chloroquine or emetine when an amoebic abscess is suspected is an important diagnostic procedure.

Hepatitis occurs commonly in malarial infections. It has been observed in malarial patients who have had only a single febrile bout. Jaundice in malarial patients in the past was thought to be due to blood hemolysis caused by the malarial parasite. Now it is apparent in some cases that the jaundice was on the basis of hepatitis. With the advent of new rapidly acting antimalarial drugs, it has become evident that the treatment of the hepatitis is as important as eradication of parasitemia. Hepatitis should be looked for in all cases of malaria.

TOXIC AGENTS

Acute liver disease may be produced by a variety of toxic agents as outlined in table 2. The clinical manifestations of toxic hepatitis may be similar to those of viral hepatitis. There is usually a shorter prodromal period and more intense gastrointestinal

TABLE 2.—*Agents Capable of Producing Toxic Hepatitis.*

Category of Agents	Examples
Chemical agents	
Therapeutic drugs	Arsphenamine
	Cinchophen
	Chloroform
Industrial hazards	Carbon tetrachloride
	Trinitrotoluene
Household poisons	Chlordane
	Phosphorus
Bacterial toxins	Pneumococcus
	Salmonella
Biological toxins	Mushroom toxins
	Snake venom
	Incompatible sera
Unidentified toxins	Toxemia of pregnancy
	Toxemia of burns

symptoms. Symptoms of respiratory or central nervous system involvement are common. Diagnosis is dependent upon a history of exposure to one of the toxic agents.

It is of current interest and importance that the newer insecticides and agricultural chemicals can produce toxic hepatitis. Household insecticides containing chlordane may be ingested accidentally by children, producing toxic hepatitis. In Houston chlordane spray is used to combat insects. Commonly groups of children follow trucks down the street bathed in a fog of chlordane. One would expect toxic effects if sufficient exposure occurs. Several roach poisons containing phosphorus are household hazards. Toxic hepatitis from this source is commonly encountered by Houston pediatricians.

VASCULAR CATASTROPHES

Lastly, acute liver disease may be on the basis of an occlusive vascular phenomenon. An acute infarct in the liver may result from inadvertent surgical ligation of the hepatic artery, or it may be secondary to a disease process involving the hepatic artery, such as mycotic aneurysm or periarteritis.

Another vascular catastrophe which can occur in the liver is thrombosis of the hepatic veins. This condition described by Chiari usually occurs in polycythemia or is secondary to cirrhosis or metastatic liver disease. Thrombotic occlusion of the portal vein, pylephlebitis, is fatal in most instances as the liver is deprived of its principal source of blood supply. With the advent of antibiotics, this condition is rarely seen, but in the past it was a common cause of the fatal outcome of acute appendicitis or other intra-abdominal infection. The vascular phenomena accounting for acute liver disease, though unusual, are frequently diagnosed today before death and actually can be proved by newer catheterization techniques.[7]

TREATMENT

Because acute diseases of the liver are similar in nature and no specific treatment has been found to be singularly effective, treatment is centered around symptomatic, nonspecific measures.

Nonspecific Therapeutic Measures

Rest is one of the most important treatments. Inactivity allows a greater volume of blood circulation to the liver. The reduced metabolic demands from inactivity also play a large part in the therapeutic value of bed rest. Routinely, I advise bed rest with bathroom privileges until jaundice is cleared and liver function begins to return to normal. Ambulation is usually allowed at this time. It is desirable for the liver function tests to return to normal before the patient resumes his usual activities.

Diet is equally important in the treatment of liver disease. Patients have varying degrees of anorexia. The degree of anorexia often serves as a prognostic sign of the patient's outlook. A patient with deep jaundice and severely deranged liver function who has a fair appetite has a good chance for complete recovery. I use every influence to encourage these people to eat more. I ask them to try to eat even if it brings tears to their eyes. Although there has always been some dispute about the composition of the liver diet, I believe that the quantity is the most important aspect. One should use as an aim 3,000 calories intake in five or six feedings. Approximately 80 to 100 Gm. of fat is necessary to make the diet palatable and maintain biliary drainage. In liver failure, conversion of ammonia to urea is impaired. On this basis, some have advocated omitting meat products and nitrogenous substances, particularly where serious derangement of liver function is suspected.

Vitamins, protein digests, choline, and methionine are supplementary dietary agents commonly given to patients with liver disease. An adequate, well balanced diet undoubtedly contains sufficient amounts of these substances so that additional amounts are of no real value except for psychological effect. Choline and methionine preparations, brewer's yeast, and occasionally multivitamin preparations are offensive to the patient and may reduce their food intake. When the patient finds them disagreeable, they are best omitted.

Vitamin K therapy is indicated in the presence of prothrombin deficiency. The basis of the deficiency may be poor absorption of the fat soluble vitamin K. A water soluble oral preparation or parenteral administration of 5 mg. daily will correct this defect. I routinely use one of the multivitamins which contains vitamin K. If the prothrombin deficiency is on the basis of poor assimilation due to liver damage, as large a parenteral dose as 72 mg. daily may fail to restore the blood clotting mechanism.

ACTH and cortisone recently have been used in the treatment of acute liver disease. The early reports indicated favorable improvement of the clinical symptoms and decrease in the serum bilirubin. This was not borne out in later reports of larger series studied. In a series of 32 treated patients and a similar group of control patients studied at the Veterans Hospital at Hines, Ill., there was no difference in the duration of the disease. In a few instances it was believed that the hormone was of immediate temporary value in increasing the food intake. It was felt that the routine use of hormones in the treatment of hepatitis was contraindicated, as some of the complications of therapy with ACTH are more severe and threatening to

life than hepatitis. I have reserved the use of this drug for selected severely ill patients whose food intake has been poor.

Sulfonamides, morphine, and barbiturates are poorly tolerated in patients with liver damage. It is advisable to exercise caution when they are given and avoid their use when practical.

Aureomycin and other antibiotics have been used as nonspecific therapeutic agents in liver disease. Although the early reports were largely favorable, they have not proved to be of value except in specific bacterial infections of the liver.

Specific Therapeutic Measures

Certain specific therapeutic agents are indicated in the treatment of some acute liver diseases.

Antibiotics may be curative in suppurative hepatitis. The effectiveness of an antibiotic depends upon the sensitiveness of the infecting bacteria.

Penicillin was claimed to be of therapeutic value in the treatment of leptospiral infections, but in a study of 79 cases treated with antibiotics singularly and in combination, Hall[3] concluded that none of them used were of any value. Despite the questionable value of antibiotic treatment of leptospiral diseases, they are usually employed on the basis of their proven in vitro effectiveness. Therapy is instituted early in the course of the disease, which requires initiation of therapy before leptospirosis has been proved by laboratory tests.

Emetine and chloraquine are specific agents to be used in amoebic infestations of the liver. Chloraquine has replaced emetine in therapy as it is more effective than emetine without the toxicity of emetine. It is important to use in combination therapy for intestinal amoeba when present.

Quinine and pentaquine are effective in the treatment of malarial hepatitis. It is important not to overlook the fact that nonspecific therapeutic measures also are indicated.

The treatment of toxic hepatitis is primarily the prophylactic avoidance of exposure to known toxic agents. When toxic hepatitis occurs, it is imperative to remove the person from the source of exposure. If the exposure is due to accidental ingestion, ridding the gastrointestinal tract of the offending agent is indicated. BAL is of value in toxic hepatitis due to metallic intoxications of arsenic, gold, and bismuth.

HEPATIC COMA

Hepatic coma occurs in cases of severe liver failure and represents the end stages of acute liver disease. Drastic alterations of the body physiology occur similar to those described by Mann and Bollman in animals in which the liver has been surgically removed. Treatment consists of parenteral alimentation with large amounts of glucose and vitamins. Hypokaliemia occurs and as much as 120 milliequivalents of potassium parenterally may be needed each day. Oxygen and blood are given. Antibiotics and cortisone are used occasionally. Nursing care and close attendance by the physician are imperative. It is wise to avoid nitrogenous substances, as there is a characteristic rise in the blood ammonia in hepatic coma. Sodium ion exchange resins containing ammonia likewise should be avoided. Recently Walshe[8] has reported the favorable effect of glutamic acid administration to patients with hepatic coma. It is thought that glutamic acid binds ammonia to form glutamine which is metabolized without liberating ammonia. Adequate clinical evaluation of the use of glutamic acid is not yet available.

Despite the most vigorous and careful treatment, the outlook of hepatic coma remains very poor. About 90 per cent of such patients have a fatal outcome.

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SURGERY ON DIABETICS

Dr. Charles R. Shuman, Temple University Hospital and School of Medicine, Philadelphia, said in the June 12 *Journal of the American Medical Association* that surgery has become as safe for the diabetic as for the nondiabetic. He reported on a three-year study of 340 patients who underwent 373 operations while under the supervision of the hospital diabetic service.

There were no deaths directly resulting from diabetes or its treatment, Dr. Shuman said. Complications of diabetes were more frequent in this study because most of the patients were more than 45 years old.

CHOLECYSTIC DISEASE AND ITS COMPLICATIONS

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WHEN a surgeon is confronted with a patient whose symptoms suggest an upper abdominal disorder, his first thought is often of cholecystitis. In the vast majority of cases its presence can be proved or disproved easily, whereas in the remainder he may be in doubt even after an exhaustive study. Once the diagnosis of cholecystic disease is made, however, his second thought concerns the treatment. From an observation of more than 4,000 private patients with cholecystitis, of whom more than 1,200 were treated surgically, I have found that several considerations are involved in the choice between medical and surgical management. This is especially true of the chronic type of the disease.

CHRONIC CHOLECYSTITIS

Although indigestion and epigastric colic are the outstanding symptoms of chronic cholecystitis, they are by no means universal. Some patients, particularly those in the younger age group, have colic but good digestion between attacks. Others have indigestion but no colic. Yet another group do not have colic but, instead, a more or less severe and constant ache in the epigastrium, generally with distress after meals.

The distinction between calculous and noncalculous cholecystitis is rarely possible by the history and physical examination. Patients with the noncalculous type may have colicky pain, though usually not like typical gallstone colic. In the typical case of calculous cholecystitis, the pain is severe, beginning either suddenly or, more often, gradually, and radiating from the right costal margin to the back, to the right, or even to the left side of the flank. Not infrequently, the colicky attacks are accompanied by some degree of jaundice. Approximately 20 per cent of my patients have observed this condition.

On physical examination, deep tenderness in the right upper quadrant may be the only positive evidence of either calculous or noncalculous cholecystitis. As a rule, the gallbladder is impalpable, especially in obese persons. Even though a mass is discovered, it may represent an enlarged liver or right kidney, a distorted and thickened omentum, a tumor of the colon or pancreas, or some other pathologic condition. The diagnosis, therefore, must rest upon the history and roentgenogram.

The chief diagnostic problem lies in those cases wherein the symptoms are not clear and the roentgenogram fails to reveal positive evidence of gallbladder disease. Not infrequently, the clinical picture suggests some other disorder. For example, cholecystitis which is accompanied by pain on the right side of the ilium is likely to be confused with appendicitis, and that which produces epigastric pain and discomfort after meals is easily mistaken for duodenal ulcer. If either appendicitis or an ulcer is associated, a correct evaluation of the mixed history and findings may be impossible. This is also true of a coexistent gastrointestinal irritability, pancreatitis or hepatitis, or diaphragmatic hernia.

In a number of cases cholecystitis gives rise to pain in the left upper quadrant, leading one to suspect heart disease. A helpful point in the distinction between the two conditions is the fact that the pain of cholecystitis is not related to effort, as is usually true of angina pectoris. In heart disease, moreover, local tenderness is not elicited on abdominal palpation. The electrocardiographic tracings are useful in clarifying the question, although not conclusive, since an abnormal tracing may be observed in cholecystitis. It is well to remember, too, that the diagnosis of cholecystitis may be obscured by some type of concurrent cardiac lesion.

Treatment

The choice between medical and surgical treatment in chronic cholecystitis rests largely upon the presence of stones. As a rule I do not recommend surgery for patients with chronic noncalculous cholecystitis, having found that the results often are disappointing. Probably an average of 35 per cent of those who have a noncalculous gallbladder removed are troubled later with biliary dyskinesia or the so-called postchlecystectomy syndrome.

The postoperative symptoms at times may be produced by overlooked stones in the ducts or reformed stones in the cystic duct remnant, or by an associated cholangitis, hepatitis, or pancreatitis. More often, they are due to removal of the gallbladder on no other basis than poor function. Although the poor function may arise from a disturbance of the sphincteric mechanism, the underlying cause probably will be found in a psychogenic disorder, some abnormal constitutional state, or an organic disease outside the gallbladder. However, if a total loss of gallbladder function is demonstrated and is accompanied by definite, severe, and persistent symptoms; if jaundice is present or the patient gives a history of jaundice; or if pathologic changes in the liver or pancreas are suspected, one may feel justified in removing the

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gallbladder despite the fact that no stones are shown in the roentgenogram. Not infrequently in such cases stones will be found in the gallbladder or obstructing the duct or both.

In my opinion, the presence of gallstones is itself ample indication for cholecystectomy. This is true even though the patient has little symptomatic evidence of cholecystitis and the function of the gallbladder is essentially normal. Left undisturbed, the stones may be expected sooner or later to give rise to complications which materially increase the dangers of operation and may even permanently impair the patient's general health.

ACUTE CHOLECYSTITIS

Since the vast majority of attacks of acute cholecystitis are induced by stones in the cystic duct, the possibility of this complication alone is a strong argument for removal of the calculous gallbladder. In the exceptional case, the acute attack is provoked either by angulation of the duct or by strangulation and edema from a chemical reaction, at times with a superimposed infection. In the latter type, the chemical reaction may be incited by a reflux of pancreatic secretion into the duct, though a concentration of bile salts in the biliary system is more likely to be responsible. In any event, an acute seizure of chemical origin frequently will subside under medical management, whereas one produced by obstruction of the cystic duct by a stone usually requires surgical treatment.

The diagnosis is made by the symptoms of upper abdominal pain generally radiating to the subscapular or interscapular region, nausea and vomiting, fever, and tenderness with rigidity over the gallbladder. A history of previous symptoms of cholecystitis, supplemented by the roentgen demonstration of a nonfunctioning gallbladder or stones, will assist in establishing the diagnosis.

Treatment

On the whole, the principles of treatment of acute cholecystitis do not differ from those of other acute abdominal disorders. In that small group of cases wherein the process is fulminant from the beginning, operation is obviously an emergency. In the less severe attacks, I believe that operation is performed best within the first forty-eight hours after the onset of the disease, in that the risk is usually slight and convalescence proceeds without incident. Since one cannot always tell from the clinical picture the exact status of the pathologic process, early operation may preclude a perforation and peritonitis. If, on the other hand, the patient is observed after forty-eight hours and the symptoms are not severe, the attack will be more than likely to subside under conservative treatment. If no evidence of abatement is apparent within seventy-two hours, however, surgery should be undertaken without further delay.

The findings which I regard as demanding immediate operation are (1) sustained pain; (2) the persistence of a palpable, tender mass in the right upper quadrant, with abdominal rigidity; (3) a systemic reaction evidenced by an elevation of temperature and a rising leukocyte count; and (4) lack of clinical improvement despite the use of supportive therapy. Sustained pain, abdominal rigidity, and a tender mass point to impending perforation and thus are positive indications for surgery. At times, the gallbladder may be so high under the costal margin that a tender mass is not palpable; even so, other manifestations will suggest the need for exploration.

COMPLICATIONS

Malignant degeneration is always a potential development in prolonged cholecystitis and particularly in the presence of stones. Various estimates have placed the incidence of carcinoma of the gallbladder in association with stones at 5 to 6 per cent of all calculous gallbladders. The average incidence is probably about 2 per cent. This is by no means a negligible figure, being, in my experience, higher than the mortality rate of cholecystectomy for chronic cholecystitis. It is in itself sufficient reason for removal of the gallbladder containing stones.

The most commonly observed complication of gallbladder disease is obstruction of the ducts by stones or inflammatory edema and consequent changes in the architecture of the biliary tree. If the obstruction is allowed to persist, the inevitable outcome is damage to the liver; the peripheral ducts and intercellular canaliculi become distended and rupture, the parenchyma undergoes degeneration, and gradually the liver cells throughout are distorted by the pressure, thus becoming atrophic. Ultimately, a state of hydrohepatosis is reached, a situation analogous to the hydronephrosis which follows blockage of the ureter. These same changes may take place in the presence of a functionless gallbladder incident to long standing chronic cholecystitis, with or without stones, wherein the ducts have taken over the gallbladder function and become enlarged.

In a like manner, obstruction of the ducts may lead to a more or less severe form of pancreatitis. I have observed pancreatitis in a large number of cases, at times so advanced as to be chiefly responsible for the symptom complex.

Because of the frequent association of duct obstruction with cholecystitis, and especially cholelithiasis, and its damaging effect upon the ducts, liver, and pancreas, the question of whether or not chole-

dochotomy should be performed often presents itself in operations upon the gallbladder. The ducts in 17 per cent of the cholecystectomies I have performed were opened and duct stones found in 73.5 per cent of the choledochotomies. The criteria for opening the ducts have been as follows: (1) a palpable stone in the duct; (2) abnormal dilatation of the duct; (3) a contracted gallbladder containing stones; (4) multiple small stones in the gallbladder and an enlarged, patent cystic duct; (5) flocculent bile, as determined by aspiration; and (6) jaundice or a history of jaundice.

Abnormal dilatation may indicate that the duct has taken over the function of the gallbladder following occlusion of the cystic duct, though more often it arises from obstruction of the distal end of the common duct. In other cases it may be secondary to a gallbladder infection and thus amenable to relief by cholecystectomy alone.

When one encounters a thick-walled gallbladder no larger than the thumb, one may be sure of a long standing disease. Even though the organ does not contain stones, they probably will be found in the ducts. Again, in the presence of multiple stones in the gallbladder and an enlarged, patent cystic duct, it is more than likely that small stones will have passed into the common duct.

Both flocculent bile and jaundice suggest an occlusion of the distal end of the duct by a stone, though other conditions, such as stricture, pancreatitis, spasm of the sphincter of Oddi, or a tumor, may produce a similar situation. Or, the jaundice may be intrahepatic in origin; this point, however, may be determined by laboratory studies and the history. Intrahepatic jaundice is not associated with colic, chills, and fever, as is usually true of jaundice incident to duct obstruction.

If the duct is to be opened, two precautions should be observed. First, the gallbladder should be removed prior to the choledochotomy; otherwise, stones may escape into the duct during manipulation of the gallbladder. Second, every possible means should be employed to clear the ducts at the time of exploration. The hepatic as well as the common duct should be searched thoroughly and the ampulla explored with scoops. After this procedure, I pass dilators through the distal end of the common duct to insure its patency, then insert a T tube and allow it to remain in situ for ten days to two weeks or longer.

An abnormal dilatation of the common duct arising from simple stricture of the distal end may require additional surgery to sidetrack the bile into the intestine. Even though the stricture may be incomplete, it is difficult to dilate the end of the duct sufficiently at the time of choledochotomy to insure continuous and ample drainage. Moreover, the dilated area tends to contract again and bring about another impediment to the flow of bile. This leads to a recurrence of the same pathologic condition; the original clinical picture is reproduced, and a second operation becomes necessary.

I have found that the obstruction in these cases is best relieved by choledochoduodenostomy. The procedure not only is comparatively easy from the technical standpoint but is physiologic in principle. All the bile is immediately made available in that part of the intestine where it normally empties, and intestinal function is restored soon. The first requisite to the operation is sufficient dilatation of the duct to permit a large stoma. By incision of both the duct and the duodenum in the longitudinal direction and side to side anastomosis, the stoma may be made of adequate length to preclude contraction and permit continuous bile drainage. Ascending cholangitis of an appreciable degree has not been observed following any of the operations of this type which have been performed by our clinic surgeons. The procedure also is applicable to obstructions by malignancies when resection is not feasible.

CONCLUSIONS

The complications of cholecystitis, that is gallstones, acute cholecystitis, perforation and malignancies of the gallbladder, duct obstructions, and damage to the liver and pancreas, are all the result of long standing disease. In addition to their permanent systemic effects, they increase the difficulty and dangers of operation and directly or indirectly are responsible for the vast majority of postoperative deaths. Early removal of the calculous gallbladder and the nonfunctioning, noncalculous gallbladder which produces severe symptoms affords protection against these complications and solves most of the problems of treatment before they arise.

ALFALFA SEED TEA NO CURE

Dr. William H. Kaufman, Roanoke, Va., warned against the drinking of alfalfa seed tea as a cure for arthritis in the July 17 issue of *The Journal of the American Medical Association*. The doctor stated that the two patients reported on suffered skin eruptions as a result of the home remedy and that 4 other possible cases have been found. He expressed belief that the custom of drinking the tea for curing arthritis, diabetes, and related disorders is apparently widespread but most patients will not admit that they have used it. Dr. Kaufman reported that the Council on Pharmacy and Chemistry of the AMA has received numerous questions about the value of alfalfa preparations in treating arthritis and diabetes and can find no evidence that alfalfa seed in any form will help.

CHEMOTHERAPY OF GONORRHEA
Clinical Observations in 201 Cases

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THIS report concerns the chemotherapy of 201 cases of gonorrhea in military service personnel. All patients were observed and treated by us on an out-patient basis, in a general dispensary on Okinawa. Each case was followed for two months after completion of therapy. The successful use of penicillin,[3] streptomycin,[6] chlortetracycline (Aureomycin),[1] and oxytetracycline (Terramycin)[1] in the treatment of gonococcal urethritis has been recorded previously. A study using various dosage schedules of the antibiotics was adopted to compare the therapeutic effectiveness of each. An attempt was made to demonstrate resistance of the gonococcus to varied antibiotics by clinical means and to interpret the role of nongonococcal organisms in gonococcal urethritis.

METHOD

Two hundred one cases of gonococcal urethritis were selected at random and alternately treated with penicillin (crystalline penicillin G), streptomycin (streptomycin sulfate), chlortetracycline (Aureomycin), and oxytetracycline (Terramycin) using varied dosage schedules. In all cases, gram-negative intracellular Diplococci were demonstrated in the purulent discharge. We frequently checked the laboratory diagnosis. All nongonococcal urethritis was excluded. Treatment schedules of antibiotics using increasing total dosage were employed arbitrarily to ascertain the minimal total dose that would result in a 100 per cent cure rate and to demonstrate resistant gonococci in vivo by clinical means. The presence of nongonococcal organisms was reported routinely on all urethral smears to evaluate the role that they might play in gonococcal urethritis.

TABLE 1.—*Penicillin Treatment Schedules for Gonorrhea.*

Penicillin (IM)	No. Cases	Bacteriologic Relapse	Cures
300,000 U	14	5	9
300,000 U for 2 days	15	3	12
300,000 U for 3 days	14	0	14
600,000 U for 3 days	23	1	22
Total	66	9	57

Four penicillin schedules were used in 66 cases (table 1) ranging from one dose of 300,000 units of penicillin intramuscularly to 600,000 units intramuscularly for three days. All treatment failures with any of the penicillin schedules received 600,000 units of penicillin intramuscularly for three days.

Five streptomycin schedules were used in 54 other cases (table 2), ranging from 1 Gm. of streptomycin intramuscularly to 1 Gm. intramuscularly for five days. All treatment failures with these streptomycin schedules received 1 Gm. of streptomycin intramuscularly for three days.

TABLE 2.—*Streptomycin Treatment Schedules for Gonorrhea.*

Streptomycin (IM)	No. Cases	Bacteriologic Relapse	Cures
1 Gm.	13	2	11
1 Gm. for 2 days	14	3	11
1 Gm. for 3 days	18	1	17
1 Gm. for 4 days	5	0	5
1 Gm. for 5 days	4	0	4
Total	54	6	48

Three chlortetracycline (Aureomycin) schedules were used in 43 cases (table 3). These ranged from 250 mg. four times a day for one day to 250 mg. four times a day for three days. All treatment failures in the chlortetracycline (Aureomycin) group were given the 3 Gm. total dose.

TABLE 3.—*Aureomycin Treatment Schedules for Gonorrhea.*

Aureomycin	No. Cases	Bacteriologic Relapse	Cures
250 mg. q.i.d. for 1 day	6	3	3
250 mg. q.i.d. for 2 days	16	3	13
250 mg. q.i.d. for 3 days	21	0	21
Total	43	6	37

Three oxytetracycline (Terramycin) schedules were used in 38 cases (table 4): 250 mg. four times daily for one day; 250 mg. four times daily for two days; and 250 mg. four times daily for three days. All treatment failures received the 3 Gm. total dose.

RESULTS

Table 1 summarizes the number of cases treated with various penicillin dosage regimens, the number of bacteriologic relapses, and the number of cures. In the discussion, reference is always made to the total dose of antibiotic employed. There were cures in about two-thirds of the cases with a single 300,000 unit dose of penicillin. This increased to four-fifths

when 600,000 units was given, and to 100 per cent when 900,000 units was employed. The paradoxical relapse of 1 case treated with 1,800,000 units is unexplained (table 1). Repeated inquiry into this case brought continued denial of new sexual exposure. This case responded to another course of similar dosage. All cases of relapse responded to 600,000 units of penicillin given intramuscularly for three days. Cures in more than four-fifths of the 66 cases treated with penicillin are not significantly different from the results obtained with the other antibiotics.

Table 2 reveals that cures occurred almost uniformly when 3 Gm. of streptomycin was given and reached 100 per cent when 4 or 5 Gm. of streptomycin was given. All cases of relapse responded to 3 Gm. of streptomycin.

The results of treatment with chlortetracycline (Aureomycin) are shown in table 3. The use of 1 Gm. of chlortetracycline (Aureomycin) resulted in cures in one-half the cases. This increased to 100 per cent in cases treated with 3 Gm. All cases of relapse responded to 3 Gm. of chlortetracycline (Aureomycin).

The results of treatment with oxytetracycline (Terramycin) are shown in table 4. When a 1 Gm. dose

TABLE 4.—*Terramycin Treatment Schedules for Gonorrhea.*

Terramycin	No. Cases	Bacteriologic Relapse	Cures
250 mg. q.i.d. for 1 day	9	4	5
250 mg. q.i.d. for 2 days	12	1	11
250 mg. q.i.d. for 3 days	17	0	17
Total	38	5	33

was employed, there were cures in half the cases; with 3 Gm., 100 per cent cures. All cases of relapse responded to 3 Gm. of oxytetracycline (Terramycin).

Acute gonococcal urethritis studied in this group of 201 cases revealed many other bacteria on the gram stain smear. The gonococcus was seen alone in 29.5 per cent of the cases. It was associated with gram-negative rods in 37 per cent of the cases, gram-positive cocci in 16.5 per cent of the cases, and gram-negative rods and gram-positive cocci in 17 per cent. In 70.5 per cent of the group, bacteria other than the gonococcus were demonstrated on the same smear.

DISCUSSION

The plan was to treat an equal number of cases with each antibiotic dosage schedule, so that the comparative survey would have more statistical significance. The necessary elimination of many cases because of improper follow-up or other irregularities made this impossible. Also, we felt an obligation to the patient to adhere to the larger dosage schedules when relapses occurred with the smaller doses. Although 201 cases of acute gonococcal urethritis were treated, the actual number of cases treated with each dosage schedule was small. Nevertheless, it is thought that certain useful information was gained from the study.

Most urethral discharges that persist after adequate antibiotic therapy are not the result of bacteriologic relapse due to the gonococcus. In this group, many were due to the mechanical irritation of frequent urethral stripping and associated conditions such as stricture and prostatitis. The presence of a mixture of bacteria prior to antibiotic therapy is an interesting observation, and gram-negative rods and gram-positive cocci were observed to remain in urethral discharges after antibiotic therapy had eliminated the gonococcus. It is conceivable that such surviving bacteria may be the cause of persistent discharge, similar to a nongonococcal urethritis de novo. This emphasizes that careful smears should be made for gonococcal and nongonococcal organisms before one incriminates antibiotic failure. The administration of penicillin, streptomycin, chlortetracycline (Aureomycin), and oxytetracycline (Terramycin) resulted in rapid cessation of the purulent discharge, usually within twenty-four to forty-eight hours. At times a scanty mucoid discharge persisted for several days, but disappeared spontaneously. There was no significant difference in cure rates for the various drugs used, and no distinct therapeutic superiority of any one drug was noted (table 5). The low per-

TABLE 5.—*Comparison of Relapse Rates of Gonococcal Urethritis Treated with Various Antibiotics.*

Treatment	No. Cases	Cases of Bacteriologic Relapse	Cures
Streptomycin	54	6	48 (88.9%)
Terramycin	38	5	33 (86.8%)
Penicillin	66	9	57 (86.4%)
Aureomycin	43	6	37 (86.0%)
Total	201	26	175 (87.0%)

centage of total cures in this study (87 per cent) perhaps may be attributed to the smaller doses of antibiotics used initially. This was done to determine the minimal total dose that would result in a 100 per cent cure rate and as a clinical method to suggest bacterial resistance to the antibiotic.

From the data it appears that such optimal dosage is 900,000 units for penicillin; 4 Gm. for streptomycin; and 3 Gm. for chlortetracycline (Aureomycin) and for oxytetracycline (Terramycin). Penicillin and streptomycin resistant strains of gonococci have been produced in vitro.[4] There are case reports of gonococcal urethritis that failed to respond to large doses of penicillin.[2] Reports in the literature do not mention resistant strains of gonococci with

regard to chlortetracycline (Aureomycin) and oxytetracycline (Terramycin). A definite correlation was noted between the use of a larger total dose of antibiotic and an increase in the cure rate. This suggests variation in the sensitivity of the gonococcus to the antibiotic. However, when a large enough dose of penicillin, streptomycin, chlortetracycline (Aureomycin), or oxytetracycline (Terramycin) was employed, there were no bona fide cases of bacteriologic relapse by smear and stain technique.

When four equally effective antibiotics are available for therapeutic use, the choice other than from incidence of side reactions and economic considerations may depend upon other factors. Therapeutic masking of coexistent venereal disease is probably the most important factor in the treatment of gonorrhea. Where gonorrhea and a penile ulcer coexist, the use of streptomycin would neither mask nor interfere with the clinical and laboratory diagnosis of a syphilitic chancre, in distinction to the other three antibiotics. It is acknowledged that in 3 cases, Willcox has shown streptomycin to have some action on the Treponema pallidum in sustained dosage,[7] but it is certainly minimal in comparison with the other antibiotics mentioned. Scott stated that chlortetracycline (Aureomycin) in total dosage not exceeding 3 Gm. does not interfere with the serologic or dark field tests for syphilis.[5] Gonorrhea and chancroid would both respond to streptomycin, chlortetracycline (Aureomycin), and oxytetracycline (Terramycin). Penicillin used for the treatment of gonorrhea would not appreciably affect a chancroidal ulcer.

SUMMARY

Two hundred one cases of gonococcal urethritis were treated with penicillin, streptomycin, chlortetracycline (Aureomycin), and oxytetracycline (Terramycin) with varied dosage schemes.

In this study, the optimal total dose of penicillin for a 100 per cent cure rate was 900,000 units; streptomycin 4 Gm.; chlortetracycline (Aureomycin) 3 Gm.; and oxytetracycline (Terramycin) 3 Gm.

No distinct therapeutic superiority of any one drug was noted when adequate dosage was employed.

Persistent discharge was usually not the result of bacteriologic relapse. Careful smears should be made for gonococcal and nongonococcal organisms before one incriminates antibiotic failure.

Strains of gonococci vary in their sensitivity to penicillin, but no penicillin resistant organisms were encountered. This also applies to streptomycin, chlortetracycline (Aureomycin), and oxytetracycline (Terramycin).

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Number of Physicians in 1953

The 218,522 physicians licensed to practice in the United States in 1953 set an all time record, according to figures from the fifty-second annual report on medical licensure of the American Medical Association's Council on Medical Education and Hospitals. The report lists 7,276 persons added to the medical profession during 1953; and 3,421 physician deaths were reported to the AMA headquarters. This gives a net increase of 3,855 in the physician population of the United States. In 1952, the increase was 2,987.

Of the 5,646 graduates of approved medical schools in the United States to take examinations, only 3.8 per cent failed. However, of the 1,463 graduates of foreign medical faculties examined, 45.5 per cent failed.

Physicians engaged in private practice in 1953 were 156,333; those in full time research and teaching, 6,677; interns or residents or physicians engaged in hospital administration, 29,161; 9,311 were retired or not in practice; and 17,040 were in government service.

DISEASE OF WAR PRISONERS

Schistosomiasis japonica, also known as Katayama disease, is a disease believed to have affected approximately 2,000 Americans during World War II, and they have never been treated, according to two Coral Gables, Fla., physicians. Dr. John L. Wolford and Dr. John M. Rumball reported in the July 17 *Journal of the American Medical Association* on 1 case discovered in a former Japanese prisoner of war and expressed their belief that the discovery of the disease after ten years stresses "the importance of looking for the disease in similar persons."

The disease attacks man through free-swimming larvae developed in snails, the larvae burrowing into the skin usually during swimming or bathing. The former prisoner of war treated by the Florida physicians had labored in rice paddies for two years, and these areas are known to be infested with Schistosoma larvae.

PATHOLOGY OF SPONTANEOUS ABORTION

II. Relationship of Decidual Hemorrhage to Spontaneous Abortion and Vitamin C Deficiency

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DECIDUAL hemorrhage can occur at any time during pregnancy and become manifest clinically as antepartum bleeding. When it occurs in the first half of gestation it is called a threatened abortion. There is little controversy as to the occurrence of the bleeding, yet contention exists as to whether decidual hemorrhage is of primary cause or a secondary effect of the spontaneous abortion. The views of both schools of thought have been summarized by Eastman[9] as follows: "Until recently it was generally accepted that the decidual hemorrhage was the primary lesion and the death of the embryo secondary. However, modern studies have demonstrated that the reverse is usually true. The death of the embryo is primary and the decidual hemorrhage is secondary." Our own preliminary observations on the pathology of 1,500 abortion patients favor the older concepts, on which it is the purpose of this article to report.

MATERIALS AND METHODS

Mall and Meyer[19] pointed out in 1921 the lack of information regarding the decidua in spontaneous abortion. This was due (and still often is) either to the conservative management of patients with incomplete abortion, namely no curettage, which resulted in little or no decidua for histologic examination, or to the failure of the pathologist to examine adequately the specimen. However, for the purpose of an extended study of spontaneous abortion still in progress and to be reported more fully when a total of 2,000 cases is reached, it has become our practice to intervene early, and as a result completion of the incomplete abortion was performed in 75 per cent of our patients. To date, 1,334 patients have had a complete gross and histologic examination of the decidua, either on the expelled specimen or on the products removed in the operating room or on both. All specimens were examined microscopically without prior knowledge of the clinical or laboratory course of the patient, with the result shown in tables 1 and 2.

TABLE 1.—*Condition of Decidua in 1,334 Spontaneous Abortion Specimens as Compared with Control Group of 361 Cases.*

	Spontaneous Abortion		Control Group*	
	No.	%	No.	%
Normal	83	6.2	268	74.2
Abnormal	1,251	93.8	93	25.8
Total	1,334	100.0	361	100.0

*Therapeutic and unintentional abortion specimens.

TABLE 2.—*Conditions Found in Decidua of 1,334 Cases Mentioned in Table 1 as Compared with 361 Control Specimens.*

	Spontaneous Abortion		Control Group*	
	No.	%	No.	%
Hemorrhage	810	60.7	31	8.6
Degeneration	680	50.9	75	20.7
Infection	572	42.8	13	3.6
Normal	83	6.2	268	71.5

*Therapeutic and unintentional abortion specimens.

Fasting blood plasma vitamin C determinations were performed on a series of 420 normal, untreated (no forced vitamin C therapy), obstetric patients at various stages in their pregnancies, using the Mindlin and Butler[20] technique. A graph of the average values is plotted in figure 1. Approximately half of the total number had been previously reported.[11] Pregnant patients with values of 0.5 mg. per 100 cc. or less were considered deficient since they were often found associated with clinical manifestations of idiopathic bleeding from the nose, gums, anus, and vagina and of an easily bruised skin. Some investigators

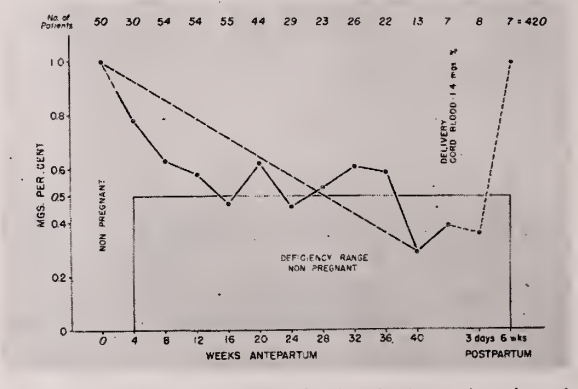

FIG. 1. Average plasma vitamin C values in 420 patients in various weeks of pregnancy. The number of patients studied in each four-week period of pregnancy is indicated at the top of the graph.

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This study has been supported by grants from the Florida Citrus Commission and the National Drug Company.

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prefer 0.4 mg. per 100 cc. for nonpregnant patients, a level which may not be applicable to pregnant patients. Table 3 gives data for 237 patients in the first half of their untreated pregnancies (all of whom also are included in figure 1) and on other cases of nontreated and threatened and spontaneous abortion.

TABLE 3.—*Plasma Vitamin C Concentration in 354 Untreated* Obstetric Patients Having Normal Early Pregnancy and/or Threatened, Spontaneous Abortion.*

	No. Cases	Plasma Vitamin C Average Value (mg./100 cc.)	Deficiency† No.	Deficiency† %
Normal pregnancy (8-22 weeks)	237	0.58	110	46.6
Threatened abortion	17	0.49	8	47.0
Spontaneous abortion	100		45	
With decidual hemorrhage	53	0.49	30	56.6
Without decidual hemorrhage	47	0.76	15	31.2
Grand total	354			

*No forced vitamin C therapy.
†0.50 mg. per 100 cc. or less.

Plasma vitamin C determinations were obtained on 103 normal, nonpregnant, gynecologic patients, as shown in table 4. Some of these had menorrhagia and some did not. Correlation was made with the plasma vitamin C determinations and the presence and absence of decidual hemorrhage in table 5. Another group of 25 normal, obstetric patients had vitamin C determination made before and during forced vitamin C therapy, consisting of a daily intake of 350 mg. of vitamin C in citrus fruits and 150 mg. as Hesperidin C (National Drug Company) with the results shown in table 6.

TABLE 4.—*Plasma Vitamin C Concentration in Normal, Nonpregnant, Gynecologic Patients with and Without Menorrhagia.*

	No. Cases	Plasma Vitamin C Average Value (mg./100 cc.)	Deficiency* No.
Without menorrhagia	75	0.79	22
With menorrhagia	28	0.48	16
Total	103	0.70	38

*0.50 mg. per 100 cc. or less.

TABLE 5.—*Decidual Hemorrhage in 100 Spontaneous Abortion Specimens Correlated with Maternal Plasma Vitamin C Concentration.*

Plasma Vitamin C Concentration*	No. Cases	Plasma Vitamin C Average Value (mg./100 cc.)	Decidual Hemorrhage No.
Deficiency (<0.50 mg./100 cc.)	45	0.22	30
Sufficiency (>0.51 mg./100 cc.)	55	0.95	22
Total	100		53

*Mindlin and Butler technique.

Clinical application of the possible relationship of forced vitamin C intake for the prevention of decidual hemorrhage was employed on 100 habitual abortion patients and the results have been published elsewhere.[16] It had been determined previously from 67 specimens of such patients that decidual hemorrhage existed in 54 per cent. A diet rich in citrus fruits provided a daily intake of 350 mg. of vitamin C, and Hesperidin C supplement provided 50 mg. three times a day for a daily total of 500 mg. Vitamin K was also employed, and the rest of the regimen consisted of no diethylstilbestrol or progesterone, no coitus, no bed rest except for threatened abortion, thyroid extract only when indicated, psychotherapy, and sedation as indicated. The results obtained with this regimen are shown in table 7.

TABLE 6.—*Plasma Vitamin C Concentration of 25 Normal Obstetric Patients in Early Pregnancy, Before and During Forced Vitamin C Therapy.**

	Plasma Vitamin C Average Value (mg./100 cc.)	Deficiency No.
Before therapy	0.42	12
During therapy	1.26	2

*High citrus diet (350 mg. of vitamin C daily) plus Hesperidin C 50 mg. three times a day (150 mg. of vitamin C daily) totaling 500 mg. of vitamin C daily.

TABLE 7.—*Distribution of 100 Habitual Abortion Patients as to Clinical Type and End Results.*

	No. Cases	Spontaneous Abortion No.	Premature and Full Term Delivery No.
Primary	76	8	68
Secondary	15	0	15
Total	91	8	83
Undelivered	9		
Grand total	100		

RESULTS

The decidua was normal in only 6 per cent of the 1,334 spontaneous abortion specimens and abnormal in 94 per cent, whereas the control group of 361 therapeutic and unintentional abortion specimens yielded values of 74.2 and 25.8 per cent respectively for these two conditions (table 1). The abnormal conditions found in the decidua are given in table 2, with decidual hemorrhage as the commonest lesion in 61 per cent of the specimens; only 9 per cent of the control group had this lesion.

Figure 1 gives the average plasma vitamin C concentration of the 420 obstetric patients. Some of these had several tests repeated in the various months of pregnancy. There is a gradual decline from an average value of 1.0 mg. per 100 cc. in the nonpregnant patient to 0.29 mg. per 100 cc. at term. Prior to this, low points were reached in the sixteenth week of gestation, by which time most of the spontaneous abortions have occurred, and in the twenty-

fourth week. The low value at term may be one of the etiologic factors in premature separation of the normally implanted placenta.

Table 3 presents data on 354 obstetric patients who had blood determinations made at the time of the first antenatal visit, at the time of hospital admission for threatened abortion, and at the time of admission for spontaneous abortion. Most of these patients had received little or no dietary instructions or vitamin C therapy prior to being studied. The average plasma C value of 0.58 mg. per 100 cc. for normal pregnancy is slightly higher than for patients with threatened and spontaneous abortion with decidual hemorrhage, these patients having values of 0.49 mg. per 100 cc., whereas the group without decidual hemorrhage had a higher value of 0.76 mg. per 100 cc. The percentage incidence of vitamin C deficiency was 56.6 per cent in the group with decidual hemorrhage and only 31 per cent in the group with no hemorrhage. The figures in table 3 also approximate the pathologic incidence of decidual hemorrhage as a cause for the abortion (table 2) as well as the incidence of other causes responsible for the miscarriage.

However the duration of a chronic vitamin C deficiency in the spontaneous abortion patient is unknown. It can be seen that less than one-third of nonpregnant, gynecologic patients without menorrhagia (table 4) and of nonpregnant, obstetric patients (fig. 1) are deficient in vitamin C, as compared with almost half of the patients in normal pregnancy. The difference represents those who have developed an acute deficiency because of the increased requirements of pregnancy. Even so, it is well known that 0.00 plasma levels can exist for months before clinical bleeding develops.

Table 4 gives the vitamin C concentration of 103 nonpregnant, gynecologic patients. Those with menorrhagia had an average vitamin C level of only 0.48 mg. per 100 cc., within the scorbutic range, and 16 patients had an actual vitamin C deficiency. This is of interest and particularly significant since some of these very patients turned up later with spontaneous abortion.

A distinct correlation was found between vitamin C deficiency and decidual hemorrhage (table 5). When there was a maternal deficiency in vitamin C, decidual hemorrhage was found in two-thirds of the

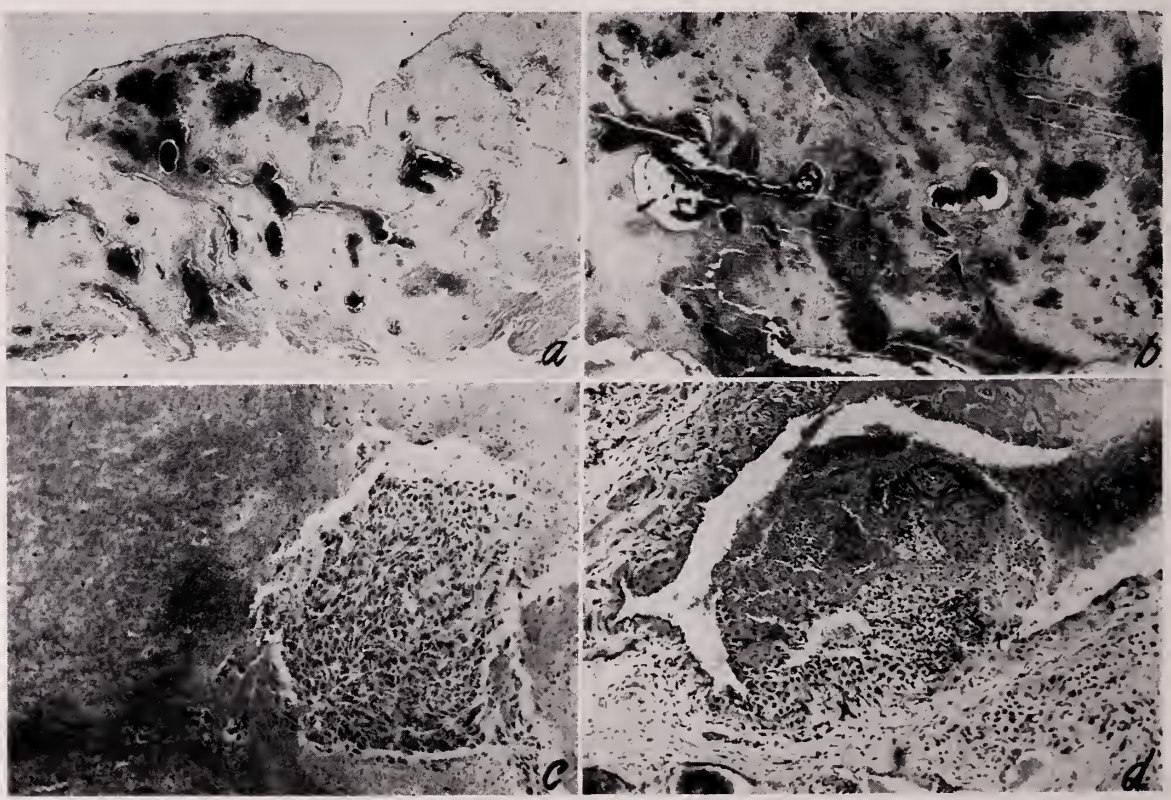

FIG. 2a. Histologic section, low power, of well preserved decidua, which was expelled spontaneously by a patient with "threatened abortion." Note hyperemia and decidual hemorrhage.

b. Decidua of spontaneous abortion specimen. The patient had symptoms of "threatened abortion." Note extensive hyperemia and decidual hemorrhage. Plasma vitamin C concentration of the patient was 0.00 mg. per 100 cc.

c. Erosion of a vein in the decidua basalis by the trophoblast accompanied by distinct decidual hemorrhage on the left side of the curettage specimen as pictured.

d. Curettage specimen showing erosion of a vein in the myometrium by the trophoblast directly beneath the implantation site of the placenta.

abortion specimens. Nevertheless, when there was a sufficiency of vitamin C, decidual hemorrhage was still observed in two-fifths of the specimens. Probably this group of patients have either uterine contractions, stretching or trophoblastic invasion of decidual veins (fig. 2c and d), vitamin K deficiency, afibrinogenemia, hormone deficiency, or other causes of decidual hemorrhage.

The evidence in table 6 suggests that the daily requirement of vitamin C during pregnancy is far in excess of the 100 mg. per day stated by the National Research Council.[28] Thysell found that this amount was necessary to produce a blood level of 1.0 mg. per 100 cc. in nonpregnant persons.

Further clinical experience with vitamin C therapy was obtained from 100 patients with "habitual abortion" (table 7). The treatment outlined previously yielded a successful outcome of the pregnancy in 91 per cent of these patients.[16] Decidual hemorrhage was a common factor in these patients, since it was found in 54 per cent of the abortion specimens of previous pregnancies not so treated. It was found in only 5 per cent of the treated habitual abortion patients.

DISCUSSION

Vaginal bleeding in early pregnancy has received considerable attention in the literature, but seldom has vitamin C deficiency been mentioned as a causative factor. However, it is well known that a person may have no plasma vitamin C for months before developing scurvy. Tissues important to pregnancy which contain much vitamin C are the corpus luteum, the adrenal gland and the pituitary gland, according to Rosenberg[24] and Bicknell and Prescott,[4] as well as the placenta. The occurrence of hemorrhage in the decidual portion of the placenta may be a manifestation of maternal scurvy.

The daily requirement of vitamin C can be obtained easily by following a diet rich in citrus fruits, which, according to Krehl and Cowgill,[17] "remain as one of the most practical sources of ascorbic acid in the nutritional economy." They found virtually no difference in the ascorbic acid content of fresh and frozen citrus juices. The average ascorbic acid content of orange juice was approximately 40 mg. per 100 cc. and of citrus salad (orange and grapefruit sections mixed) 30 mg. per 100 Gm. The amount of vitamin C required to maintain sufficient blood plasma levels is definitely increased in pregnancy. When patients have had repeated abortions, a total of 500 mg. is provided daily. A high citrus diet provides 350 mg., and vitamin C supplement or Hesperidin C provides an additional 150 mg. Occasionally, some patients with values of 0.00 mg. per 100 cc. respond poorly to oral vitamin C and require 1,000 mg. intravenously, after which adequate levels usually can be maintained by the oral medication.

Vitamin C in pregnancy is required for the rapid growth of the products of conception. Obviously any protoplasmic mass, whether plant or animal, requires adequate nutrition, including ample amounts of vitamin C. At the end of the first half of gestation (22 weeks) the average fetus weighs 500 Gm., which represents an increase of more than 1,000 times the initial weight of the previllous embryo. In the last 18 weeks of pregnancy the infant grows from 500 Gm. to approximately 3,500 Gm., an increase of only seven times.

Some of our pregnant patients with slight vaginal bleeding have given a history of idiopathic bleeding from the nose, gums, anus, and skin ecchymoses, with no specific pathologic conditions to account for the hemorrhage. Our studies on such patients often revealed a low blood plasma vitamin C concentration, ranging from 0.00 mg. per 100 cc. to 0.35 mg. per 100 cc. Forced vitamin C therapy raised the blood values to normal and controlled this bleeding tendency in the majority of the patients. Neiwert, Engleberg, and Pirk[21] studied 104 patients with nosebleeds and nearly half of these had no apparent cause for the bleeding. Yet 65 per cent had vitamin C levels less than 0.5 mg. per 100 cc., which responded to vitamin C therapy. These authors concluded that vitamins C and K have a definite place in the management of idiopathic nasal hemorrhage. Some of our gynecologic patients with menorrhagia had low vitamin C levels (table 4), which responded to therapy with vitamins C and K. A few of these patients were not so treated, and they developed spontaneous abortion in a subsequent pregnancy.

Pathologic studies have shown that there are many fetal and maternal factors that cause spontaneous abortions. These have been summarized by DeLee and Greenhill[8] as diseases of the amnion, chorion, placenta, cord, and fetus. Each of these factors was correlated with vitamin C deficiency and only decidual hemorrhage had a high incidence (61 per cent) in the 1,334 spontaneous abortion specimens (table 2).

The decidua usually degenerates and atrophies progressively with the endometrium so that at term much of it is cast off with the placenta, where it can be seen in the histologic sections. However, in early pregnancy it is usually in a better state of preservation, and after spontaneous abortion much of it remains within the uterus, as determined by a study of the curettage specimens, especially when the fetal death has followed extensive decidual hemorrhage or premature separation of the placenta. On the other hand, when the fetus has died in utero of a cord com-

plication[15] with delay in expulsion as in a "missed abortion," the decidua is usually degenerated as in a term pregnancy and is not hemorrhagic.

Occasionally a patient with a threatened abortion will expell "tissue" which is sent to the laboratory for study. Histologic section of it usually reveals degeneration and/or extensive decidual hemorrhage (fig. 2a). Frequently the abortion becomes inevitable and completion becomes necessary. Decidual hemorrhage is usually found in the curettage specimen of such patients (fig. 2b), which reveals a degree of hemorrhage even more extensive than was observed in the decidua expelled spontaneously (fig. 2a). Clinical experience teaches that antepartum bleeding interpreted as threatened abortion is not always followed by spontaneous abortion. In a study of 439 patients with bleeding in the first trimester of pregnancy, Stander[26] found that 67 per cent subsequently had a premature or full term delivery, as did 70 per cent of 1,570 such patients observed by Colvin, Bartholomew, Grimes, and Fish.[6] Perhaps some of these patients had vaginal bleeding not from the decidua but from a cervical polyp or an erosion, either of which could have been detected by speculum examination.

Many of the recent studies suggest that 60 per cent of the abortion specimens have pathologic ova, embryos, and fetuses. However, the incidence of such fetuses was only 22 per cent in our 1,500 consecutive cases studied to date. These data are suggestive of the occurrence of decidual hemorrhage as a primary factor in spontaneous abortion rather than the intrauterine death of the fetus as mentioned by Eastman.[9] Moreover, decidual hemorrhage was found in only 9 per cent of the control patients, most of whom had a therapeutic abortion, which excludes trauma of the curette as the cause of the decidual hemorrhage as some have contended.

Decidual bleeding in early pregnancy is also affected by certain interrelated physiologic, biologic, chemical, physical, and pathologic factors. There is difficulty in arriving at these factors, for only rarely does one have the human conceptus sufficiently intact with the surrounding uterus for the determination of the various conditions causing the abortion. In other words, the uterus and decidua remain in the patient and often only the castoff fetal products of conception, in various stages of preservation, are available for pathologic examination. Consequently, few studies have been made of the decidua in utero and the work of Rutherford[25] in 1942 is outstanding. He obtained decidual biopsies on 100 consecutive patients with threatened abortion and found "decidual apoplexy," consisting of hemorrhage, necrosis, cellular infiltration, and vascular thrombosis, similar to that shown in figure 2a and b. He attributed these pathologic changes in many of the cases that subsequently aborted to progesterone deficiency and therefore advocated corrective endocrine therapy.

At about the same time Javert and Stander[11] postulated that deficiency in vitamins C and K also caused decidual bleeding and offered this theory as a factor in the pathogenesis of spontaneous abortion. They presented laboratory evidence of hypovitaminosis C and K and offered clinical data on their therapeutic value. Meanwhile, pathologic studies of the relationship of vitamin C deficiency and decidual hemorrhage were initiated but were postponed because of World War II. These studies were recently resumed and form the basis for this report.

Barnes[2] made assays of vitamin C of the placenta in 1947, and Holzaepfel and Barnes[10] found the greatest concentration of vitamin C in the syncytial layer of the villi, which is of fetal origin. This is in agreement with the high fetal values found in the fetal cord blood by Javert and Stander;[11] Teel, Burke, and Draper;[27] Abt, Farmer, and Epstein;[1] and Braestrup.[5] The decidua is the only maternal part of the placenta and the vitamin C concentration of this tissue has yet to be studied thoroughly. Meanwhile, in 1948 Power[22] reported 13 patients with a degenerated decidua which he regarded as a cause of the decidual bleeding and he questioned the value of endocrine therapy. Javert and Finn[13] in a preliminary study in 1950 of 500 consecutive spontaneous abortion specimens found evidence of decidual hemorrhage in 45 per cent. They suggested preventive measures such as a diet rich in citrus fruits and the use of vitamin C and K supplements.

Ramsey[23] found in the rhesus monkey that the spiral arterioles of the myometrium and endometrium uncoiled like a rubber hose as the pregnant uterus increased in size. However, the veins were usually straight and distended and became stretched as the uterus enlarged. Here then, is another normal physical factor which may cause decidual hemorrhage if the veins become hyperemic, engorged, and overstretched to the breaking point and the bleeding and clotting mechanism is not in balance.[16] Add to this the biologic factor of trophoblastic erosion of both decidual and myometrial veins (fig. 2c and d) and the stage is set for slight bleeding, which is to be regarded as a normal physiologic process since it is often recognized clinically as the "placental sign" or as "implantation bleeding." However, when such bleeding becomes more extensive, it is pathologic and one has either a partial or a complete premature separation of the placenta (decidual hemorrhage) in the first half of gestation. The relationship of capil-

lary fragility and vitamin C deficiency to these events seems rather obvious.

Finally, as stated in table 5, decidual hemorrhage was found in 22 of 55 spontaneous abortion patients with a sufficiency of vitamin C, signifying that there are other causes of such bleeding. Although investigation of the other causes of decidual hemorrhage were not within the scope of this study, conditions other than those mentioned previously may cause it, namely, premature uterine contractions, placenta previa, vitamin K deficiency, afibrinogenemia, surgical excision of the corpus luteum in early pregnancy, and increased maternal blood volume.

CONCLUSIONS

A pathologic study of 1,334 patients with decidua present in their spontaneous abortion specimens revealed decidual hemorrhage in 61 per cent.

In cases in which the mothers had a plasma vitamin C deficiency, two-thirds of the abortion specimens had decidual hemorrhage. Decidual hemorrhage was found in more than half of 67 habitual abortion specimens.

The plasma vitamin C concentration decreases in normal pregnancy from an average nonpregnant value of 1.0 mg. per 100 cc. to 0.29 mg. per 100 cc. at term. This decline is due to the growing protoplasmic mass of the fetus and the nausea and vomiting of the mother.

The obstetric patient was considered deficient in vitamin C when the plasma vitamin C value was 0.50 mg. per 100 cc. or less since abnormal bleeding occurs more frequently from the nose, gums, anus, and vagina and into the skin under such circumstances.

Approximately 45 per cent of three groups of obstetric patients, those with normal pregnancy and with threatened and spontaneous abortion, had plasma vitamin C deficiency. This is in contrast to deficiency in less than one-third of the normal nonpregnant women.

When the spontaneous abortion specimens had decidual hemorrhage, maternal deficiency was found in 56.6 per cent and when there was no decidual hemorrhage, the incidence was only 31 per cent.

Avitaminosis C was eliminated in all but 2 patients with forced vitamin C therapy in 25 pregnant patients. Their average plasma vitamin C value of 0.42 mg. per 100 cc. was raised to 1.26 mg. per 100 cc. during pregnancy by a diet rich in citrus fruits providing 350 mg. of vitamin C and a Hesperidin C supplement of 50 mg. three times daily for a total of 500 mg. daily.

Prepartum and antepartum therapy with vitamins C and K in 100 patients with histories of habitual abortion yielded successful outcome in 91 per cent. Decidual hemorrhage occurred in only 5 per cent of these treated pregnancies.

Histochemical studies of vitamin C should be made on the decidua.

Decidual hemorrhage was found in two-fifths of the specimens when there was a maternal sufficiency of vitamin C, so that other interrelated physiologic, biologic, chemical, physical, and pathologic factors, such as premature uterine contractions, stretching and trophoblastic erosion of decidual veins, increased maternal blood volume, placenta previa, vitamin K deficiency, afibrinogenemia, and surgical excision of the corpus luteum, may also cause its production.

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A bibliographic list may be obtained from the author.

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Unusual Heart Operations Reported

Dr. Michael E. DeBakey and Dr. Denton Cooley, Houston, report in the August 14 *Journal of the American Medical Association* surgical success with a blood vessel graft during which the flow of blood was stopped for an hour.

The Houston physicians, in perhaps the first operation of its kind, stopped a patient's circulation for an hour while a new section was grafted into a faulty main artery just above the heart. The patient suffered no apparent damage to the spinal cord or vital organs which usually follows stoppage of circulation for even a few minutes. "Freezing" the patient by gradual cooling for several hours before the operation prevented damage, the doctors report.

Grafts have been used on straight portions of vessels in similar cases of aneurysms, but the doctors believe this to be the first successful graft on the aorta where it arches over the heart.

In the same issue of the journal, two additional unusual operations near the heart are described. Two New York doctors, Dr. Cranston W. Holman and Dr. Israel Steinberg, tell of a successful operation on a patient for gradual closure of a blood vessel. Drs. William J. Potts, Paul H. Holinger, and Arthur H. Rosenblum, Chicago, report that they successfully cut and relocated a misplaced vein which pressed against the windpipe and aorta of a five month old baby.

'Cancer Cure' Only Cough Medicine

The American Medical Association's Bureau of Investigation reported in the June 12 *Journal of the American Medical Association* that the only "pharmacologically active" ingredient in the so-called Hoxsey "cancer tonic" is a drug which is used mainly in cough medicine. The bureau reported that the drug "is without therapeutic merit in the treatment of cancer" and that it sees no reason for the AMA further to investigate the remedy.

TREATMENT OF ACUTE OPHTHALMIC INJURIES

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EXCEPT for the injuries from a lateral direction, nature has provided moderately good protection for the eye and the adnexa by the brows, lids, and bony orbital margins.

An American College of Surgeons news bulletin stated that in time of war, eye injuries could be expected to represent about 5 per cent of all hospital admissions for battle wounds and 10 per cent or more of all accidental, noncombat-incurred injuries. This should hold true for mass civilian casualties in any future war.[1]

Abrasions of the cornea and conjunctiva, with or without superficial foreign bodies (nonpenetrating), are probably the most common ocular injuries seen, either in civilian or military life.

Intra-ocular foreign bodies are not considered in this paper, other than to suggest that a flat roentgenogram should be taken if in doubt and an intra-ocular localization should be done after referring the patient to a competent eye surgeon for treatment. Fractures of the bones of the orbit are not discussed.

After checking the visual acuity, if possible, 1 per cent Pontocaine Hydrochloride and 2 per cent fluorescein should be used in the conjunctival sac to determine the extent of the injury. If there is a foreign body present, it should be removed gently and carefully by washing with saline, by using a saline dampened cotton pledget, or by using a spud. If the foreign body is metallic and has been present a few hours, the rust stain also should be removed with a spud or by means of a small rounded dental bur (held in the fingers or by a small handle) by an ophthalmic surgeon.

Provided the visual acuity is adequate in the opposite eye, I prefer to patch firmly most of these abrasions after first instilling medication, repeating this daily until healing has occurred as indicated by failure of the epithelium to take a stain. Swan[13] showed that medication used in the conjunctival sac, to be effective, should be used in a proper vehicle.

It was shown that some medications in ointment form retarded epithelial healing more than they did in solutions. As suggested by Leopold,[6] I prefer one of the antibiotics (bacitracin, neomycin, Polysporin, and the like) which is not used systemically as are penicillin, Terramycin, Aureomycin, and others. In case of sensitivity the latter drugs may be used for generalized infections. He also stated that Gantrisin and sulfacetimide (15 per cent, half strength), either in ophthalmic solution or ointment, were the topical sulfonamides of choice. Depending on the severity of the lesion, the age, and the ocular tension, cycloplegics (2 per cent homatropine and 1 per cent atropine) may or may not be used to splint the iris and ciliary body.

Read before Section B (Surgical), Texas Medical Association. Annual Session. San Antonio, May 4, 1954.

CONTUSIONS

Contusions are injuries that do not cause a break in the surface structures. "B-B" guns are one of the worst offenders, accounting for the loss of several eyes each year. Hogan[3] stated that compared with other ocular injuries, contusions were not common in either civilian or military life.

Eyelid contusions ("shiner," "mouse"), due to the thin skin and loose subcutaneous tissues, are characterized by marked edema and ecchymosis. The edema usually subsides with or without cold compresses or a piece of "raw meat." The blood pigments undergo their color changes (red, blue, yellow, green) until the tissues have returned to their previous state and color (within one to three weeks).

Occasionally the fluid in the lids may have to be incised and drained. Antibiotics and sulfonamides are indicated to prevent infection. Conjunctival contusions require little if any treatment, though hot compresses will hasten absorption of the blood. If the hemorrhage does not stop, cold compresses might be used. When the conjunctiva protrudes over the lid margin, an incision might be considered.

Unless there is a tear in Descemet's membrane, corneal contusions respond to rest, firm patching, and mydriatics. With a rent in the glass membrane, the cornea may become hazy with edema and may even become blood stained from blood in the anterior chamber.

Limbal and scleral contusions may cause rupture of the eyeball with little damage to the interior of the eye. Where possible, these ruptures should be sutured (black silk or catgut) after excising protruding tissue and covering with a conjunctival flap. If the globe has collapsed, the eye should be enucleated.

Temporary iridoplegia from contusions of the eye may occur with or without iridodialysis. Bed rest and mydriatics may be required at the time of the injury. Later (two to three weeks) a surgical repair of iridodialysis may be done by pulling the iris into the limbal section and either suturing it or touching it with a diathermy needle. A conjunctival flap should cover the limbal section. Contusions which

tear the ciliary body are best treated by bed rest and cycloplegics.

Thygeson and Beard[14] have recently brought out the importance of the hyphemia resulting from tears of the ciliary body and base of the iris. They stressed the importance of absolute bed rest, bilateral patching, homatropine five times daily, and 100 mg. of vitamin C and 60 mg. of rutin three times daily (there is no clinical proof of the value of vitamin C and rutin). Lock[7] of England advocated the repeated use of homatropine. Fralick and others used miotics to pull the iris away from the angle.

According to Thygeson and Beard, with secondary hemorrhage (three to ten days, usually from the ciliary body rather than from the iris) the visual function of the eye may be impaired or the eye may be lost. Repeated paracentesis with removal of blood, if possible, to prevent staining of the cornea and to lower intra-ocular tension, and miotics along with bed rest and patching of both eyes are imperative.

Contusions of the eyeball may cause tears in the choroid and retina with hemorrhage into the vitreous. Bed rest, patching, and cycloplegics or Cortone or ACTH systemically are indicated. Vitreous opacities have been reported as responding to lipotropic substance.[2]

Contusions of the lens may cause subluxation, luxation, or various types of opacities. These injuries usually require no immediate treatment, but later the lens may have to be removed and the ocular tension controlled by surgery.

Optic nerve injuries from contusions are not common. Papilledema may result from a contrecoup lesion. If hemorrhage occurs into the nerve or nerve sheath and vision does not improve when the edema subsides, treatment is of little value. Aside from the injuries caused by fractures of adjacent orbital bones, contusions of the head may cause intra-orbital hemorrhage and proptosis. This hemorrhage usually subsides with no treatment. The extra-ocular muscles that may be temporarily paralyzed from contusions usually return to normal function without treatment unless there is a fracture or intracranial injury. The detachment of the oblique pulley may require surgical reattachment.

LACERATIONS

Scheie has recently discussed the importance of proper treatment of lacerations of the eye and adnexa.[11] First aid for lacerations of the eyelid should involve sterile dressings and protection of the eyeball, if exposed. The wound edges should be cleansed with sterile saline and all foreign bodies removed. Because of the excellent nutrition of the tissues, little débridement is indicated. The cornea, if exposed by an extensive laceration, should be protected by an ophthalmic ointment or a conjunctival flap.

The general condition of the patient should always be observed. Intra-ocular damage, orbital injuries (fracture), and intracranial lesions should be ruled out before extensive surgery is attempted. General anesthesia and a tetanus booster or antitoxin, with or without antibiotics, are indicated. A great deal of hospital time and needless plastic procedures could be prevented if the primary eyelid surgery could be done by a competent ophthalmic surgeon.

Where the laceration extends through the lid margin, early repair is imperative. After seven to ten days the results of surgery are not as good, and notching due to fibrosis and retraction of the margins is the rule.

One of the better methods of repair was described by Wheeler as follows: the skin and orbicularis muscle are cut back on one margin of the laceration and the tarsus and conjunctiva are trimmed an equal amount and sutured with a 3-0 plain or chromic catgut, burying the suture and closing the skin with a 5-0 black silk, thus giving a lattice-like closure and preventing notching. Hughes sometimes uses a tongue and groove closure of the inner half of the lid with a long skin flap covering the inner sutures so that the suture lines will not be superimposed. He stressed the importance of firm pressure for one to two weeks.

Still another method is direct closure in layers with especial attention to the lid margin by suturing with silk in the greyline. If some of the lid tissue is lost, the defect may be repaired by canthotomy and undermining the skin to cover the defect or Hughes' halving procedure may be used along with a tarsorrhaphy. Healing is usually by primary intention due to the excellent blood supply of the lids. Though the eyeball may be lost, the lids should be repaired over a conformer so that a prosthesis can be retained and worn.

Lacerations of the lid that tear through the canaliculus are a definite problem. The loose areolar tissue between the tarsus and canthal ligament makes it difficult to find the cut ends of the ligament, and sutures frequently pull out because of the pull of the orbicularis muscle. The canaliculus is a small canal consisting of two epithelial layers, and the two cut ends are usually difficult to identify.

Scheie described one of his methods for repairing the lower lid. He took a piece of the lower border of the tarsus leaving the medial end attached, passed it under previously undermined skin to the anterior lacrimal crest, and sutured it after the canaliculus had been identified and catheterized with a nylon suture which was then brought out through the lacrimal sac and skin. The tarsal tongue relieved the tension. The

subcutaneous tissues and skin were closed with catgut and silk sutures. Silk or nylon tubing also has been used in repairing these injuries.

Another method of relieving the tension is to use mattress sutures tied over rubber pegs anchoring them to the periosteum, then brought out through the skin and again tied over rubber pegs. Sutures (tarsorrhapy) between the two lids further reinforce the lacerated lid.

In lacerations of the eyeball, Scheie believed that it was safer to use atropine than to worry about the undesirable side effects that sometimes occur. Antibiotics and tetanus toxoid should be given. Examination of the lacerated eye should be made by a competent eye surgeon, using the proper instruments and anesthesia to prevent further trauma by the patient squeezing his lids.

The type of surgery depends on the condition of the eye, that is, whether there is hemorrhage, foreign body, present loss of vitreous, and the like. Lacerations of the cornea, if small and with no protrusions of the ocular contents, may be treated with atropine and antibiotics. Otherwise the protrusion should be excised and the cornea closed with fine 6-0 silk and a conjunctival flap pulled over the wound. Limbal and scleral wounds should be sutured and covered with a flap. Topical and systemic Cortone should be considered along with the previously mentioned medications. The eye should be observed closely at frequent intervals for one year for evidences of sympathetic ophthalmitis, secondary infection, and glaucoma.

With damage to the lens, endophthalmitis phacoanaphylactica should be kept in mind. Cortone both topically and systemically has helped in preventing and treating this condition. Scheie stressed the fact that if there is doubt as to the development of sympathetic ophthalmitis, the eye should be enucleated during the first two weeks.

BURNS

The general systemic condition of any patient with a burn of the eye should receive prompt attention to combat shock and loss of fluids. If indicated, systemic Cortone, morphine, whole blood, plasma, or saline, along with antibiotics to prevent infection, may be given.

Thermal Burns

Leahey[5] stated that thermal burns of the upper face, besides endangering sight, cause more cosmetic defects than burns of similar extent elsewhere. Skin burns of the eyelids should be cleaned gently without débridement and covered with thin Vaseline gauze and a gentle pressure dressing.

First degree burns require little treatment other than boric acid ointment or one of the other soothing preparations (boric acid when used on extensive burns has been reported as causing toxic symptoms). Superficial second degree burns may heal in two weeks without scarring. Dressings, if they are clean and dry, may be left on seven to ten days. However, second and third degree burns usually soak through the dressing, and it must be changed daily. Besides using bandage to hold the pressure dressing in place, stockinet has been used.

Deep second degree and third degree burns usually require prolonged treatment before all the necrotic tissue is removed and before the tissue is ready for either split or full thickness skin grafts, with a base from infection. Split thickness grafts usually take more readily than full thickness ones, but scarring is more marked. Skin grafting should be done as early as possible to prevent further scarring and ectropion, but it is usually three weeks or more before this is feasible.

When third degree burns are small, they may be excised and a full thickness graft done immediately for good cosmetic result. If the eyeball is not damaged, a tarsorrhaphy may be done to immobilize the lids further.

Fortunately, because of the wink reflex, relatively few burns of the eye occur. Shenk, Silcox, and Godfrey reported only 12 per cent (27) as having burns of the cornea in a series of 212 burns of the eyelids.

Thermal burns of the conjunctiva and cornea from a welder's arc are quite painful, especially about midnight. Cold compresses and ophthalmic ointment with or without patching usually relieve the patient. If 1/2 per cent Pontocaine is used, the eyes should be patched. Goggles are the best prevention.

Severe burns involving the palpebral and bulbar conjunctiva should have at once a graft taken from the other eye or from the mouth, to prevent formation of a symblepharon. Daily separation with ointment and a glass rod may help prevent this formation if a mucous graft is not done. Plastic conformers are not too satisfactory. Deep bulbar conjunctival burns should be immediately grafted.

In severe burns of the cornea or the sclera, the eye may perforate in one to four weeks. Sometimes the conjunctiva may heal before the cornea perforates. Suturing the lids may splint them enough to allow the cornea to cicatrize without rupture and without the formation of symblepharon.

Chemical Burns

McLaughlin[9] suggested that all employees in chemical plants should receive instruction as to first aid for chemical burns of the eye. Such patients should be instructed to wash the eye for five minutes with

tap water, using a fountain covered with a rubber tip to prevent further injury; and they should be sent then to the dispensary where the treatment consists of the instillation of 1/2 per cent Pontocaine followed by 2 per cent fluorescein. All foreign bodies are removed, and the eye is washed for fifteen minutes. Stain is reapplied and flushed. If stain is retained, another fifteen minutes of washing with warm saline follows. If stain is retained after reapplying fluorescein and flushing, the eye is considered to have a chemical burn. The eye is snugly patched, and the patient is sent to an ophthalmologist at any hour of the day or night. Unfortunately, patients outside of chemical plants do not always get such excellent care.

McLaughlin stated that after again staining with fluorescein the eye should be studied with a biomicroscope to determine the extent of the injury. Mechanical removal with a sterile cotton swab after instilling 4 per cent cocaine to soften the epithelium is done to all the damaged tissue. The swab is passed over the conjunctiva and caruncle, down into the fornices, and over the lid margins in an effort to remove all of the chemical from the eye. If the chemical involves Bowman's membrane, scarring usually results.

The after care consists of the use of antibiotics with or without mydriatics, cortisone, and patching. If healing has not resulted within forty-eight hours, the eye should be treated daily for infection.

Corneal opacities have been treated with 1 per cent choline chloride with some favorable results.

In spite of the work done by Swan and others, McLaughlin stated that healing was not retarded chemically by the use of ointments (bacitracin and Aureomycin).

Also, in a series of cases studied using Hydrosulphosol,[8] McLaughlin proved to his satisfaction that the drug was no more effective than his denuding method and certainly more irritating to use. It is imposisble for this substance to neutralize each and every chemical.

Hughes[4] stated that conservative treatment was effective for mild and moderately severe alkali burns. This consists of (1) immediate irrigation of the eye with water or any bland solution, (2) removal of all alkali particles and instillation of a buffer solution (pH 4.5), (3) use of mydriatics, (4) use of 10 per cent neutral ammonium tartrate (or lactate) as a corneal bath after lime burns, (5) use of antibiotics to prevent secondary infection, and (6) prevention of symblepharon. (Hughes suggested the use of 2.9 cc. of glacial acetic acid, 6.8 cc. of sodium acetate, pH 4.5 in 100 cc. of distilled water.)

For severe burns, immediate conjunctival graft (Denig) within the first six to eight hours was suggested by Hughes. He emphasized that alkali burns are progressive and late complications may occur. Spaeth,[12] quoting Würdemann,[15] stated that in chemical burns the physical and chemical alteration of the tissues is the most important factor. Attention is called to the penetration of chemicals into the interior of the eye, causing further damage. Pichler[10] practiced immediate paracentesis of the cornea for ammonia burns.

Various solutions are recommended to neutralize the chemicals that get into the eye, but McLaughlin believed that copious irrigation with saline was the best treatment rather than awaiting the preparation of a specific solution.

CONCLUSIONS

All eye injuries should be carefully examined and treated by a competent surgeon.

This treatment, provided the patient's general condition is satisfactory, should be done within the first forty-eight hours.

The attending physician or surgeon, if inexperienced with treating eye injuries, should call an eye surgeon for consultation.

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ABSTRACT OF DISCUSSION

DR. JAMES P. ADERHOLD, San Antonio: Early evaluation of the extent of the injury with prompt attention to its proper care is urgently indicated by Dr. Maxwell.

I would stress the early repair of lid lacerations, particularly those through the margins. These may be readily repaired soon after injury with a good functional and cos-

metic result, but after a week or more, contractures occur which make the procedure a formidable one.

In chemical burns involving the bulb, copious irrigations should be carried out as soon as possible after the accident. Tap water which is usually available is a good irrigant. There is considerable controversy as to the efficacy of neutralizing solutions, but I believe that after a thorough lavage with either tap water or normal saline, one may use either acid or alkaline solutions as indicated. It should be remembered that organic chemicals, many unorganic ones, and alkalies act slowly on the eye. Acids act rapidly and completely before first aid can be administered. In each case early removal of damaged superficial cells, leaving a mechanical abrasion to heal, is indicated.

The management of traumatic hyphema is a matter of controversy among many capable ophthalmologists. Drs. Thygeson and Beard have approached the subject in a manner that appeals to me. Because of the incidence of secondary hemorrhage in two to five days after the first, which they believed comes entirely from ciliary body damage, they advised the following: complete bed rest, sedation, bandaging of both eyes, and the use of 5 per cent homatropine five or six times daily. A pressure bandage may be used, and various drugs influencing capillary fragility may be of value. The delayed secondary bleeding is unexplained and is serious, usually precipitating glaucoma or corneal staining. At this time of course the treatment is changed to strong miotics and paracentesis as indicated. The prognosis is poor, however. It is thought that approximately 25 per cent of patients with traumatic hyphema will have a residual vision of less than 20/40 Snellen and that the poor results will be in those cases with secondary hemorrhage.

Finally, I believe it is advisable to make a roentgenogram if there is any doubt of the presence of a foreign body in the eye.

MANAGEMENT OF RECENT NASAL FRACTURES

WILLIAM K. WRIGHT, M. D., and FRED R. GUILFORD, M. D., Houston, Texas

FRACTURES of the nasal pyramid are frequently mishandled or overlooked entirely because of the presence of swelling, hemorrhage, and ecchymosis. The resulting malalignment of structures may cause cosmetic deformities and functional nasal impairment necessitating rhinoplastic procedures, reconstruction of the nasal septum, or submucous resection.

While good results are obtained with these late procedures, proper recognition and handling of the acute fracture is a simpler and easier method requiring less specialized technique. This paper concerns only the acute aspect of this problem.

PITFALLS

Failure to recognize a fracture. It may easily happen that a physician fails to recognize a fracture. The usual epistaxis may have been minimal or in a greenstick fracture, absent. Deformity is masked by rapidly developing swelling and ecchymosis; crepitus and palpation of fragments may be missed because of tenderness; and roentgen rays fail to reveal a fracture almost 50 per cent of the time. Avoiding this frequent pitfall is equally easy. A physician should not commit himself to the patient and should not tell him for sure that he does not have a fracture until after five to seven days when the swelling is down. At this time the patient should be reexamined for deformity, crepitus, and residual tenderness or swelling of both the external nose and the septum. The patient may be reassured during this interim that the ideal time for reduction of nasal fractures is just after the swelling has subsided.

Too early an attempt at reduction. There is a period of thirty to sixty minutes after trauma during which there is relative anesthesia with easily palpable fragments. This is the ideal time to reduce a nasal fracture. Unfortunately, reduction is seldom possible during this time, and once swelling and ecchymosis occur, accurate approximation of fragments cannot be made for four to seven days. Nasal fracture reductions are exacting, and an asymmetry of even one-sixteenth of an inch is definitely noticeable. If a reduction is done too early, residual deformity may be noted when the swelling has completely subsided.

Delaying reduction too long. If the patient consults a physician early and is properly followed, reduction never will be delayed too long. Actually, this period is a relative one. Preliminary healing is by fibrous union, and by the application of slightly increased pressure, fractures three and four weeks old often can be reduced. This fibrous healing may be permanent, but even if bony healing occurs, we have reduced fractures three and four years old by making intranasal incisions, elevating the soft tissues, and using a chisel to open the fracture lines.

Failure to recognize associated facial fractures of the orbit, malar bone, superior maxilla, and mandible. Roentgen rays are useful on patients with facial fractures of the orbit, malar bone, superior maxilla, and mandible. Postero-anterior and verticomental views of the skull and dental films are especially helpful. Palpation of all structures and checking of the occlusion also should be done. The management of these frac-

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tures is not discussed in detail in this paper, but proper recognition and care of these associated fractures, of course, are necessary.

Improper care of associated lacerations and compounded bone fragments. All open wounds should be carefully cleansed of foreign material to prevent tattoo marks and irrigated with saline to reduce contamination. We use a pHisoderm preparation on the entire area. Bone and cartilage chips are cleansed and replaced as nearly as possible in their proper locations under direct vision. The wound is carefully closed with fine sutures.

Débridement should be conservative with careful preservation of all possible structures; completely evulsed skin is trimmed of fat, cleaned, and sutured back in place. Intact portions of the nose (as tip or alae) are treated likewise. Full thickness skin losses are replaced with full thickness grafts from behind the ear. Only in cases of infected wounds are the lacerations left open, and in such cases secondary closure is done as soon as possible to prevent scarring.

Improper reduction technique. Each nasal fracture is individual and different, depending upon the force and direction of the blow, the degree of ossification, and the thickness of the bones and cartilage. Each case must be treated slightly differently, but a classification of types with associated techniques is helpful.

The general management consists of a pHisoderm preparation on the face and nose including the vestibule. The patient is draped. General anesthesia is used in children, but local anesthesia is preferable in adults because of the reduction of the bleeding. The local anesthesia consists of 10 per cent cocaine with Adrenalin applied to the nasal mucosa with applicators. The external structures are anesthetized with 2 per cent Novocain with 1 cc. of Adrenalin per ounce. This is injected to anesthetize the infra-orbital inferior and superior trochlear and external nasal nerves.

The instruments used in reducing nasal fractures consist of the Joseph elevator, a curved Kelly forceps, and the Asch or Walsham forceps. The tips of these instruments are wrapped in cotton or thin rubber tubing to prevent excessive trauma of the mucosa. Fixation consists of packing the nose loosely with one-half inch Vaseline gauze. A Stent modeling compound splint padded with felt is moulded to the outside of the nose and taped in place. If the septum is excessively comminuted, dental wax is placed on each side and held in place with mattress sutures.

MANAGEMENT

Greenstick fractures. No bleeding is encountered in the greenstick fracture. There is a depressed fragment at the junction of the maxilla, and the septum is bent away from the blow. If the deformity is slight, roentgen ray may show nothing. Reduction is accomplished by elevating the depressed bone from within with a Joseph rasp or elevator and applying pressure on the septum on the convex side in the reverse direction of the blow with the Asch forceps or Joseph rasp.

Linear fractures. No displacement is visible after ice packs have reduced the swelling, and roentgen ray may be the only way of demonstrating the fracture.

Lateral fractures. There is a depression of the nasal bone on the side of the blow, a separation of the nasal bones, and an overriding of the maxillary process by the opposite nasal bone. The fractured septum deviates to the side opposite the blow. Reduction is achieved by elevating the depressed segment and by molding the two nasal bones together in the midline. Occasionally the depressed segment must be unlocked by a downward pressure on the maxillary process with the fingers. If the septum is not brought into the midline by this procedure, it is straightened with the Asch forceps, or if dislocated, it is replaced in its groove.

Frontal fracture. A frontal fracture may result in separation and depression below the maxillary processes of the thin lower portion of the nasal bone. In more severe cases there is also depression of the upper portion of the nasal bone and infraction of the maxillary processes themselves. This type of fracture should be reduced early as scar tissue present after late reduction tends again to pull down the fragments. A crushed septum and associated fracture of the zygoma and maxillary bone are frequently present in this type of fracture. Reduction is accomplished by elevation of the fragments with the Joseph elevator from within, or the fragments may be rotated out with the Asch forceps. Pressure against the nasofrontal process of the maxilla at the base of the nose is important. If there is a failure of the fragments to maintain their position, it may be necessary to use the Kanzanjian head splint, the Brown method of through and through wire fixation through lead plates on either side of the nasal pyramid, or the Hilger method of fixation with a Kirchner wire. In some cases maintenance of elevation is almost impossible, and a later rhinoplasty must be carried out with implantation of cartilage along the depressed nasal dorsum.

Laterofrontal fractures. In the first of the two types of laterofrontal fractures, the nasal bone on the side of the blow overrides the opposite nasal bone and is locked under the frontal bone. In reducing this, it is necessary to depress further the superior portion of the nasal bone while applying pressure downward to unlock it from beneath the frontal bone. In another variation the nasal bone on the side of the blow may be depressed under the nasal processes and maxilla

with separation of the nasal bone. In this case the fracture may be treated as a lateral fracture. The opposite nasal bone is always depressed beneath the maxilla and usually can be elevated from within the nose while applying pressure on the maxillary process. In some cases the Asch forceps must be used to rotate the depressed nasal bones from beneath the maxillary process.

Fracture from below. Fracture from below results in a separation of the nasal bones which also override the frontal bone, resulting in an obliteration of the glabellar notch. Occasionally underriding occurs with increased glabellar angle. It is reduced by grasping the fragments with the Asch forceps, pulling them down, and molding them together with the fingers.

Recently an open reduction method by the rhinoplastic approach has been advocated for the therapy of all nasal fractures. This is done without waiting for swelling and acchymosis to subside. We have always been interested in any contribution which might better our method of handling cases and have tried this method. We believe that it has merit in certain severely comminuted cases, but in general there is no particular advantage in using it routinely, and it should be considered only occasionally in the therapy of fractures.

SUMMARY

Nasal fractures are one of the most common fractures encountered and are frequently poorly handled. Generally speaking, failure of perfect reduction is much more obvious than in any other type of fracture. In the management early reduction is always desirable. However, if the fracture is masked by swelling, late reduction is satisfactory, with delay as long as one week being perfectly permissible except in cases of children. It is desirable to apply internal and external fixation in all cases to prevent curling of the cartilage secondary to hematoma. Associated complications such as intracranial injuries, cerebrospinal rhinorrhea, and associated fractures of the maxilla and zygoma should always be looked for. Proper reduction and maintenance of fixation is almost always possible by the methods outlined. Finally, late reduction is possible by making intranasal incisions and breaking up osseous or fibrous union along the fracture lines with a chisel.

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ABSTRACT OF DISCUSSION

DR. CHARLES F. ENGELKING, San Angelo: We are all aware of the general principles in the treatment of nasal fractures, but I would like to emphasize them again. Seldom is hemorrhage an alarming factor, but it should be controlled by adequate pressure, external application of ice, use of intranasal tampons, or, if necessary, ligation. After hemostasis has been secured, the skin of the nose and face is cleansed with soap and water and wiped with ether, which I think is as good as pHisoderm, which the authors use, and may be more readily available than pHisoderm. I wish to stress again that all embedded foreign bodies or material such as road dust, grease, and tars should be carefully removed to avoid permanent tattoo marks after healing has taken place.

As the authors mention, all small bone and cartilage fragments should be preserved and should not be removed as they help to maintain the nasal contour and seldom undergo sequestration because of the good blood supply of the nose. The nasal fossae should be carefully cleaned and all blood clots and loose foreign bodies irrigated out with warm boric acid or a hydrogen peroxide solution. Displaced or even detached soft tissues should be carefully cleansed, returned to their normal locations, and sutured in place.

Superficial wound margins should be approximated with a Dermalon or an intradermic suture to minimize the final scar. If the skin loss is too extensive to permit direct approximation, the raw area may be covered with a skin graft taken from behind the ear, as the authors suggest, or I have used skin from the upper eyelid. In one instance where the ala of one side of the nose was completely absent and could not be found, I used the lobule of the ear for the defect and later strengthened it with a preserved septal cartilage implant with satisfactory results. In the case of a through and through wound opening into the nasal cavity, the mucous membrane and perichondrium require separate approximation. When the full thickness of the nose has been destroyed and skin grafts cannot be used, the skin should be sutured to the mucous membrane to prevent subsequent contraction and distortion.

Wounds seen after twelve hours are drained for twenty-four hours, after which time they are sutured, provided signs of infection are absent. The danger of infection should be controlled through the use of adequate sulfonamides and antibiotics given internally or locally.

If the patient is not observed until after marked edema and ecchymosis have set in, rather than subject the tissues to further trauma and predispose them to infection, it is advisable to wait three or four days for the swelling to subside. Cold compresses may hasten the process. If at all possible reduction of the fractured bones should not be delayed for more than seven to ten days, since after this period preliminary ossification will have taken place. It is true that fractures three or four weeks old can be reduced, as the authors state, but if fibrous union is present, it will require more than slightly increased pressure to overcome the pull of this fibrous union as well as the prolonged period of fixation and immobilization through the use of the Stent mold, head splints, or wire fixations. Repositioning of the cartilages, however, may be postponed for as long as three weeks if necessary, inasmuch as organization of these structures does not proceed as rapidly as that of bone.

The patient in shock certainly should be treated by appropriate measures simultaneously with the other factors besides his nasal fractures. Tetanus antitoxin and gas gangrene serum should be used in the same manner as for wounds in other portions of the body.

Other complications for which a physician should watch are osteomyelitis, abscess, and necrosis of the bones and cartilages. Should the emphysema and swelling persist for more than a week or ten days, a search should be made for

foreign bodies or sequestrums, which, if formed, must be removed.

Fractures of the septal cartilage are probably the most frequent and common fractures of the nose, and I believe the most important thing is to see if swelling of the septum is present and then to differentiate between the hematoma and septal abscess. Wide incision of the mucosa and mucoperichondrium is made in either case and a drain inserted for twenty-four hours and kept open daily with a spreading hemostat until swelling subsides. If this care is not given, the pressure may cause a necrosis of the cartilaginous septum and consequent sloughing. Of course if this occurs, a rhinoplasty with cartilaginous or bony implants will have to be done at a later date. Recently I have had 2 such cases of fracture of the cartilaginous septum with abscess formation, and in 1 the cartilage had completely sloughed except for a small margin along the dorsum. These patients were referred to me because of continued nasal obstruction several weeks following trauma to the nose.

ENDOSCOPIC OBSERVATION IN VARIOUS TYPES OF BRONCHIAL OBSTRUCTION

A Study of 50 Cases

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THERE are times when early bronchial obstruction does not manifest itself either subjectively or objectively. The degree of obstruction usually is a gauge as to the severity of the symptoms. When obstruction does manifest itself clinically, it does so in one of two ways, obstructive emphysema or obstructive atelectasis in the affected lung area supplied by that bronchus. This might be called effect rather than cause. So it is that the results of bronchial obstruction can be determined but the disease or disease entity producing the obstruction is not always apparent, though at times the history is almost entirely diagnostic.

Pasteur's[2] original contributions in 1890 on atelectasis started an almost continuous study which led to the present clarification of the subject. Jackson[7] added much to understanding the mechanism by which this condition developed.

Atelectasis may be conveniently divided into the following three separate types:[10] first, the compression state as occurs in pneumothorax, fluid and pus in the pleural cavity, or any condition preventing the lung or a portion of the lung from expanding; second, chronic inflammatory conditions preventing air from entering the lung due to fibrous tissue binding and contracting the lung; third, obstructive conditions which may be divided into two types. These types are peribronchial conditions as occur in tumors or lesions outside the bronchus but cause pressure on it, and endobronchial obstructive conditions as are found in foreign bodies, inflammations, new growths, or plugs of mucus in the bronchus.

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In order to understand the mechanism of this phenomenon developing in the lung as a result of bronchial obstruction, a little of the physiology of the tracheobronchial tree must be reviewed. The tracheobronchial tree is lined by a ciliated columnar epithelium. Hilding[3] has shown in experimental work on the trachea of chickens that this ciliary beat can produce a vacuum equal to 35 mm. of water when normal mucus occluded the trachea. From this experiment it is concluded that abnormal secretions retained in the bronchi may produce atelectasis by the constant pumping out of the air due to the ciliary beat, as well as by the fixed plugging and absorption of air below the area. Experimental atelectasis[1] has been produced in animals by tying the bronchus. Oxygen was absorbed in forty-five minutes, whereas it took nitrogen twenty-four hours.

The fact that the tracheobronchial tree has many normal movements (respiratory, pulsatory, deglutitory, and bechic[9]) differs from the fundamentals in the mechanics of engineering. Also the fact that we are dealing with gases, solids, and liquids at the same time makes the description as well as understanding more complicated. The fact that the trachea and bronchi elongate and dilate on inspiration and shorten and contact on expiration, increasing with the extent and force of respiration, tends to make this problem more complex than ever.

Emphysema of the segment, lobe, or lung may be the first sign of bronchial obstruction, and this phenomenon can occur only when the inlet to air is not obstructed but the outlet is either partially or completely obstructed. The next phase of obstruction is that of complete obstruction which always ends in atelectasis below the obstruction. Many times the

obstruction is the check valve type which does not permit air to enter the lung. More frequently, however, ingress to the flow of air does not occur until the cohesiveness and adhesiveness of secretions produce the complete bronchial obstruction. Bronchial obstruction producing atelectasis can be present from the onset.

The cough reflex or the "watch dog of the lungs"[6] is a further force which changes the mechanism. The normal forces which try to drive out exogenous and endogenous intruders from the lumen of the lower air passages are ciliary wafting, tussive squeeze, and bechic blast.

Again the impairment of these by destruction of the cilia, oversedation, paralysis of normal muscles of respiration, cerebral anesthesia due to toxicity, or general weakness due to debility increases the hazard in addition to the existing bronchial disease.

In the diagnosis of bronchial obstruction Holmes[5] stressed in addition to a complete history and physical findings, fluoroscopy and roentgenograms made with the patient upright at full inspiration and expiration as well as lateral films of the chest. He believed that the earliest sign is diminished density distal to the obstructed area.

Foreign bodies have offered the earliest and most interesting study of this subject. Jackson[8] was one of the first to recognize the mechanics of both obstructive atelectasis and emphysema.

REVIEW OF CASES

A review of 50 selected cases I treated is analyzed in this study to determine if there are any newer clinical concepts of bronchial obstruction (table 1).

TABLE 1.—*Types of Bronchial Obstruction in This Review.*

Types of Cases	No. Cases
Foreign body of the bronchus	
Seen within twenty-four hours	10
Seen from forty hours to nine months	7
Bronchogenic carcinoma	12
Mediastinal tumors	2
Tuberculosis of the bronchus and lung	4
Postoperative atelectasis	4
Inflammatory obstruction	5
Asthma	3
Post-tracheotomy	3
Total	50

Foreign Body of the Bronchus.—Of the cases of foreign bodies of the bronchus, 10 patients were seen within the first twenty-four hours; 6 of these showed emphysema of the affected side by roentgen ray, 2 showed atelectasis, and 2 did not show either atelectasis or emphysema, though 1 showed a radiopaque foreign body. All of these patients were children 5 years of age or younger.

Seven cases were seen from forty hours to nine months following the aspiration of the foreign body. Six of these cases were of children 3 years or younger and 1 of a 70 year old woman. Four of these patients showed atelectasis, 2 emphysema, and 1 no change on roentgen-ray study.

In the first group, when roentgen-ray evidence was that of emphysema or there was no apparent change in the aeration of the affected side over the unaffected side, the endoscopic findings always showed a bronchus free of inflammation and secretions. The foreign body did not completely or uniformly fill the lumen. This was especially noticed on inspiration. Frequently the foreign body moves to a lower level on inspiration and to a higher level on expiration until the bronchus clamps around it. In some instances of incomplete obstruction, the foreign body did not move at all.

One case is worthy of special mention since a tracheotomy was necessary to deliver the foreign body, a bean. Unquestionably, there must have been some swelling of the bean as it appeared to have been uncooked or only slightly so. This problem does not occur often, and I would not have believed it possible for swelling to occur to such an extent that the bean would not come through the subglottic larynx had not the forceps' hold been examined and an attempt made to remove it through the larynx after tracheotomy.

From the study of the 7 patients seen forty hours or later after aspiration, only 2 showed evidence of inflammation of the bronchus and only 1 of these showed real suppuration. All of those with atelectasis did show thick secretions in the region of the foreign body.

Another of these also offered a special problem because of the repeated stripping of the foreign body. It is believed that death was due to anoxia and a prolonged bronchoscopy. Reassembling the foreign body offered some explanation for the repeated stripping, which is believed to have been due to improper grasping of the foreign body.

A niche broken out of the side before aspiration allowed the half of a peanut to lie almost transversely with the niche fitting over the carina. This presented the problem of accurately aligning the foreign body with the bronchoscope. No doubt the foreign body was grasped slightly transversely rather than in a longitudinal manner. In retrospection, turning the peanut so that the niche would have been to the right would have made alignment better for grasping.

Roentgen-ray evidence is not always present in cases of foreign body in the bronchus. Sometimes the obstructive emphysema is so slight that it cannot be detected on expiratory or inspiratory films. In cases in which the clinical picture and the history are strongly suggestive of obstructive emphysema and the

roentgen ray does not confirm the suspicion, a bronchoscopy should be done.

Bronchogenic Carcinoma.—In the group of 12 cases of bronchogenic carcinoma, 5 were definitely diagnosed as carcinoma by bronchial biopsy before thoracotomy. All of these were in the major bronchi. Though all cases showed considerable bronchial obstruction, the amount of atelectasis noted by roentgen ray was surprisingly small. Little study by the roentgen-ray department was undertaken to determine the amount of segmental emphysema. It seems from the findings that as a bronchus becomes more rigid, even though the lumen diminishes in size, it does not decrease in size with expiration as does the normal bronchus.

Seven cases showed definite bronchial obstruction of the segmental lobe bronchi, but no tissue was seen or recovered which represented tumor. One of these cases, however, was of a large bronchus, but no tumor tissue was recovered. This lung showed evidence of emphysema with an increase in density of the hilar mass. All the other cases showed atelectasis of varying degrees, as one would expect from the bronchoscopic findings in which the segmental bronchus appeared to be completely occluded. In 4 of the cases a study of the lung, after it was removed surgically, bore out the endoscopic findings.

Mediastinal Tumors.—Two cases representing mediastinal tumors caused partial bronchial obstruction. In both of these there was definite pressure on the main stem bronchus, not of sufficient degree to produce atelectasis but enough to produce emphysema. One of these was proved at surgery to be lymphoblastoma; the other was thought to be some type of malignant lymphoma by clinical response to roentgen-ray therapy. The rather rounded type of projection into the lumen was almost entirely diagnostic of a mediastinal tumor.

Tuberculosis of the Bronchus and Lung.—Two cases showed a definite endoscopic picture of bronchial obstruction due to peribronchial disease as well as endobronchial disease. In spite of the suspected tuberculosis, it could not be proved by either multiple sputum examination or endoscopic biopsy in either case. Presumably in most of these cases with peribronchial masses and obstruction, secondary infection involves the bronchial mucosa in the major bronchi and obscures the deeper disease.

Two other cases are interesting because of the early age of the patient with tuberculous involvement. In both, the physical findings of bronchial obstruction were manifested clinically by emphysema of the affected side. In 1 case the obstruction was due to a caseous mediastinal lymph gland eroding into the bronchus, and in the other the findings were that of bronchitis. The underlying disease causing the obstruction was not suspected in either case until the bronchoscopy was done.

Postoperative Atelectasis.—Sometimes known in the past as "ether pneumonia," postoperative atelectasis is still common in spite of the frequent use of intratracheal anesthesia followed by aspiration of the tracheobronchial tree. Four cases are typical examples of postoperative atelectasis. In several instances no doubt atelectasis was due to surgery following too closely an acute bronchitis. The findings endoscopically are typical when there is massive collapse. The bronchus is usually filled with a rather thick type of secretion. Ordinarily when this secretion is removed and marked sedation, as was manifested in these cases, is discontinued, there is no recurrence. In all of these cases in which the affected lung had become atelectatic, even on coughing, there was some movement of the secretion seen at endoscopy, but never enough to dislodge it into the trachea.

Inflammatory Obstruction.—Two cases represent the so-called unresolved pneumonia described by Holinger.[4] Typical of the endoscopic picture, especially in 1 of these, was the thick globule of mucus which on expiration bulged out into the main stem lumen and disappeared on inspiration. In the other there is a question as to the cause except to call it inflammatory in nature. Too much time had elapsed from the onset to make the picture clear. An inflammatory exudate, however, filled the segmental bronchus.

Another case also represents an inflammatory lesion at the time of endoscopy, though the age of the patient and history were strongly suggestive of a carcinoma.

There were 2 cases of aspiration of irritating fluids which caused an inflammatory reaction of many of the smaller bronchi as well as the major bronchi. This was sufficient to cause definite expiratory wheezes as evidence of bronchial obstruction. The endoscopic picture showed a reddened mucosa throughout with edema of the orifices of some of the secondary bronchi.

Asthma.—The crescent shaped bronchus seen on expiration in the asthmatic patient was demonstrated in 3 cases, all of which were of chronic asthma patients. In 1 of these, in addition to the asthma, the patient had a massive atelectasis. The red mucosa was indicative of a secondary infection.

All of these cases showed considerable mucus in the larger bronchi, but most of the secondary bronchi, especially the orifices, were swollen.

Post-Tracheotomy.—Bronchial obstruction after tracheotomy, in acute laryngotracheobronchitis, ordinarily does not and should not occur. Sometimes,

however, when the factor of humidity is not well controlled, because of nursing laxity and poor humidification equipment, severe symptoms appear as a result of crusting. One case represents a problem of partial pneumothorax with increasing respiratory difficulty. The differentiation could not be made between emphysema and pneumothorax until bronchoscopy revealed the crusts which had produced an obstructive emphysema on the opposite side of the pneumothorax. The obstruction could be seen on expiration through the bronchoscope when the bronchus closed around it. Another case showed practically the same findings on each side and was identical except for the absence of pneumothorax.

The last case represents a type of atelectasis which develops in those persons who have lost the muscular power to breathe or those poliomyelitis patients who have bulbar paralysis as well as the respiratory form and must have a tracheotomy. These patients, especially if they have a great deal of secretion, frequently develop atelectasis on the left side because the tracheal suction nearly always enters the right main bronchus. Any patient who has been doing well and for some unexplained reason shows sign of cyanosis even with all mechanical equipment in order, must have a bronchoscopy to eliminate early bronchial obstruction on the left side. A number of these cases have been observed.

SUMMARY

A study of 50 cases of bronchial obstruction is presented.

Early cases of obstruction by foreign bodies are likely to produce an obstructive emphysema. Foreign bodies that have been present for some time are likely to produce an obstructive atelectasis due to secretions which form secondary to infection.

Tumors also are likely to produce obstructive emphysema early rather than atelectasis. A surprisingly small number of patients had a positive biopsy. Bronchial obstruction could be seen in all patients, either directly or by the right angle telescope. Papanicolaou smears and washings were entirely disappointing in these cases, though the pathology department was not well equipped at that time to do exhausting studies.

Tuberculosis of the lung in the child, when causing bronchial obstruction, may be due to primary disease of the mediastinal glands or bronchus. Two such cases are summarized.

Postoperative atelectasis, inflammatory obstruction, asthma, and post-tracheotomy bronchial obstruction offer no new bronchoscopic problems. Poliomyelitis patients who show signs of increasing difficulty are in respirators after having been tracheotomized and should have a bronchoscopy to rule out a left side obstruction due to secretion.

It is recommended that all early patients with suspected primary bronchial obstruction or segmental bronchial obstruction have roentgenograms made on inspiration and expiration. This may give some early evidence of bronchial obstruction manifested by emphysema.

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MIGRAINE HEADACHES IN BABIES

A New York physician says in the July *American Journal of Diseases of Children* that babies as young as two weeks old can suffer migraine headaches. Dr. Jerome Glaser, Rochester, stated that symptoms of infant migraine headaches are much like those for adults, but a positive diagnosis cannot be made until the child is old enough to describe his feelings. He said that in children the condition may be due to an allergy, particularly to such foods as chocolate, eggs, wheat, and milk.

Dr. Glaser said that a child may be unusually restless the night before a headache and show a gradual temperature rise up to 104 degrees in the morning. Other symptoms he listed are distended abdomen; dizziness; bad breath; and a definite change of behavior to sadness, excessive gaiety, or definite irritability. Even though one of the most common causes is eye trouble, Dr. Glaser said that many suffer because of allergy to certain foods.

Long-Acting Penicillin for Infections

One shot of a new long-acting penicillin can replace multiple injections of penicillin, tests on patients with infections from burns, compound fractures, and surgery show.

Dr. John F. Hankins and George H. Yeager, Baltimore, have tested 46 patients and report in the August 7 *Journal of the American Medical Association* that the one-shot treatment controlled infection in all of the patients. Benzathine penicillin G has already been found useful for treating infections accompanying rheumatic fever, for children with streptococcic infections, and for gonorrhea, the physicians say.

CASE REPORTS

A New Uretero-Intestinal Anastomosis for Use in Pelvic Evisceration

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THE operation of total pelvic evisceration has been employed by us since 1949.[1] The majority of the patients suffered from advanced carcinoma of the cervix that had not responded to adequate irradiation. Pelvic evisceration entails the removal, in one large mass, of the uterus, tubes, ovaries, broad ligaments, all lymph node bearing tissue, the bladder, the lower ureters, the rectum, the pelvic diaphragm, the levator muscles, the vagina, the anus, and the external genitalia. Of 9 patients subjected to exploratory procedures, 2 were inoperable because of massive involvement of the aortic chain, invasion of the iliac vessels, or both.

Of the remaining 7 patients, 3 have since died from recurrence of their disease. The remaining 4 are alive and apparently free of disease at the present time. The longest time elapsed is four years, and the least, one year.

The techniques used in these procedures have varied for reasons of expediency. Some measures have evolved from the work of others in this field. In the diversion of the urinary stream, our inclination had been to implant the ureters into the sigmoid colon 5 inches from the colostomy opening on the abdominal wall. This left the patient with a "wet" colostomy which was managed by a Rutzen bag.

In the long-term after-care of these women, repeated episodes of urinary infection of varying intensities have occurred, usually manifested by chills and fever, and at times accompanied by pain in the flank.

This brief report is prompted by the satisfactory results obtained in 1 of these patients who was operated upon in July, 1952. In this instance, after division of the sigmoid colon was done, the open end of the proximal segment was closed, and a loop 10 inches from this cut end was brought out through a separate incision in the left midabdomen as a double-barrelled colostomy over a glass rod. The ureters were then implanted into the side of the sigmoid distal to the colostomy (fig. 1). Although this still leaves a "wet" colostomy, the fecal stream no longer passes over the ureters, thus minimizing the opportunity for retrograde urinary infection. The small pouch of bowel just distal to the colostomy now acts as a minor reservoir for the urine, and does allow the patient some freedom from the use of the Rutzen bag while bathing, changing clothes, and cleaning the colostomy equipment. Because of the relatively small absorptive surface of the colonic pouch, not enough reabsorption of nitrogenous end-products has occurred to alter the nonprotein nitrogen or the chloride concentration in the blood.[2]

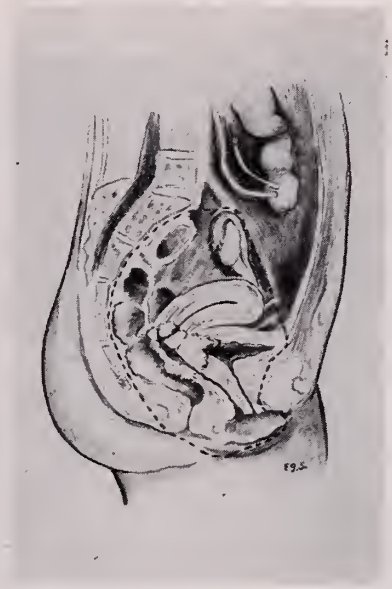

FIG. 1. The ureters are implanted into the blind sigmoid pouch. The area resected is outlined by a dotted line.

CASE REPORT

Mrs. R. E. S., a 41 year old woman, was first known to have a carcinoma of the cervix in May, 1950, when a biopsy was made of an ulcerating cervical lesion. She received irradiation, exact amount not known, but the lesion did

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not completely regress. Five months later she received further irradiation by the insertion of radium needles.

Because of persistence of the ulcerated lesion, the finding of a mass in the soft tissues of the pelvis, and the further formation of a rectovaginal fistula, an exploration was done in July, 1951. At this time the growth was considered inoperable, and a colostomy done.

When first seen at the Fort Worth Clinic, the patient was emaciated, weighed 71 pounds; had a profuse, irritating vaginal discharge; and was using daily 2.5 grains of morphine, which still failed to relieve completely her pain. Two biopsies failed to show the carcinoma, but because of the attendant radionecrosis, this was not surprising.

A roentgen-ray survey of the chest, pelvis, and kidneys was done. No metastatic involvement was found, but bilateral hydro-ureter was noted. An advanced microcytic anemia was present. Serologic studies were positive for syphilis. There was a moderate decrease in the circulating blood volume. The remaining laboratory results were normal.

On July 28, 1952, after the usual preparation of the bowel and correction of the diminished circulating blood volume, a total evisceration was done with removal of the uterus, ovaries, tubes, broad ligaments, bladder, lower ureters, lower sigmoid colon, pelvic diaphragm, levator muscles, vagina, anus, and external genitalia.

After division of the sigmoid colon, the proximal end was closed, and the ureters were implanted into the side of the bowel, distal to the colostomy. A short tunnel was formed through the muscular coats of the colon, and the ureters were left with more than .25 inch projecting within the mucosa of the bowel.

The pathologist reported areas of viable carcinoma in the broad ligaments, the urinary trigone, and at the site of the rectovaginal fistula.

The postoperative course was in no way unusual for this operation. There was a sustained fever of 103 F. the first two days and considerable bloody drainage through the large perineal defect, but severe shock was not encountered. Five pints of blood were used during the operation, and a pint on each of the first two postoperative days.

Morphine requirements from the first day did not exceed 1 grain total, less than half of the preoperative need. In three weeks codeine was substituted. The patient has used no narcotics of any kind since April 12, 1953. Her perineal wound closed at that time.

Ten months postoperatively, on May 20, 1953, blood studies were normal, and pyelograms (fig. 2) were almost normal. Shortly after this visit the patient returned to work. At no time in the entire course has there been an episode suggestive of pyelitis.

SUMMARY

An instance of pelvic evisceration is presented in which the ureters were implanted into the blind loop of sigmoid distal to the double-barrelled colostomy.

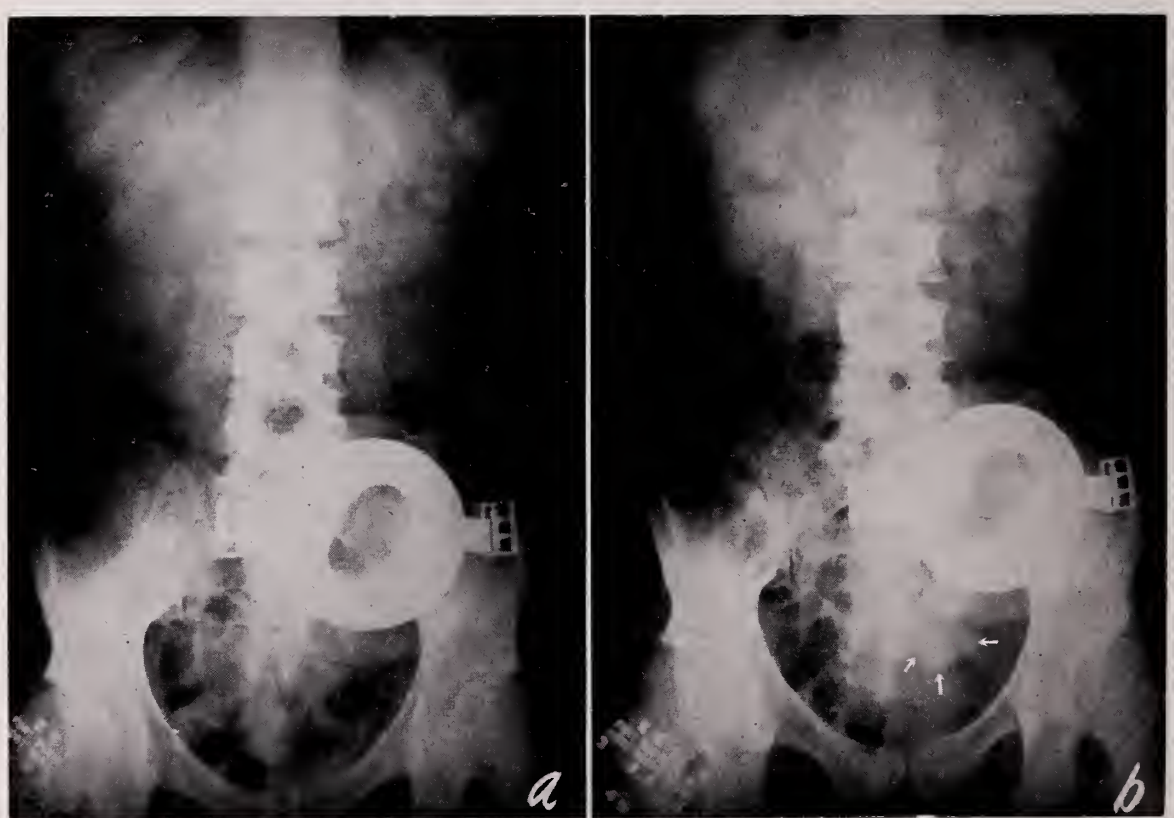

FIG. 2a. A plain kidney, ureter, and bladder roentgenogram of the abdomen, with the Rutzen bag in place, made eight months postoperatively.

b. The blind pouch of sigmoid into which both ureters drain can be seen as a lobulated mass just below the Rutzen bag. This intravenous pyelogram also indicates the function of both kidneys.

Management of the colostomy was facilitated and no urinary infections have appeared in one year's time. There has been no disturbance of nitrogen or chloride levels in the blood. The patient is well, working, and without evidence of recurrence as of March 25, 1954.

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NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, Fort Worth, April 24-27, 1955. Dr. F. J. L. Blasingame, Pres.; Mr. N. C. Forrester, 1801 Lamar Blvd., Austin, Executive Secy.

American Medical Association, Miami, Fla., Nov. 30-Dec. 3, 1954. Dr. Walter B. Martin, Norfolk, Va., Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice, Los Angeles, March 28-31, 1955. Dr. W. B. Hildebrand, Menasha, Wis., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. Bayard Carter, Durham, N. C., Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Atlantic City, N. J., April 24-26, 1955. Dr. Edward S. Welles, Saranac Lake, N. Y., Pres.; Dr. Paul C. Samson, 3959 Happy Valley Rd., Lafayette, Calif., Secy.

American Association of Genito-Urinary Surgeons, Monterey, Calif., May 22-25, 1955. Dr. Fletcher H. Colby, Boston, Pres.; Dr. John A. Taylor, 2 E. 45th St., New York 22, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 9-11, 1954. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Chicago, April 25-30, 1955. Dr. Homer Prince, Houston, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, Atlantic City, N. J., June 2-5, 1955. Dr. William A. Hudson, Detroit, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Philadelphia, April 25-29, 1955. Dr. C. C. Sturgis, Ann Arbor, Mich., Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 4, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-19, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress on Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chairman.

American Congress of Physical Medicine and Rehabilitation, Washington, D. C., Sept. 6-11, 1954. Dr. William B. Snow, New York, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Belleair, Fla., April 17-21, 1955. Dr. Richard S. Weiss, St. Louis, Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, Atlantic City, N. J., June 4-5, 1955. Dr. Dwight L. Wilbur, San Francisco, Pres.; Dr. H. Marvin Pollard, University Hosp., Ann Arbor, Mich., Secy.

American Gynecological Society, Quebec, Canada, May 23-25, 1955. Dr. Philip F. Williams, Philadelphia, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, New Orleans, Oct. 26-30, 1955. Dr. E. Cowles Andrus, Baltimore, Pres.; Mr. Irving Hexter, 44 E. 23rd St., New York 10, Secy.

American Hospital Association, Chicago, Sept. 13-16, 1954. Mr. Ritz E. Heerman, Los Angeles, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Hollywood, Fla., March 15-17, 1955. Dr. Kenneth M. Day, Pittsburgh, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Chicago, June 13-15, 1955. Dr. Percival Bailey, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, W. Sulphur Springs, W. Va., June 2-4, 1955. Dr. Everett L. Goar, Houston, Tex., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, W. Sulphur Springs, W. Va., June 19-22, 1955. Dr. J. Warren White, Honolulu, Hawaii, Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Quebec, Canada, June 13-17, 1955. Dr. Alfred H. Washburn, Denver, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, New York, June 1-4, 1955. Dr. A. W. Martin Marino, Brooklyn, N. Y., Pres.; Dr. Karl Zimmerman, 3500 Fifth Ave., Pittsburgh 13, Secy.

American Psychiatric Association, Atlantic City, N. J., May, 1955. Dr. Alfred P. Noyes, Norristown, Pa., Pres.; Dr. William Malamud, 80 E. Concord St., Boston 18, Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Cincinnati, Oct. 25-30, 1954. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists, Washington, D. C., Sept. 6, 1954. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Philadelphia, April 27-29, 1955. Dr. John H. Gibbon, Jr., Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, Los Angeles, May 16-19, 1955. Dr. W. Joseph McMartin, Omaha, Neb., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Delegates Interim Meeting, Chicago, Oct. 1-2, 1954. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter, Chicago, Sept. 7-10, 1954. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Milwaukee, May 23-27, 1955. Dr. John H. Skavlem, Cincinnati, Pres.; Mrs. Morrell DeReign, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nashville, Pres.; Dr. George Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, Oct. 21, 1954. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, Nov. 17-19, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Oklahoma City, Sept. 20-22, 1954. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secy.

Tri-State Medical Assembly, Fall, 1954. Dr. Joe D. Nichols, Atlanta, Pres.; Dr. Broox C. Garrett, 940 Margaret Pl., Shreveport, La., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice, Galveston, Sept. 9-11, 1954. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris. 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 11-12, 1954. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association. Dr. J. S. Minnett, Dallas, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, Fort Worth, April 24, 1954. Dr. Howard E. Smith, Austin, Pres.; Dr. John Wiggins, 1707 Medical Arts Bldg., Fort Worth, Secy.

Texas Club of Internists. Victor E. Schulze, San Angelo, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, Fort Worth, April 24, 1955. Dr. Paul H. Power, Waco, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, Fort Worth, April 4, 1955. Dr. George M. Jones, Dallas, Pres.; Dr. Hugo Engelhardt, P. O. Box 2180, Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Geriatric Society, Fall, 1954. Dr. Henry H. Niehuss, Longview, Pres.; Dr. Frank V. Mondrik, 214 Bramlette Bldg., Longview, Secy.

Texas Heart Association, Fort Worth, April 25, 1955. Dr. George R. Herrmann, Galveston, Pres.; Mr. Edgar M. Brown, Jesse H. Jones Library Bldg., 1133 M. D. Anderson Blvd., Houston, Executive Director.

Texas Hospital Association, Houston, April 12-14, 1955. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropyschiatric Association, Galveston, Oct. 24-25, 1954. Dr. Edgar S. Ezell, Fort Worth, Pres.; Dr. Bruce H. Beard, 1519 Pennsylvania, Fort Worth, Secy.

Texas Orthopedic Association, Fort Worth, April 25, 1955. Dr. Brandon Carrell, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, Oct. 22-23, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society. Dr. Jack Kerr, Dallas, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 13-16, 1955. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Soicety, Houston, Jan. 21-22, 1955. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, Fort Worth, April 25, 1955. Dr. Raleigh White, Temple, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred W. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Mineral Wells, 1955. Dr. Charles N. Burrows, San Antonio, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 3, Executive Secy.

Texas Society of Anesthesiologists, Fort Worth, April 24, 1955. Dr. Frank O. Barrett, El Paso, Pres.; Dr. Milton M. Rosenzweig, 200 Wildwood Dr. E., San Antonio, Secy.

Texas Society of Gastroenterologists and Proctologists, Fort Worth, April 25, 1955. Dr. Charles Hardwicke, Austin, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, Dallas, Jan. 30, 1955. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Galveston, April 15-16, 1955. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 208 E. Ninth, Austin, Executive Secy.

Texas Urological Society, Corpus Christi, 1954. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg., Corpus Christi, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society. Dr. John R. Mast, Midland, Pres.; Dr. M. J. Loring, 304 North N St., Midland, Secy.

Third District Society, Borger, April, 1955. Dr. M. C. Overton, Jr., Pampa, Pres.; Dr. William Klingensmith, 215 Fisk Bldg., Amarillo, Secy.

Fourth District Society, San Angelo, Oct. 21, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi. Dr. John J. Sloan, Corpus Christi, Pres.; Dr. E. Jackson Giles, 705 Medical-Professional Bldg., Corpus Christi, Secy.

Seventh District Society. Dr. William McLean, Austin, Pres.; Dr. John Rainey, 1709 San Antonio, Austin, Secy.

Eighth District Society, Victoria, September 23, 1954. Dr. Howard Z. Fretz, Wharton, Pres.; Dr. George E. Glover, Jr., Victoria, Secy.

Ninth District Society. Dr. Thomas H. Giddings, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. John M. White, Port Arthur, Pres.; Dr. Rider Stockdale, Jasper, Secy.

Eleventh District Society, Jacksonville, Oct. 27, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society. Dr. Neil Buie, Marlin, Pres.; Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society, Abilene, March 2, 1955. Dr. Mal Rumph, Fort Worth, Pres.; Dr. Robert D. Morteon, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society. Dr. J. David Thomas, Denton, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Mount Pleasant, 1955. Dr. R. L. Johnson, Mount Pleasant, Pres.; Dr. R. L. Hardman, Mount Pleasant, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 14-17, 1955. Dr. Lawrence B. Sheldon, Dallas, Pres.; Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco. Dr. Ross Shipp, Waco, Pres.; Dr. Milton Spark, 3805 Herwal, Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 7-10, 1955. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference, Wichita Falls, Sept. 22, 1954. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls, April, 1955. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences, Austin, Oct. 22-23, 1954. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, Dec. 2-4, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

American Fracture Association

The annual meeting of the American Fracture Association will be in Houston, October 11-14. Dr. Henry W. Meyerding, Rochester, Minn., president, will preside. Formal essays, panel discussions, and group round table discussions on various phases of fracture treatment will be included on the program.

Texas Hospital Association

The silver jubilee convention of the Texas Hospital Association was held in Houston, May 18-20. Officers elected were Boone Powell, Dallas, president-elect; D. S. Riley, Big Spring, vice-president; and H. M. Cardwell, Lufkin, treasurer. John G. Dudley, Houston, was installed as president.

Among the speakers were Dr. F. J. L. Blasingame, Wharton, President of the Texas Medical Association; Dr. Everett C. Fox, Dallas; Dr. Frank R. Bradley, St. Louis; Dr. Edwin L. Crosby, Baltimore; and Dr. Merrill F. Steele, Cincinnati.

Other organizations meeting at the time of the Hospital Association were the Texas Association of Medical Record Librarians, Texas Association of Nurse Anesthetists, Texas Conference of the Catholic Hospital Association, and Texas Association of Hospital Auxiliaries.

Southwest Cancer Conference

Immediately preceding the meeting in Fort Worth of the Texas Pediatric Society, the Eighth Annual Southwest Regional Cancer Conference will be held on October 21 with "Tumors of Infants and Children" as the subject. Except for a clinic which will be held at the Fort Worth Academy of Medicine building at 8 p. m., the conference is scheduled for the Hotel Texas from 9 a. m. to 5 p. m., including a luncheon and round table discussion.

Guest speakers will be Dr. Robert M. Moore, professor of surgery and chairman, Department of Surgery, University of Texas School of Medicine, Galveston; Dr. Edith L. Potter, pathologist, Chicago Lying-In Hospital, and pathologist-in-chief, Chicago Health Department, Chicago; and Dr. Martin H. Wittenborg, assistant clinical professor of radiology, Harvard Medical School, and radiologist, Children's Hospital, Boston.

Dr. Moore will speak on "Congenital Teratomata" and "Surgical Management of Tumors in Children." Topics to be discussed by Dr. Potter are "Tumors of Childhood" and "Resumé of Selected Tumor Cases." Dr. Wittenborg's discussions will be on "Radiological Aspects of the Diagnosis of Tumors of Infants and Children" and "Radiological Aspects of the Treatment of Tumors of Infants and Children."

The evening clinic will consist of the presentation and discussion of tumor cases by the guest speakers and by visitors.

There is no registration fee for the conference, the program for which was planned by Dr. John L. Wallace, chairman of the Tarrant County Cancer Committee.

Physician-Owned Pharmacies Decried

The Board of Councilors of the Texas Medical Association has given its wholehearted approval to a resolution adopted by the Texas Pharmaceutical Association at its diamond jubilee convention in San Antonio, July 25-28. The resolution, reflecting the attitude of the 3,000 members of the druggists' organization, follows:

"*Whereas,* the principles of medical ethics provide that an ethical physician does not engage in barter or trade in the appliances, devices, or remedies prescribed for patients, but limits the sources of his professional income to professional services rendered the patient, and

"*Whereas,* the Judicial Council of the American Medical Association has ruled that it is unethical for a physicain to have a financial interest in a pharmacy in the area in which he conducts his professional activities and where he profits directly or indirectly from the sale of devices or remedies prescribed for his patients, and

"*Whereas,* this is particularly true when the services of other reputable pharmacies are readily available, and

"*Whereas,* the question of rental of space to a pharmacist in a clinic or office building owned or leased by physicians, when such space is rented to pharmacists on a sliding scale or a percentage of the income received by the pharmacy, is equivalent to receiving a rebate from the prescription and is, therefore, unethical in accordance with the ruling of the Judicial Council of the American Medical Association, and

"*Whereas,* the continued trend of physician-owned clinic pharmacies is disruptive to the long cherished necessity for cooperation between the healing arts, therefore,

BE IT RESOLVED, by the 75th Annual Convention of the Texas Pharmaceutical Association that physician-owned clinic pharmacies are not considered to be ethical or in the best interest of medicine and pharmacy in Texas, and that a copy of this resolution be forwarded to the Texas Medical Association for promulgation to its membership, and that copies of the resolution also be forwarded to drug industry publications for dissemination to all registered pharmacists in this State."

PERSONALS

Dr. R. K. Daily, Houston, and *Dr. Gaynelle Robertson,* Texas City, recently presented papers at the Interim Congress of the Pan American Association of Ophthalmology in Sao Paulo, Brazil. They also spoke in Buenos Aires at the meeting of the Argentina Oto-Neuro-Ophthalmological Association.

Commemorating the fiftieth anniversary of the voluntary tuberculosis control movement, *Dr. W. M. Brumby,* Houston, organizer of the Texas Tuberculosis Association in 1908, was honored with a bronze medallion by the board of directors of that group at their July 25 meeting.

Dr. Elliott Mendenhall, Dallas, has been appointed to the advisory board of the American Trudeau Society. Dr. Mendenhall is currently vice-president of the Texas Tuberculosis Association and chairman of its committee on public information.

Dr. Edmond K. Doak, Houston, recently has been appointed to represent Texas on the newly-created Board of Governors of the American Diabetes Association.

Dr. Joseph F. McVeigh, Fort Worth, was given a watch as a momento of appreciation and devotion for twenty-six years as adviser to the faculty of St. Joseph's Hospital's School of Nursing in a surprise ceremony during July.

Dr. John Tunnel, Taft, spoke to the Aransas Pass Lions Club on "Snakes" recently. Dr. Tunnel has studied snakes as a hobby since his boyhood.

Dr. Joe D. Nichols, Atlanta, spoke to the San Antonio Rotary Club on "Some Occupational Diseases of Business Executives" on July 23.

Dr. James Holman, Dallas, and Nancy Jane Holmes, D. D. S., were married July 19 in Dallas.

Dr. and Mrs. J. C. Watkins, Harlingen, were honored with a dinner-dance by the Cameron-Willacy Counties Medical Society on June 29, commemorating the couple's golden wedding anniversary and the doctor's fiftieth year of practicing medicine.

The bulletin of the Alumni Association of the University of Texas Medical Branch, Galveston, lists *Dr. and Mrs. C. R. Goodwin,* Nederland, as recent parents of a girl, and *Dr. Leon Kopecky and Dr. Ina Moodie Calhoun Kopecky,* San Antonio, as parents of a boy, born May 23.

Miss Elizabeth Dingham and *Dr. Felix Shepley,* Wichita Falls, were married on August 6 in New York City.

"Military forces are not a substitute for civil defense. We regard civil defense as a co-equal partner with the military in the defense of the nation."—Secretary of Defense Robert A. Lovett.

Oklahoma City Clinic

The Twenty-Fourth Annual Fall Conference of the Oklahoma City Clinical Society will be held October 25-28. Lectures and discussions by sixteen guest speakers and an address by Dr. Walter B. Martin, Norfolk, Va., President of the American Medical Association, are included in the four day postgraduate teaching program. General assemblies, panel discussions, and daily luncheon round table question and answer sessions will also be included. Dinner meetings, a dinner-dance, and a stag smoker will constitute the entertainment planned for the members. All physicians who are members of a county medical society are invited to attend the clinic.

The guests participating in the teaching program are Dr. George C. Adie, New Rochelle, N. Y.; Dr. Herbert S. Alden, Atlanta; Dr. L. Henry Garland and Dr. Ralph Soto-Hall, San Francisco; Dr. Arnold S. Jackson and Dr. William S. Middleton, Madison, Wis.; Dr. William O. Johnson, Louisville; Dr. Russell J. Blattner, Houston; Dr. William J. Dieckmann, Chicago; Dr. Lloyd G. Lewis, Washington, D. C.; Dr. John J. Modlin, Columbia, Mo.; Dr. James L. Poppen, Boston; Dr. William G. Sauer and Dr. K. M. Simonton, Rochester, Minn.; Dr. David E. Smith, St. Louis; and Joseph F. Volker, D.D.S., Birmingham, Ala.

Additional information may be obtained from the executive secretary, 503 Medical Arts Building, Oklahoma City.

TUMOR SEMINAR

The annual Tumor Seminar sponsored by the San Antonio Society of Pathologists in conjunction with the College of American Pathologists and the Texas Division of the American Cancer Society will be held on November 6 at Brooke Army Hospital, Fort Sam Houston.

The meeting will be devoted to the pathology of bone tumors, brain tumors, and genitourinary tumors, and radiation reaction. The speakers will be from the Armed Forces Institute of Pathology and will include Gen. Elbert DeCoursey, director, who will discuss radiation reaction; Dr. Webb E. Haymaker, chief of the neuropathological section; Dr. Lent C. Johnson, chief of the orthopedic pathology section; and Dr. Fathollah K. Mostofi, chief of the genitourinary pathology section.

Dr. A. O. Severance, Baptist Memorial Hospital, San Antonio 2, can give details concerning the meeting.

POLIOMYELITIS CASES

Poliomyelitis cases nationally are running 7 per cent behind the total reported through July of last year, the United States Department of Health, Education, and Welfare has announced.

For the first seven months of this year, 9,185 reported cases compare with 9,840 cases for the same period in 1953. Both years are below the 10,582 record number of cases reported during the first seven months in 1952.

More than one-third of the cases have been in three states this year. They are California, 1,525 cases; Texas, 1,400; and Florida, 619. By the same time in 1952, Texas had reported more than 2,000 cases.

Druggists to Meet in Houston

The first convention in Texas of the National Association of Retail Druggists will be held in Houston October 10-12. This will be the fifty-sixth annual meeting of the association. Among the speakers will be Congressman Sam Rayburn, Democratic leader of the House of Representatives, and Mr. C. W. Crawford, Commissioner of Food and Drugs, United States Department of Health Education, and Welfare.

Postgraduate Study at San Angelo

The University of Texas Postgraduate School of Medicine, San Angelo Division, is offering a series of courses to be held the second Sunday of each month from September through May, 1955. Part one of the program, the first hour, is a clinical pathologic conference, with case material supplied from the M. D. Anderson Hospital and Tumor Institute, Houston. Taught by Dr. Lloyd R. Hershberger, San Angelo, part one gives nine credit hours. Part two, clinical seminars, offers fourteen hours' credit.

On September 12, the subject for the second part of the course was "Management of Peripheral Vascular Disorders." The remaining schedule for the second hour is as follows: October 1, "Recognition and Management of Common Hematological Problems by the General Practitioner"; November 14, "Care of the Newborn"; and December 12, "Head Injuries." The 1955 subjects and dates will be January 9, "Management of Fractures in General Practice"; February 13, "Obstetrical Emergencies"; March 13, "Management of Burns in General Practice"; April 10, "The Use and Abuse of Antibiotics"; and May 8, "The Acute Abdomen."

Dr. John E. Ballard, San Angelo, will be the radiologist in charge of part three of the program, fundamentals of roentgen-ray interpretations. September and October programs are on the chest; November and December, gastrointestinal tract; January, urology; February, skull; March, spine; April, extremities; and May, therapy.

SOUTHWESTERN POSTGRADUATE COURSE

Southwestern Medical School of the University of Texas and the Dallas Southern Clinical Society will sponsor a postgraduate course for physicians on "Recent Advances in Internal Medicine." The course will be held October 4-6 at Dallas, with meetings from 9 a. m. to 5 p. m., and twenty-one credit hours will be given members of the American Academy of General Practice.

Instructors for the program will be Drs. Carleton B. Chapman, Alfred W. Harris, H. M. Winans, Sr., Donald W. Seldin, D. O. Shields, William F. Miller, John S. Chapman, and E. E. Muirhead.

Also there will be Drs. Donald A. Sutherland, Paul J. Thomas, A. I. Braude, Charles B. Shuey, Albert M. Tocker, William C. Grater, James B. Howell, Arthur G. Schoch, and W. Grady Reddick. Drs. Howard C. Coggeshall, Leonard L. Madison, John S. Bagwell, T. Haynes Harvill, Cecil O. Patterson, and M. O. Rouse will also teach the course.

Registration for the course is $5, and tuition is $25. The fees should be sent to the office of the dean, Southwestern Medical School, 2211 Oak Lawn Avenue, Dallas 19.

HOUSTON POSTGRADUATE COURSE

Baylor University College of Medicine and the University of Texas Postgraduate School of Medicine will offer a course in "The Growth and Development of the Child in Relation to Parents and Physicians," November 5-7. The course will be taught by Dr. Frances L. Ilg, co-director of the Gesell Institute of Child Development, and Dr. Harry Backwin, a psychiatric pediatrician and head of the Department of Pediatrics of New York University.

The Institute will be held at the Texas Children's Hospital Auditorium, Texas Medical Center, Houston, with sessions from 10 to 12 a. m. and 8 to 10 p. m. on November 5, 6, and 7. Each afternoon from 2 to 4 p. m. local psychiatrists and members of ancillary professions will take up detailed and specific questions that may arise. Dr. Russell Blattner, Dr. David Mendell, and Dr. David Vinson, Houston, are the local group directing the course, and Dr. Mendell will be the moderator for the panel and group programs.

CONTAGIOUS DISEASES IN CHILDREN

Basing his conclusions on a twelve-year study of children from 125 New York families, Dr. Nathan Epstein reported in the May *American Journal of Diseases of Children* that children are more likely to get contagious diseases at about 5 years of age than any other time.

However, the children experience upper respiratory infections at an even rate from birth to 12 years, Dr. Epstein said. The study shows that a child has about one out of five chances of being free from upper respiratory infections during any year, but between the ages of 10 and 12 the chance is one in three. He stated that 2 of 3 children experienced one or more mild upper respiratory infections during any year. Of the 200 children studied, each averaged one or two mild and one severe infection a year, regardless of age, the physician stated.

Hospital Grants

The status of all Hill-Burton hospital construction in Texas on June 30 included ninety-nine projects completed and in operation, thus providing 5,852 additional hospital beds. The total cost of $82,636,456 was supplemented by $28,525,286 in federal funds. Twelve projects under construction at that time will provide 2,193 beds, for a total cost of $27,052,656. The federal government contributed $8,924,875 to these projects. One hospital, which is designed to supply 744 additional beds but is not yet under construction, has been approved for the total cost of $15,600,000, including $1,500,000 in federal funds.

FELLOWSHIPS OFFERED

The National Foundation for Infantile Paralysis is now offering a limited number of senior fellowships to physicians interested in study and research in the teaching of preventive medicine. These are being offered in order to increase the number of well trained teachers in the field.

Stipends ranging from $4,500 to $7,000 a year, depending on marital status and number of dependents, will be given for one or more years. The program of study may be taken at an approved medical school of public health or in a department of preventive medicine of an approved medical school.

Candidates, who must have completed at least one year of internship and who must have had not less than two years of additional training and experience, will be selected on a competitive basis by the Clinical Fellowship Committee of the National Foundation for Infantile Paralysis.

The foundation's Division of Professional Education, 120 Broadway, New York 5, is in charge of applications, which can be submitted any time during the year.

Medical and Research Grants

Among the recipients of medical division grants to support clinical studies made by Sharp and Dohme were Baylor University College of Medicine, Houston, and the University of Texas School of Medicine, Galveston. The University of Texas, Austin, was one of the ten recipients of the research division grants, which totaled $17,900. Research and clinical studies grants totaling $43,100 have been made by the company since January 1 of this year.

LIBRARY SECTION

THE BUSINESS SIDE OF MEDICAL PRACTICE

Many doctors have realized that they must depend upon their own initiative to develop satisfactory business procedures in their offices. While they may have a natural dislike of business details, closer attention to the development of efficient and complete business records and practices can result in a saving of time and money as well as improvement of relations with the patient. Professional ability and service are of primary consideration, but they need to be implemented by efficient and productive business procedures.

Choosing a location can have an important effect on the financial success of the physician. Outlying districts and rural areas may be desirable for a doctor beginning practice because of the ease of getting started. The area that needs a doctor the most may be the most lucrative because of the assurance of an adequate practice. In urban areas, sharing an office location with other physicians can decrease overhead and be mutually beneficial financially.

The efficiency and appearance of the doctor's office play an important part in the doctor-patient relationship. The reception and consultation rooms and the laboratory, if any, should be arranged efficiently, on the advice of an architect when possible.

Competent office assistants are not easy to obtain. Often the doctor must train a receptionist, nurse, and technician or a combination of the three. The ability and attitude of these assistants may be the determining factors in establishing a successful business operation. Salaries should be large enough to permit employees to maintain adequate standards of living. If a feeling that they are a part of the professional practice can be instilled in the assistants' minds, they will be more inclined to do their best work and to be satisfied with their jobs. The manner in which office assistants treat the patients is an important part of maintaining a proper professional relationship.

Financial records need not be extensive or complicated but should reflect essential information completely. The system should be thoroughly understood by the doctor, and he should examine the records to keep himself informed. There is no one correct type of bookkeeping or record system. In most cases the records should be tailored to meet the needs of the individual practitioner. There are innumerable bookkeeping systems that have been devised by commercial concerns, but practices, particularly the specialties, vary greatly as to the type and extent of services rendered. Attention should be given to complete records of patients' accounts and accurate records for income tax purposes. Most physicians maintain patients' accounts on an accrual basis to record the amount of work performed but report their income for tax purposes on a cash basis. This is, of course, completely ethical since this choice is permitted by law.

Care should be taken in preparing case records. In addition to furnishing background material to the physician in his treatment, they possibly may be required as evidence in court. Printed forms are available for these records, but an evaluation of individual needs should govern the selection of the forms. Many doctors use dictating machines of the disc, cylinder, or wire recorder type to save time. The records of treatment and the accounting records are related and should be kept in a manner that will make this relationship easy to trace. Accurate, well kept files will save the doctor's time and permit him to find needed information quickly.

To reduce the number of delinquent accounts, they should be given early attention. When possible, payment for major

operations and extended treatment should be discussed with the patient in advance. Collection measures which antagonize the patient should be avoided. If collection is turned over to an outside agency, the doctor should be sure that the methods they use will not impair public relations or his professional standing. Collection letters should be written in the same manner that the physician uses in speaking to his patients. Installment payments may be successful if adhered to. The method of payment should be agreed to mutually by the patient and the doctor or his assistant.

The physician should familiarize himself with the legal aspects of his contractual relationship with the patient and of maintaining records for tax purposes.

In general, attention to the establishment of adequate records and routines can become an investment of the doctor's time that will result in a larger income and better patient relationships.

If a physician has a problem with records or business procedures, the business office of the Texas Medical Association will be pleased to discuss it with him and make suggestions. The business office also would be interested in receiving any suggestions on methods to improve its business services.

The Memorial Library of the Texas Medical Association has available the following publications on this subject:

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MacKenna, R. M. B.: Modern Trends in Dermatology, series 2, New York, Paul B. Hoeber, 1954.

Rigler, Leo G.: Chest, Handbook of Roentgen Diagnosis, ed. 2, Chicago, Year Book Publishers, 1954.

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Weinstein, Paul: Glaucoma Pathology and Therapy, St. Louis, C. V. Mosby, 1953.

Zoethout, W. D.: Laboratory Experiments in Human Physiology, St. Louis, C. V. Mosby, 1954.

CONTRIBUTIONS TO THE LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library for the following recent gifts:

Dr. J. M. Coleman, Austin, 1 book.

Dr. N. L. Schiller, Austin, 15 journals, 13 reprints.

BOOK NOTICES

Cure Your Nerves Yourself

LOUIS E. BISCH, M. D., Ph. D. *247 pages. $3.50. New York, Wilfred Funk, Inc., 1953.*

In this volume, written for the lay public, the author has assumed that those individuals with minor emotional problems can help themselves.

The book is written in simple language and is readable. Each chapter deals with a specific problem that people face in their everyday living. The book should be helpful to many who have minor adjustment problems and are completely open minded about their problems, willing to discard their old habits and make new adjustments. The book cannot replace the aid of a psychiatrist.

[1]French's Index of Differential Diagnosis

Edited by ARTHUR H. DOUTHWAITE, *London,* M. D., F.R.C.P., *Senior Physician, Guy's Hospital; Honorary Physician, All Saints' Hospital for Genito-Urinary Diseases. Seventh edition. 1,046 pages. $20. Baltimore, Williams and Wilkins Company, 1954.*

The main signs and symptoms of disease are meticulously dealt with and in comparison with the former edition there is more conciseness and less repetition. It is simple in its usage because its articles on the various symptoms are arranged in alphabetical order.

More important than the alphabetical order of symptoms is the discussion of differential diagnosis in connection with the symptom or symptoms involved. To use this book effectively, it must be realized that the body of the book deals with symptoms, whereas the index gathers these together under the headings of the various diseases in which they occur.

Extensive use of the general index will keep the reader from missing a number of places in which the diagnosis of the disease or diseases in question is discussed. Even though each symptom is discussed only once, each disease is likely to come under discussion in a number of places under several of its more important symptoms.

It is called to the attention of the early users of the

[1]*Joe C. Rude, M. D., Austin.*

book that borderline headings and various signs such as von Graefe's and Stellwag's are found in the index and that use of the index speeds up the usage of this compact volume.

Treatment, pathology, and prognosis as indicated in the preface to the volume are not dealt with except insofar as they bear upon differential diagnosis; for example, the use of salicylates in distinguishing rheumatic from other types of arthritis.

The illustrations are well chosen, and the colored ones add a great deal to the informative value of this work.

This book is an excellent index of differential diagnosis and is a valuable addition to any physician's reference book shelf.

Review of Physiological Chemistry

HAROLD A. HARPER, Ph. D., *Professor of Biochemistry, University of San Francisco; Lecturer in Surgery, University of California School of Medicine, San Francisco. Fourth edition. 328 pages. $4. Los Altos, Calif., Lange Medical Publications, University Medical Publishers, 1953. Spanish edition, Madrid, Spain, Ediciones Morata.*

Peripheral Nerve Injuries, Principles of Diagnosis

WEBB HAYMAKER, M. D., *Chief, Neuropathology Section, Armed Forces Institute of Pathology, Washington, D. C., and* BARNES WOODHALL, M. D., *Professor of Neurosurgery, Duke University School of Medicine, Durham, N. C. Second edition. 333 pages. $7. Philadelphia, W. B. Saunders Company, 1953.*

In the second edition of the Haymaker and Woodhall monograph the text has been thoroughly reworked and supported by references. New chapters and illustrations have been added. Many of the changes were in response to criticism of the previous edition. The authors describe the motor, sensory, autonomic, and reflex changes resulting from injuries of peripheral nerves, roots, and plexuses. The book, originally a product of World War II, was a guide for medical officers of the armed forces. Further experience with civilian and military nerve wounds has been the source of the new information. The book is excellently illustrated by photographs and line drawings. It should be a valuable reference book for all students and for physicians and surgeons who frequently treat traumatic cases.

The Mechanism of Inflammation

Edited by G. JASMIN, M. D., *and* A. ROBERT, M. D., *Institut de Medecine et de Chirurgie experimentales, Universite de Montreal. 308 pages. Montreal, Canada, Acta, Inc., Medical Publishers, 1953.*

At the Nineteenth International Physiological Congress in Montreal in 1953, a symposium was held by contemporary investigators in the field of inflammation. This was the first international symposium on the subject. Twenty-four papers were presented in written form, and a panel discussion was held. In this monograph the complete proceedings, the formal papers, the prepared remarks, and the free discussion are presented. There is a serious divergence of opinion among the investigators, the leading controversies being histamine and ground substance. The symposium was financed by pharmaceutical companies in the United States and Canada.

Conserving Human Resources

Proceedings, 1952 Annual Convention, National Society for Crippled Children and Adults, October 26-29, 1952, San Francisco. The Easter Seal Society Chicago. 107 pages. The National Society for Crippled Children and Adults, Inc., Chicago, 1953.

Disability Evaluation, Principles of Treatment of Compensable Injuries

EARL D. MCBRIDE, M. D., F.A.C.S., *Assistant Professor in Orthopedic Surgery, University of Oklahoma School of Medicine; Attending Orthopedic Surgeon, St. Anthony's Hospital; Chief of Staff, Bone and Joint Hospital, Oklahoma City, Okla. Fifth edition. 715 pages. $15. Philadelphia, J. B. Lippincott Company, 1953.*

As a pioneer in the field of disability evaluation, the author again has presented a comprehensive coverage of the field.

Since the publication of the first edition, doctors and lawyers have consulted this reference in formulating opinions. The relation of injury to disease is timely, and those forced with forming an opinion will find the material most helpful.

The variety and complexity of injuries make it difficult to establish a fixed schedule for ratings for all the known occupations.

This reference book will greatly assist the physician in preparing his testimony concerning disability, and should be considered a "must" for the orthopedist and industrial surgeon.

Treatment of Toxic Goiter with Radioactive Iodine

LINDON SEED, M. D., *Director, Isotope Laboratory, Grant Hospital; Clinical Associate Professor of Surgery, College of Medicine, University of Illinois, Chicago, and* THEODORE FIELDS, M. S., *Assistant Director, Radioisotope Laboratory, Hines Hospital, Hines, Ill.; Instructor in Radiology, Northwestern University Medical School, Chicago. Preface by George V. LeRoy, M. D., Associate Dean, Division of Biological Sciences, University of Chicago. 116 pages. $3.75. Springfield, Ill., Charles C Thomas, 1953.*

This monograph, written by a surgeon and a radiophysicist, is based on their experience with the treatment of toxic goiter. It should prove valuable to those who are interested in installing a small isotope laboratory. It gives the indications for isotope therapy as well as the results of the treatment and includes a discussion of the complications such as hypothyroidism, exacerbation of symptoms, local reaction, and exophthalmos. The authors prophesy that the present surgical treatment of exophthalmic goiter will be replaced by radioiodine therapy.

[2]Water, Electrolyte and Acid-Base Balance; Normal and Pathologic Physiology as a Basis for Therapy

HARRY F. WEISBERG, M. D., *Assistant Professor of Clinical Pathology and of Clinical Medicine, Chicago Medical School; Clinical Chemist, Mount Sinai Medical Research Foundation and Hospital; Associate Attending Physician, Cook County and Mount Sinai Hospitals, Chicago. 245 pages. $5. Baltimore, Williams and Wilkins Company, 1953.*

If the clinician is looking for an oversimplified formula to understand the principles of fluid and electrolyte balance and the treatment of alteration thereof, he will not find it in Dr. Weisberg's book. If he is looking for a detailed physiobiological-physiochemical treatise on the subject, here again he would not be satisfied. However, for those who want this problem explained in moderately applied physiological vernacular and want to gain a working knowledge encompassed in such a complex and still not completely understood pattern of exchange and interchange between cell membranes, he will have in this book the answer—albeit not a complete one—which will be of benefit to him and through him to his patients.

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[2]*Bernard Willett, M. D., Austin.*

Dr. Weisberg takes his reader through a discussion of normal physiology and inculcates an understanding of it. This clarifies the essential fragments which are the working elements of this problem. He concisely explains and delineates the concept of body water and its analysis, he describes the function and place of the body electrolytes, and he combines them both into a clear explanation of acid-base balance.

With this information he takes the reader into an understanding of those deviations from normal which plague the surgeon, the internist, and the general practitioner. He presents clinical syndromes and the reason for them. Water imbalance and sodium, potassium, and other electrolytic deficiencies become clear in their relationships to one another. The migration of fluid and electrolyte across semipermeable membranes from one compartment into the next in response to body demands and endocrine stimuli becomes a picture almost as vivid as water flowing over a dam in response to gravity.

Lastly, he describes the various solutions which can be used to treat these aberrations (or to prevent them) giving rationale as well as logical deduction a predominant place in the proper use of them. Possibly Dr. Weisberg has not contributed to the medical literature an original idea or concept in this book, but he has contributed to the interested clinician the clearing of misunderstood and nonunderstood concepts of man's internal environment.

Physiological Methods in Clinical Practice

WILLIAM S. MIDDLETON, M. D., *Department of Medicine, University of Wisconsin Medical School, Madison. The Beaumont Lecture, Wayne County Medical Society, February 2, 1953. 40 pages. American Lecture Series, Number 216. $1. Springfield, Ill., Charles C Thomas, 1953.*

[3]The Ballistocardiogram; A Dynamic Record of the Heart Beat

JOHN R. BRAUNSTEIN, M. D., Ph. D., *Associate Professor of Biophysics and Assistant Professor of Medicine, University of Cincinnati. Publication 143, American Lecture Series. A Monograph in American Lectures in Circulation. 84 pages. $3. Springfield, Ill., Charles C Thomas, 1953.*

Dr. Braunstein has presented "a picture of this most challenging and rapidly moving field"—ballistocardiography. Functional tests of the heart are badly needed, and the present exercise test, often done with misgivings and many warnings as to possible danger, is not the answer. Now we have an instrument that promises to record safely the valuable information as to how well the heart is performing its vital function.

At present no segregation of facts is obtainable as to just how this functional output is obtained, but in time the complex will be worked out and be more valuable. Is the valve leaky? Does the ventricular musculature show damage? The present ballistocardiograph does not delineate each query but it does give the over-all picture and likewise does interpret the first failure of function—often long before the electrocardiogram. Perhaps in the future we can correlate pathology and this record of heart function now known as the ballistocardiogram.

The book is divided into an excellent history dating back to 1877 and shows various displacement ballistocardiograph machines. Modern instruments are presented, and both displacement and velocity machines are discussed. The velocity machine has the great advantage of ease of recording and simplicity of equipment. With the electromagnetic pick-up of the Dock type of instrument the patient is comfortably relaxed on the padded electrocardiograph table and the ballistocardiograph is taken "before they know it."

Next, the author discusses the normal ballistocardiogram followed by a chapter on the abnormal tracing. He shows the relationship to respiration and its effect on the ballistocardiogram.

Physics is brought into play in the chapter on cardiac output and again in the excellent appendix. This gives a clear understanding of the mechanics involved in the studies.

The next two chapters are on the clinical significance of the abnormal pattern and of the abnormal output.

Sixteen pages are devoted to the vectorballistocardiogram. The reviewer is of the opinion some of its electronic armamentariums will be more widely adopted to medical use in the near future.

Dr. Braunstein's small book is the beginning of a promising field. The instruments are quite easily constructed and are also available commercially. The reviewer has made several instruments for his friends.

A bibliography is attached at the end.

Third Annual Report on Stress

HANS SELYE, M. D., Ph.D. *(Prague)*, D.Sc. *(McGill)*, F.R.S. *(Canada), Professor and Director of the Institut de Medecine et de Chirurgie experimentales, Universite de Montreal, and* ALEXANDER HORAVA, M. D. *(Lausanne), Research Associate and Librarian of the Institut de Medecine et de Chirurgie experimentales, Universite de Montreal. 637 pages. Montreal, Canada, Acta, Inc., Medical Publishers, 1953.*

[4]The Action of Insulin

NEILS HAUGAARD, Ph. D., *Assistant Professor of Physiological Chemistry in Research Medicine, School of Medicine, University of Pennsylvania, Philadelphia, and* JULIAN B. MARSH, M. D., *Assistant Professor of Physiological Chemistry, Graduate School of Medicine, University of Pennsylvania, Philadelphia. 113 pages. $3.75. Springfield, Ill., Charles C Thomas, 1953.*

This is a well-written, well-edited, and well-printed monograph, which summarizes the present knowledge of the complex problems of the action of insulin in an adequate manner. The subject is discussed in eight chapters dealing successively with essentials of intermediary metabolism, the chemistry of insulin, the physiology of insulin action, experimental metabolism, the relationship of anterior pituitary and adrenal cortical factors to the action of insulin, some clinical aspects of the action of insulin, and the mechanism of action of insulin. The data are presented briefly and concisely. The bibliography appears to be adequate and well chosen. This reviewer feels that the authors have accomplished their aim: ". . . to present the results of recent investigations dealing with the problem of the mechanism of insulin action in a manner which might interest the clinician as well as the research worker."

Manual for Student Nurse Recruiters

Compiled by MRS. LILLIAN CHRISTENSEN GRIFFITH *under a grant from the National Foundation for Infantile Paralysis. 63 pages. Published by the Committee on Careers, National League for Nursing, New York, 1953.*

The manual is arranged for a community committee and is divided into three parts. The first outlines the plan of organization and the selection of the committee. The second part details the program; speakers; schools, radio, newspaper, and television publicity; and financing. The last two sections contain valuable suggestions for special programs

[3]*David R. Womack, M. D., Austin.*

[4]*George W. Parson, M. D., Texarkana.*

with the aid of doctors and nurses in the community and a list of aids available from the Committee on Careers of the National League for Nursing.

This should be a great help to the Auxiliary in its nurse recruiting program.

Rehabilitation Centers in United States

HENRY REDKEY, *Consultant on Rehabilitation Centers, Office of Vocational Rehabilitation, United States Department of Health, Education, and Welfare, Washington, D. C. 128 pages. $1.50. Chicago, National Society for Crippled Children and Adults, 1953.*

This publication is a compilation of information submitted by forty rehabilitation centers for the first National Conference on Rehabilitation Centers, held December 1-3, 1952, under the sponsorship of the National Society for Crippled Children and Adults and the Office of Vocational Rehabilitation, United States Department of Health, Education, and Welfare.

[5]Planning Guide for Radiologic Installations

By the Committee on Planning of Radiologic Installations of the Commission on Public Relations of the American College of Radiology, WENDELL G. SCOTT, M. D., *Chairman. 336 pages. $8. Chicago, Year Book Publishers, 1953.*

This book fills a much needed phase in the development of radiologists in private and hospital practice. The principles of adapting the radiologic facilities to the needs of the community and the demands made upon it cannot be too strongly emphasized. The planning of a department not only for its present work load but also for its future increase in duties is a good idea, and the fact is not overlooked that as the size increases so will the teaching and instruction responsibilities. Miniature sketches and pictures showing the flow of work through a department even depict the relationship of various workers in the roentgen-ray department with each other.

A good analysis of hospital radiologic practice bearing on the number of patients, number of examinations, and ratio of therapy to diagnostic work in relationship to the populations being served is presented. It is also helpful to find a discussion of the amount of floor space needed and of the team composed of the radiologist, administrator, trustees, and other professional staff members who are vitally affected by roentgen-ray and therapy plans.

The roentgen-ray and radium therapy section is well dealt with as to both size and arrangement for reception, treatment, and examination. A valuable section is devoted to the "don'ts" of construction and should be digested by not only the radiologist, but the administrator, trustees, and architect as well.

I was disappointed in the section on the construction and arrangement of dressing booths and lockers and had the feeling that more preparation and attention should have been paid to allowing patients access to their examining rooms instead of having to parade down corridors for examination.

The dark room section is well done. The discussion is especially good on film drying and the actual processing of films. Accessories, temperature control, and humidity all come in for their share of importance and discussion. Microfilming of overage films to save storage space and preserve records is stressed. In the case of photofluorography the point is well taken that it should be placed near the entrance and between the clinics and the roentgen-ray department to save time and confusion. The suggestion about electric outlets on all floors is good. Having fluoroscopic timers is an excellent suggestion and should be standard equipment in all such units.

The discussion of radiation protection has been well done by a battery of well trained people who have developed this section adequately, and it should be studied by anyone who has radiation duties, be they diagnostic or therapeutic. It is not within the scope of a book review or my ability to discuss this section in a short space. The protective requirements in particular for both patients and personnel cannot be stressed too much or too often.

A Handbook of Practical Bacteriology, Guide to Bacteriological Laboratory Work

T. J. MACKIE, M. D., LL.D., D.P.H., *Professor of Bacteriology, University of Edinburgh; Consultant Bacteriologist to the Royal Infirmary, Edinburgh, and the South-Eastern Regional Hospital Board, Scotland, and* J. E. MCCARTNEY, M. D. *(Edinburgh and Adelaide),* D.Sc. *(Edinburgh), Medical Bacteriologist, Institute of Medical and Veterinary Science, Adelaide, South Australia. Ninth edition. 677 pages. $5.50. Baltimore, Williams and Wilkins Company, 1953.*

Scientific Principles in Nursing

M. ESTHER MCCLAIN, R. N., M. S., *Instructor in Nursing Arts, Providence Hospital School of Nursing, Detroit, Michigan. 449 pages. Second edition. $3. St. Louis, C. V. Mosby Company, 1953.*

[6]Classics in Clinical Dermatology with Biographical Sketches

WALTER B. SHELLEY, M. D., Ph. D., *Chief, Clinic of Dermatology, University of Pennsylvania Hospital; Associate Professor of Dermatology and Syphilology, University of Pennsylvania, and* JOHN T. CRISSEY, M. D., *Instructor, Dermatology and Syphilology, University of Pennsylvania. Introduction by* JOHN H. STOKES, M. D., *Emeritus Professor of Dermatology and Syphilology, School of Medicine, University of Pennsylvania, Philadelphia. 467 pages. $10.50. Springfield, Ill., Charles C Thomas, 1953.*

In the course of the rather hectic task of trying to keep abreast of modern medical literature, the reader occasionally encounters a book which is a sheer pleasure for readability and enjoyment. Such an opus, to any who profess an interest in cutaneous medicine, is this book.

The book is a collection of first, or at least of early, definitive descriptions of the majority of important dermatologic entities recognized today. Usually the original description is given in toto; occasionally it is somewhat abstracted. With each description is given a short biographical sketch of the author thereof. Since almost all great clinicians of the past hundred years were keen clinical observers, it works out that the volume encompasses most of the great names of dermatology, and it is therefore in effect a practical Who's Who. Naturally, however, there are also a number of less familiar physicians whose names are immortalized by their having been the first to recognize an entity.

It is striking to notice how clear and how complete in their descriptions of a disease were some of the older authors especially, so that but little of importance can be added today after decades of further study. On the other hand, however, every dermatologist will note with interest that some of the original concepts have been enlarged and sometimes radically changed in modern times.

The paper is good and the typography is handsome; the illustrations are acceptable. One is impressed with the large amount of source research and translations the authors have had to do to bring out this excellent compendium.

[5]*Joe C. Rude, M. D., Austin.*

[6]*Morris Polsky, M. D., Austin.*

Dermatologists will be grateful to Drs. Shelley and Crissey for making available this belles-lettres dermatologica; and the general medical public will also read this with much interest and gain.

Electrical Methods of Blood-Pressure Recording

FRANK W. NOBLE, M.E.E., *National Heart Institute, National Institute of Health, Public Health Service, Federal Security Agency, Bethesda, Md. 56 pages. $3. Springfield, Ill., Charles C Thomas, 1953.*

[7]Salt and the Heart

EDWARD T. YORKE, M. D., *Attending Cardiologist, Alexian Brothers Hospital, and Associate Cardiologist, St. Elizabeth Hospital, Elizabeth, N. J.; Consultant in Medicine, Rahway Hospital, Rahway, N. J. 83 pages. $3.45. Linden, N. J., Drapkin Books, 1953.*

This new book covers an up-to-date subject in this modern era of medicine. The author introduces his subject with a typical case seen by the average physician in his office. From this, one sees the importance of questioning the patient as to what he is eating and how his foods are prepared.

Chapter two discusses the physiology of salt metabolism and excretion under normal and abnormal conditions. The current views of the author are well founded in that an excessive intake of salt cannot produce disease.

The author's views on hormones as a cause of premenstrual discomforts are still controversial. His physiologic explanation of congestive heart failure is basically simple the way he tells it. It should be heartening to the medical profession to hear that swollen ankles do not always mean heart trouble.

The chapter on reserve of the heart explains a lot of simple things which many physicians and medically minded people will appreciate. For example, he states that the heart muscle fibers can always stretch a little bit more to continue when the extra load placed upon them seems impossible.

In using low sodium restricted diets, every physician should be constantly on the alert for any symptoms of the low salt syndrome. At this time, the use of resins is not as popular, and their use in the future in regard to the use of salt with heart disease is very questionable. The author's view on salt and sodium in hypertension stimulates much thought. He will have a big following in the belief that overeating which includes an excessive amount of salt is more likely the damaging effect rather than purely excess salt.

The remainder of the book deals with foods containing high and low amounts of sodium. Physicians prescribing the use of a low sodium diet with heart disease should be able to discuss intelligently at least the foods high in sodium. The results obtained with the use of such diets depend upon the intelligence of the individual. One cannot expect many patients to understand the importance of a low sodium diet and the number of grams and milligrams necessary for restricted diets. These patients should be given a list of actual foods to eat.

A review of the subject from the standpoint of a cardiologist or physician dealing with heart disease is elementary but should be enlightening to those unfamiliar with the subject. I believe this book would be of definite value to a young physician, medical student, dietitian, or intelligent patient—with its understandable explanations of the basic physiology relative to salt in the body as a normal function as well as in disease related to the cardiovascular system.

[7]*Henry E. Mehmert, M. D., Greenville.*

ORGANIZATION SECTION

TEXAS MEDICAL ASSOCIATION

EXECUTIVE COUNCIL MEETING

The headquarters building in Austin was the scene September 3-5 of council and committee activities and the semiannual session of the Executive Council of the Texas Medical Association, the governing body between annual meetings of the House of Delegates. Dr. F. J. L. Blasingame, Wharton, President, presided over the Council on September 5, at which time Dr. A. L. Thomas was presented with a plaque as General Practitioner of the Year for Texas. Dr. Thomas, Ennis physician for almost fifty years, was voted to receive the honor by the House of Delegates at its May meeting in San Antonio. He accepted the plaque from Dr. Mayo Tenery, Councilor of the Fourteenth District.

Six past presidents of the Association were in Austin for the meeting. They are Dr. John H. Burleson, San Antonio; Dr. L. H. Reeves, Fort Worth; Dr. B. E. Pickett, Sr., Carrizo Springs; Dr. G. V. Brindley, Temple; Dr. T. C. Terrell, Fort Worth; and Dr. George Turner, El Paso. Dr. Reeves called attention to the Spanish oak tree planted at the entrance to the Association building which he presented in memory of Dr. Holman Taylor and Dr. R. B. Anderson, Jr. Dr. Turner commended Dr. Blasingame on his outstanding job as President, and the others expressed their pleasure at being able to accept Dr. Blasingame's invitation to attend the Council meeting.

Before most Association activities got under way, there was an interprofessional meeting on September 3 with approximately forty representatives present from the Texas Medical Association, Texas Dental Association, Texas Pharmaceutical Association, State Department of Health, Texas Graduate Nurses Association, Texas League for Nursing, Chiropodists Society of Texas, Texas State Veterinary Medicine Association, Group Hospital Service, Texas Public Health Association, and Texas Joint Commission for the Improvement of the Care of the Patient. The group decided that a committee should be appointed to make the necessary arrangements to form a permanent body for discussion of mutual problems and possible joint action where such seems indicated.

After a day of committee meetings September 4, reports were accepted by the Executive Council from the various councils and committees of the Association. Some of the many items of business discussed follow.

The visitation program, which was begun in June to aid county societies in strengthening their membership, attendance, and programs and to learn their needs, was praised by the Board of Trustees, the Board of Councilors, and the Committee on Public Relations. To date, visitations, made by officers and central office personnel, have been scheduled to approximately fifty county medical societies, and it is expected that many additional societies will respond with invitations during the year.

Malpractice insurance rates were studied by several councils. The Council on Medical Defense, in cooperation with the Council on Medical Jurisprudence and following a man-

date from the House of Delegates, is preparing for submission to the Texas Legislature a bill which will modify or exempt malpractice insurance rates from the single rating law to provide some relief for physicians from excessive malpractice insurance rates. As a result of the increased incidence of malpractice suits in Texas, the Council on Medical Defense is studying ways and means by which it can inform individual physicians of better ways to protect themselves and their patients.

Federal legislation concerning medicine was a major part of the report of the Council on Medical Jurisprudence. Status of such items as social security, Hill-Burton Hospital Construction Act, reinsurance, and medical tax deductions was given.

The 1955 annual session of the Association, scheduled for April 24-27 in Fort Worth, will add to its agenda thirty refresher courses taught by distinguished out of state and Texas physicians, it was reported by the Council on Scientific Work. At the time of its report fourteen guests had accepted invitations to participate in the program, and additional speakers were being invited to assure an outstanding program. The Committee on Public Relations commented that adequate publicity is essential to a successful meeting. To supplement the usual methods employed, the committee discussed placards in hospitals and public places, personal invitations from the Fort Worth area physicians, and sufficient publicity through the TEXAS STATE JOURNAL OF MEDICINE.

The Bar M. D. Ranch suite at the American Medical Association convention in San Francisco had more than 1,300 visitors in the three days it was open, according to a report from the Texas Delegates to the AMA. Two Texans were reelected to AMA offices.

Membership in the State Association has reached 6,785, the highest in the history of the Association, according to a report from the Board of Trustees. Texas membership in the AMA is 5,602 not counting exemptions. It is likely that membership in the AMA will exceed 6,000 this year, allowing an additional delegate for Texas.

The appropriation of funds sufficient to operate the Postgraduate School of Medicine on a basis in keeping with the other departments of the University of Texas was recommended by the Council on Medical Education and Hospitals as a resolution to be presented to the Texas Legislature in view of the fact that there is increasing enrollment in the postgraduate courses offered throughout the state.

The Library Endowment Fund has received only $20,214.80 in the past fourteen years, and the Library Endowment Committee is planning to encourage donations through reminders in the TEXAS STATE JOURNAL OF MEDICINE, the visitation program, and the Woman's Auxiliary.

Doctor distribution surveys have been completed in Districts 7 and 8, and a survey is under way in District 4. The Committee on Rural Health and Doctor Distribution plans to survey District 9 and then District 1 to determine the need for physicians.

Purchase of the lot adjoining the headquarters building has been completed by the Board of Trustees. The lot extends 219 feet on Nineteenth Street.

Executive Council to Meet January 22-23

Dr. F. J. L. Blasingame, Wharton, President of the Texas Medical Association, has set January 22-23, 1955, as the dates for the next Executive Council meeting. Since the Legislature will be in session, it is advisable for those planning to attend to make hotel reservations early.

General Practitioner of Texas

Commemorating his selection as Texas' General Practitioner of the Year, Dr. A. L. Thomas of Ennis was presented with a bronze plaque at the September 5 meeting of the Executive Council of the Texas Medical Association. Dr. Thomas, the sixth Texas physician to be so honored, received the plaque from Dr. Mayo Tenery, Waxahachie, Councilor of District 14. He was elected by the House of Delegates at the 1954 annual session in San Antonio.

Born in Auburn, Ga., on August 7, 1875, Dr. Thomas moved to Ennis with his parents, Alfred N. and Amanda (Betts) Thomas, when he was 11 year sold. He attended country schools and was graduated from Polytechnic College, Fort Worth, after which he taught in a one room school in Bardwell in 1898. Receiving his medical education in Kentucky, Dr. Thomas was graduated from the University of Louisville School of Medicine in 1903.

Dr. Thomas began the general practice of medicine at Cryer Creek, Navarro County, in 1903, and he spent the next year at Terrell as an intern at the North Texas Hospital for the Insane, now the Terrell State Hospital. In

DR. A. L. THOMAS

January of 1905 he moved to Ennis and has practiced there continuously. Dr. Thomas was the first man in the county to do microscopic work, and he studied many specimens sent to him by neighboring physicians particularly to establish the diagnosis of tuberculosis. For some time he was the only anesthetist in the county, and he was the second doctor to own and operate an x-ray machine in the county. He has done postgraduate work in New York, Chicago, and New Orleans.

Dr. Thomas made his first calls by horse and buggy unless the roads were too bad; then he went by horse. He also has made calls on muleback and by railroad hand car as well as on foot. He did his first surgery in the homes on a portable table which he had brought in his buggy. The table was covered with a quilt and a sheet.

Although he is now 79 years old, the doctor is still operating, delivering babies, and helping the spiritual and mental as well as physical needs of his patients. He estimates that he has delivered moer than 3,000 babies since

he began practicing. Last year Dr. Thomas was honored by the Ellis County Medical Society on the completion of his fiftieth year of practice.

Health officer of Ennis for several years, Dr. Thomas has been active in civic work in that town. He is a past president of the Kiwanis Club, was the first person to be chosen "Citizen of the Year" by popluar poll sponsored by the Ennis Lions Club, and has been chairman of the board of trustees for the Ennis public schools for the past twenty years. Dr. Thomas was the first chairman of the library board and holds the first card issued, with which he checked out "The Life of Pasteur."

He joined the Methodist Church in 1882 and has been active in every phase of church work. He is a member of the board of stewards, many times chairman; a member of the choir; a teacher of the Men's Bible Class for many years; and a lay delegate to conferences of the Methodist Church.

A member of the Texas and American Medical Associations through Ellis County Medical Society continuously since 1908, Dr. Thomas served as president from 1941 until 1944. He is past president of the Weekly Doctors Luncheon Club of Ennis.

Dr. Thomas and the former Miss Edna May Williams of Decatur were married on October 26, 1905. In recent years the Thomases have visited Cuba, Guatamala, Hawaii, and Canada, from Quebec to Victoria. Last year they toured Alaska, and this year they took a 4,500-mile automobile trip through the northwestern part of the United States. They have four daughters, Mrs. Ralph Bell, Houston; Mrs. C. A. McMurray and Mrs. J. R. Jeter, Ennis; and Mrs. Eugene Epting, Athens, Ga.

The most recent honor bestowed upon Dr. Thomas was the insertion by Senator Lyndon B. Johnson in the Congressional Record of May 6 the Associated Press story on his selection as General Practitioner of the Year in Texas.

VISITATIONS FOR OCTOBER

Officers and members of the staff of the Texas Medical Association have scheduled visits to five county medical societies during October. They will also participate in the program of the Fourth District meeting at San Angelo, October 21. Societies scheduled to be visited are Bell County, October 6; Hale-Floyd-Briscoe-Swisher Counties, October 12; Williamson County, October 12; Bowie County, October 14; and Travis County, October 19.

AMERICAN MEDICAL ASSOCIATION

'A Life to Save'

The American Medical Association's newest film entitled "A Life to Save" and produced especially for use on local television stations by state and county medical societies, will be available for bookings October 1 through AMA's TV Film Library. The film is a story of how a woman's family doctor saves her life after a quack healer is exposed. The premiere showing was held at the third Medical Public Relations Institute in Chicago, September 1-2.

"Operation Herbert" Available

"Operation Herbert," an amusing motion picture film produced by the American Medical Association became available for showings at clubs, schools, fairs, and other meetings after September 1. The 16 mm. film, lasting 30 minutes and starring Jackie Kelk as a young hospital patient, demonstrates that an appendectomy costs less today than it did in 1937. The film may be reserved through Modern Talking Pictures Service, Inc., 45 Rockefeller Plaza, New York 20.

COUNTY SOCIETIES

Cameron-Willacy Counties Society

June 21, 1954

(Reported by Harry A. Miller, Executive Secretary)

Surgical Treatment of Duodenal Ulcer—Robert M. Moore, Galveston.

Cameron-Willacy Counties Medical Society met on June 21 at Brownsville with the woman's auxiliary for dinner and a business and scientific meeting. A committee was appointed to meet with the regional director of Blue Cross to discuss a proposed program for the society, and George Thurman was elected a member of the society. Dr. Moore presented the above scientific paper.

Hale-Floyd-Briscae-Swisher Counties Society

June 8, 1954

(Reported by John C. Long, Jr., Secretary)

Hale-Floyd-Briscoe-Swisher Counties Medical Society met in Plainview on June 8. C. Thomas Hill, Jr. was elected to membership.

A film on "Anemia" was shown to the group, and a discussion led by E. L. Dye, Jr., Plainview, followed.

Lubback-Crosby Counties Society

June 1, 1954

(Reported by Richard K. O'Loughlin, Secretary)

Interpretation of the Electrocardiogram—Mike Scurry, Dallas.

At the June 1 meeting of Lubbock-Crosby Counties Medical Society in Lubbock, it was decided to begin a savings account for the society. The above scientific paper was heard, and a discussion followed by L. B. Smith, Allen T. Stewart, William H. Gordon, Sam G. Dunn, John Selby, and Roy Sheffield, Lubbock.

Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Society

June 11, 1954

Symposium on Pulmonary Tuberculosis—W. D. Anderson, San Angelo; Lloyd R. Hershberger, San Angelo; C. E. Rush, Sanatorium; and R. F. Allison, Sanatorium.

The Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Medical Society met on June 11 in Del Rio. After hearing the above scientific program, the doctors had dinner with the woman's auxiliary. Dr. and Mrs. George Cox, Austin, were special guests.

Nueces County Society

June 8, 1954

(Reported by G. S. Ahern, Secretary)

Some Health Unit Experiences in Tornado—D. R. Reilly, San Angelo.

After a short business meeting on June 8 of the Nueces County Medical Society, the above program was heard. A resolution expressing sympathy to the families of Dr. C. N. Meador and Dr. J. M. Cameron, Corpus Christi, was passed.

San Patricia-Aransas-Refugia Counties Society

June 2, 1954

Knee Injuries and Their Treatment—George B. Barnes, Corpus Christi.

The San Patricio-Aransas-Refugio Counties Medical Society met on June 2 in the home of Dr. and Mrs. W. A. Guynes, Mathis. After hearing the above scientific paper, a panel discussion on the subject was held. Preceding the program, Dr. and Mrs. Guynes and Dr. and Mrs. Daniel R. Baen, Mathis, were hosts to members of the society and auxiliary at a buffet supper.

Tarrant County Society

June 1, 1954

(Reported by S. W. Wilson, Secretary)

Symposium on "Headache"—T. J. Coleman, Ronald Smith, Bruce Beard, and William C. Hendrix, Jr., Fort Worth.

Tarrant County Medical Society June 1 meeting in Fort Worth included the scientific program outlined above and a short business meeting. S. W. Wilson, secretary, announced that members of the society had been invited to hear the founder of Alcoholics Anonymous speak and also announced that a party was to be given for members and their wives on June 2 by Mr. E. E. Weaver.

DISTRICT SOCIETIES

Fifth and Sixth Districts Society

July 8-10, 1954

Treatment of Adenomatous Polyps Based on Their Pathology—Lauren V. Ackerman, St. Louis.
Radioactive Iodine Therapy in Incapacitated Cardiac Patients—Edward Massie, St. Louis.
Management of Post-Phlebitic Limb—Davitt A. Felder, Minneapolis.
Rubella in Pregnancy—Stewart A. Fish, Dallas.
Surgery of Arteriosclerosis—Dr. Felder.
Tumors of the Parathyroid—Dr. Ackerman.
Anticoagulant Therapy in Coronary Disease—Dr. Massie.
Complete Perineal Laceration—Dr. Fish.
Medical Aspects of Surgical Therapy for Mitral Stenosis—Dr. Massie.
Pathologist's Responsibility in Diagnosis and Treatment of Cancer—Dr. Ackerman.
Amenorrhea—Dr. Fish.
Practical Method of Phlebography—Dr. Felder.

The Fifth and Sixth Districts Medical Society met July 8-10 in Corpus Christi. Included in the three day program were the above scientific presentations, and round table discussions, business meetings, and entertainment. Dr. F. J. L. Blasingame, Wharton, President of the Texas Medical Association, addressed the group on the first day of the meeting.

New officers elected at the meeting are John J. Sloan, president; R. Gayle Spann, vice-president; and E. Jackson Giles, reelected secretary-treasurer. All three are from Corpus Christi.

Twelfth District Society

July 13, 1954

The Twelfth District Medical Society met in Corsicana on July 13. E. R. Hayes, Milton V. Davis, and Frank H. Kidd, all from Southwestern Medical School of the University of Texas, Dallas, participated in the scientific portion of the program. J. L. Cochran, San Antonio, President-Elect of the Texas Medical Association, and A. L. Thomas, Ennis, 1954 Texas General Practitioner of the Year, were guests and participated in the program also.

AUXILIARY SECTION

HIGH LIGHTS OF THE NURSE RECRUITMENT PROGRAM

The nurse recruitment program of the Woman's Auxiliary to the Texas Medical Association is a means of guiding young persons to become so interested in the prospects for service in the profession that they will choose nursing as a career.

During the past ten years there has been a growing recognition of the fact that just as the need for more nurses is a community problem, so is the recruitment of those nurses a community responsibility. No one group can solve the problem alone. The nursing profession and the medical profession must help by informing the youth of the opportunities and the fields of nursing, and the Woman's Auxiliary will continue to help. Doctors and their wives should serve as speakers on club, television, and radio programs so that the public will be better informed.

For a number of years the various county medical auxiliaries have been interested in securing more students to study nursing. The primary consideration is to counsel young men and women and give the best possible advice. Of course, the auxiliary members must be informed as to the opportunities, necessary training, and fields of nursing before any recommendations may be offered.

At present approximately fifty-two Future Nurses Clubs have been organized in Texas. It is vital that the medical auxiliaries and societies cooperate to the fullest extent with these groups and the Committee on Careers in Nursing. Future Nurses Clubs offer students an opportunity to have their own stimulating program through which, together, they can explore a shared, special interest—nursing.

Realizing that financial difficulties often cause the nursing profession to be deprived of fine nurses, the auxiliaries have established extensive scholarship and loan funds. It is hoped that these funds will continue to be available. There are approximately twenty-six funds established by various auxiliaries, five of which were made possible by securing money from other organizations. At the present time, approximately $6,000 is being made available in scholarship and loan funds by county auxiliaries in Texas.

This year the state Committee on Nurse Recruitment has the following objectives:

1. Publish and distribute a manual for members of Future Nurses Clubs. This manual will include basic information on how to organize a club, with suggestions for programs, projects, and services. It is the hope of this committee that the manual will enable clubs in Texas to become more standardized and also will be beneficial in organizing new clubs.

2. Distribute a pamphlet on available schools of nursing in Texas. Information on admission requirements, length of the program, affiliations, accreditations, and types of schools will be included.

3. Assist in organizing more Future Nurses Clubs in high schools.

4. Cooperate with the Committee on Careers in Nursing in planning the first state convention for Future Nurses Clubs.

5. Make a survey of the available scholarship and loan funds for nursing.

There is no auxiliary too large or too small to do a good job in recruiting professional and practical nursing students. All successful results will depend on the cooperation and long term planning of the members of the auxiliaries and nursing staffs in the community. Good public rela-

Officers of the Woman's Auxiliary to the Texas Medical Association: President, Mrs. Mark H. Latimer, Houston; President-Elect, Mrs. Joseph H. McCracken, Jr., Dallas; First Vice-President, Mrs. Mal Rumph, Fort Worth; Second Vice-President, Mrs. Harold Lindley, Pecos; Third Vice-President, Mrs. Howard R. Dudgeon, Jr., Waco; Fourth Vice-President, Mrs. Troy A. Shafer, Harlingen; Fifth Vice-President, Mrs. August J. Streit, Amarillo; Recording Secretary, Mrs. P. M. Kuykendall, Ranger; Corresponding Secretary, Mrs. William M. Palm, Houston; Treasurer, Mrs. J. C. Terrell, Stephenville; Publicity Secretary, Mrs. A. H. Neighbors, Jr., Austin; Parliamentarian, Mrs. John E. Hill, Marshall.

tions may be established in any community by carrying on a well organized nurse recruitment program. With the growing demand for more nurses, it is the auxiliaries' responsibility to see that pertinent information reaches the public.

Doctors and doctors' wives must do all they can to help those men and women who accept the challenge of human service. The Woman's Auxiliary must constantly assure them of the high rewards and everlasting satisfaction derived from being a nurse.

COUNTY AUXILIARIES

Henderson County Auxiliary met July 15 at the home of Dr. and Mrs. Nolen D. Geddie, Athens, and heard a review of the book, "A History of the Texas Medical Association, 1853-1953," by Dr. Pat I. Nixon, San Antonio. The book was presented to the Texas Medical Association Memorial Library in memory of Dr. Don Price, who recently died.

Bosque County Auxiliary met with the county medical society on July 7 at the home of Dr. and Mrs. Van D. Goodall, Clifton, and heard the society's guest speakers. They were Dr. Tom Lyles, Clifton; Dr. M. O. Rouse, Dallas, who spoke on medical jurisprudence; Mr. N. C. Forrester, Austin, executive secretary of the Texas Medical Association; and Mr. R. V. Voyer, Dallas, general director of the David Graham Hall Foundation for the betterment of Texas health. Mrs. S. L. Witcher, Clifton, gave a talk on the auxiliary's proposed projects.

Fifth and Sixth Districts Auxiliary

The Fifth and Sixth Districts Medical Auxiliary held a luncheon-style show in Corpus Christi on July 9 honoring Mrs. Mark H. Latimer, Houston, President of the Woman's Auxiliary to the Texas Medical Association. Mrs. Latimer addressed the group prior to a business meeting conducted by Mrs. June Yates, Corpus Christi, council woman for District 6. Mrs. E. Jackson Giles, Corpus Christi, president of Nueces County Auxiliary, presided at the luncheon.

About 150 motion picture films appropriate for audiences versed in medicine and 50 suitable for laymen may be borrowed from the Library of the Texas Medical Association, 1801 Lamar Boulevard, Austin.

DEATHS

L. MACKECHNEY

Dr. Laurie Mackechney, Wichita Falls, Texas, died at a local hospital on May 31, 1954, after a brief illness.

Born in San Augustine in 1870, Dr. Mackechney was the son of John and Martha (Scurlock) Mackechney. His father was born in Quebec, Canada, and moved to San Augustine when he was 12 years old. Dr. Mackechney attended school in San Augustine and was graduated from Tulane University of Louisiana School of Medicine, New Orleans, in 1895. He began practicing in San Augustine in 1909 and in 1913 moved to Wichita Falls. He practiced in Iowa Park from 1938 until 1951, when he returned to Wichita Falls. At that time he retired from active practice.

A member of the Texas and American Medical Associations continuously since 1908, through Shelby County and then Wichita County Medical Societies, Dr. Mackechney was elected an honorary member of the Texas Medical Association in 1951. He was one of the organizers of the Northwest Texas Clinic, which operated in Wichita Falls for about fifteen years, and later, during World War II, he was superintendent of the Wichita Falls State Hospital. He belonged to the Masonic Lodge, the Shrine, and the Episcopal Church.

Dr. Mackechney and the former Miss Lucy Bell were married in 1897. She died in 1902. He was also preceded in death by six brothers and one sister. Surviving are a son, John H. Mackechney, and three nephews, M. E. Mackechney, John Thomas, and J. S. Mackechney, all of Wichita Falls, and several nieces.

P. J. DOMINGUES

Dr. Polycarp Joseph Domingues, Kerrville, Texas, died on May 30, 1954, at his home.

Dr. Domingues was born in Iberia Parish, La., in 1869. He was graduated from the St. Mary's University in Lebanon, Ky., and from the Tulane University of Louisiana School of Medicine, New Orleans, in 1893. He practiced in Jeanerette, La., until 1898, when he moved to Kerrville. He had attended many patients in Kerr and adjoining counties when horse and buggy or riding horseback provided the only means of transportation. Dr. Domingues bought the first Ford automobile sold in Kerr County.

Dr. Domingues was formerly a member of the Texas Medical Association through Kerr-Kendall-Gillespie-Bandera Counties Medical Society.

Retiring from medical practice six years ago, Dr. Domingues remained active in his business interests until two months prior to his death when failing health forced him to give it up.

Dr. Domingues and the former Miss Evelyn Bowman were married in Jeanerette; she died in 1946. He is survived by a daughter, Mrs. Alice Jobes, and a son, Louis Domingues, both of Kerrville; eight grandchildren; and two great-grandchildren.

D. P. WALL

Dr. Dick Parker Wall died on July 18, 1954, of emphysema at his home in Galveston, Texas.

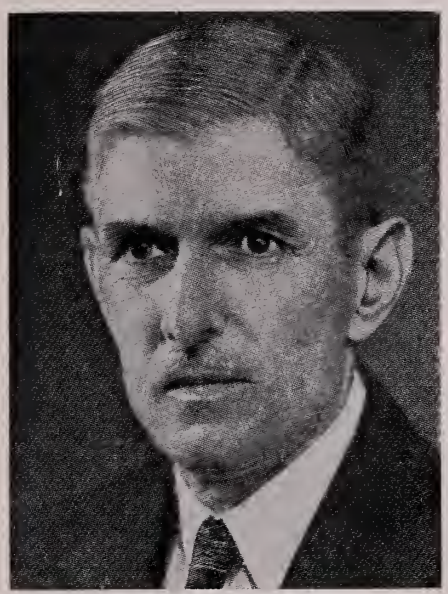
The son of Simeon Venable and Nancy Jane (Comer) Wall, Dr. Wall was born in Chapel Hill, Tenn., November 3, 1884. His father conducted a private school for boys in Franklin, Tenn., and later in Honey Grove, Texas, in which Dr. Wall received his early education. He was graduated from the University of Texas School of Medicine, Galveston, in 1913. After interning at John Sealy Hospital, Galveston, he began the general practice of medicine in Galveston in 1915, also teaching at the medical school. During World War I Dr. Wall served as a captain in the United States Army Medical Corps and was discharged as a major in the medical corps reserve. He did postgraduate work in eye, ear, nose, and throat in New York and St. Louis. From 1920 until his death he specialized in that field and was a professor of otolaryngology at the University of Texas School of Medicine from 1920 until 1943. For many years he was attending physician and surgeon of the United States Public Health Service Hospital, Galveston.

A member of the American, Southern, and Texas Medical Associations almost continuously since 1915, he was

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

president of the Galveston County Medical Society in 1938. Dr. Wall served as secretary of the Section on Eye, Ear, Nose, and Throat of the 1927 annual session of the Texas Medical Association, and in 1949 he was one of the members of the Association's Council on Medical Education and Hospitals selected to recommend a location for the new state medical school. He was a charter member of the Texas Society of Life Insurance Medical Directors. He was a member of the Association of Life Insurance Medical Directors of America, being medical director of the American National Insurance Company from 1943 until his death.

Dr. Wall belonged to Beta Theta Pi fraternity and Alpha Mu Pi Omega medical fraternity. He was a Scottish Rite



DR. DICK P. WALL

Mason and a vestryman and senior warden of the Trinity Episcopal Church.

On December 22, 1923, Dr. Wall and the former Miss Bessie Belle Tips were married in Seguin. He is survived by his wife; two sons, Dick Parker Wall, Jr., Galveston, and Robert Edward Wall, Austin; three grandchildren, Robert Edward, Jr., Laura, and Lisa Wall, all of Austin; and one brother, Robert Wall, Boyle, Miss.

G. P. STOKER

Dr. George Pinkney Stoker, Red Oak, Texas, died on July 23, 1954, at his home of a stroke at the age of 95.

A native of Lodi, Miss., Dr. Stoker was born on December 18, 1858. He was graduated from the Missouri Medical College, St. Louis, in 1887 and from the Hospital College of Medicine, Louisville, Ky., in 1902. He later did postgraduate work at the Polyclinic Medical College, New Orleans, and Tulane University of Louisiana School of Medicine, New Orleans.

A member of the Texas and American Medical Associations almost continuously since 1907, Dr. Stoker had practiced in Lodi before moving to Texas. He practiced in Archer City, Mount Pleasant, and Jacksonville before settling in 1919 in Red Oak, where he was a member of the Texas Medical Association through Ellis County Medical Society. Dr. Stoker was elected an honorary member of the Texas Medical Association in 1947. He was health officer of Archer County for five years. Dr. Stoker was a Mason for more than fifty years and was a member of the Methodist Church.

Dr. Stoker is survived by five sons, Allen Stoker, Floyd Stoker, and Dewey Stoker, all of Dallas; Clyde Stoker, Big Spring; and Lynn Stoker, Red Oak; three daughters, Mrs. Nancy Robbins, Dallas; Mrs. Mabel Friday, Uvalde; and Mrs. Grace Walters, West Beach, Fla.; two sisters, Mrs. Lundy Haynes, Cleburne, and Mrs. Susie Akin, Breckenridge; a brother, Bun Stoker, Mineral Wells; six grandchildren; and two great grandchildren.

L. L. ZARR

Dr. Luther Lynn Zarr died July 22, 1954, of acute myocardial infarction at his home in Houston, Texas.

The son of Mr. and Mrs. Luther Zarr, Dr. Zarr was born in Temple on January 1, 1911. He attended St. Mary's University of San Antonio; the University of Texas, Austin; and the University of Oklahoma, Norman. He was graduated from the Tulane University of Louisiana School of Medicine, New Orleans, in 1938. After interning at Scott and White Hospital, Temple, Dr. Zarr began his practice in Temple and in 1939 moved to Houston where be practiced until his death. He was on the staff of Heights Hospital for fifteen years.

DR. L. LYNN ZARR

A member of the Texas and American Medical Associations continuously since 1939 through Harris County Medical Society, Dr. Zarr was a member of the American Academy of General Practice, Alpha Tau Omega fraternity, Nu Sigma Nu medical fraternity, the Houston Country Club, Pine Forest Country Club, Lower Lake Hunting Club at Eagle Lake, and the Episcopal Church. He was an honorary member of the Rotary Club.

Dr. Zarr and the former Miss Elizabeth Sinclair were married on October 11, 1934, in Houston. Survivors include Mrs. Zarr, a son, Lynn Sinclair Zarr, and a daughter, Miss Lucy Ann Zarr, all of Houston; his mother, Temple; and a sister, Mrs. Edwin Bigbee, Palestine.

H. S. TAYLOR

Dr. Harvey Stokley Taylor died at his home in Dallas, Texas, of a heart attack on May 19, 1954.

Born on March 20, 1884, in Comanche County, the son of Mr. and Mrs. A. C. Taylor, Dr. Taylor was graduated from Southwestern University Medical College, Dallas, in

1911. As a general practitioner, Dr. Taylor practiced in Pickton from 1911 until 1922, in Winnsboro from 1922 until 1926, and in Kaufman from 1927 until 1947. He retired in 1947 and moved to Dallas.

Dr. Taylor had been a member of the Texas and American Medical Associations almost continuously since 1918, being a member first through Hopkins County, then Wood, Kaufman, and Dallas Counties Medical Societies. He was elected to honorary membership in 1952 and had been president of Kaufman County Medical Society in 1939. He was a member of the Baptist Church.

Dr. Taylor is survived by his wife and six daughters, Mrs. Dan Evans, Mrs. Carroll Kiser, Mrs. Kelton Ray, and Mrs. Stanley Heaps, all of Dallas; Mrs. C. T. Ashworth, Fort Worth; and Mrs. W. E. Peters, Garland. His father, A. C. Taylor, Winnsboro; a sister, Mrs. Z. T. Bridges, Winnsboro; and two brothers, W. S. Taylor, Winnsboro, and T. M. Taylor, Houston, also survive.

O. H. JUDKINS

Dr. Oscar Hunt Judkins, San Antonio, Texas, died in a local hospital of coronary thrombosis on May 27, 1954.

The son of Andrew Lafayette and Elizabeth (Bristow) Judkins, Dr. Judkins was born in Taylor County on October 5, 1883. He was graduated from the University of Texas School of Medicine, Galveston, in 1907. He did postgraduate work at Tulane University of Louisiana School of Medicine, New Orleans, and the University of Vienna.

A member of the Texas and American Medical Asosciations almost continuously since 1908, Dr. Judkins was a

Dr. Oscar Hunt Judkins

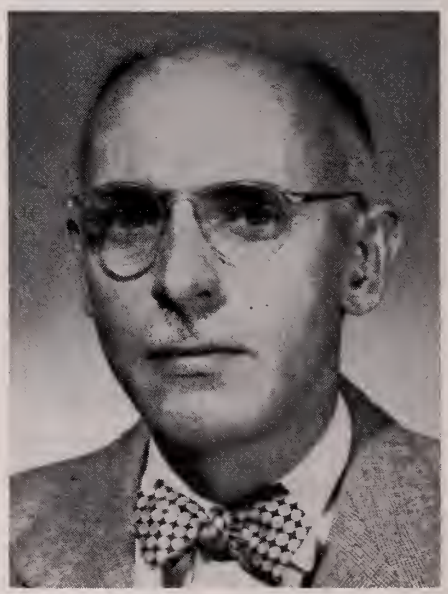
member first through Hale-Floyd-Briscoe-Swisher Counties, then LaSalle County, then Travis County, and from 1920 until 1954, Bexar County. He was secretary of the Section on Eye, Ear, Nose, and Throat for the 1925 annual session of the Texas Medical Association. Dr. Judkins was a fellow of the American College of Surgeons and a diplomate of the American Board of Otolaryngology. He was a member of the Conopus Club and the San Antonio Country Club.

Dr. Judkins and the former Miss Corrine Russell were married in San Antonio on October 20, 1917. Surviving are his wife; two daughters, Mrs. Joyce Judkins Braly, El Paso, and Mrs. Jean Judkins Horner, San Antonio; and two sisters, Mrs. T. R. Burnett and Mrs. Vernon Brandon, both of El Paso.

J. CARSWELL

Dr. James Carswell, Jr., McKinney, Texas, died on July 9, 1954, at a local hospital of septicemia.

Born in Glasgow, Scotland, on December 27, 1901, Dr. Carswell was the son of James and Agnes Carswell. His family came to the United States when he was young and settled in Streator, Ill., where his elementary education was completed. Dr. Carswell attended the University of Illinois, Urbana, and received his medical education at the University of Illinois College of Medicine, Chicago, having been graduated in 1927. He interned at the Swedish Covenant Hospital, Chicago, 1927-1928, and practiced in that city for a year. He practiced medicine and surgery in Camden, Maine, from 1929 until 1944 when he began a residency in thoracic surgery at the Herman Kiefer Hospital, Detroit. He was



Dr. James Carswell, Jr.

appointed to the staff of the Veterans Administration Hospital, McKinney, on January 1, 1947, and served as chief of the thoracic surgery section until the time of his death.

A member of the Texas Medical Association since 1948, Dr. Carswell also had belonged to the American Medical Association. He was president of Collin County Medical Society and a member of the Texas Surgical Society, the American Society of Thoracic Surgery, the American Trudeau Society, and the National Tuberculosis Association. He was a diplomate of the American Board of Thoracic Surgery and an active participant in the organization of the Bandera Conferences, later known as the Koppa Conferences at Hunt, Texas, which are dedicated to the control of tuberculosis in Texas. Dr. Carswell served as clinical assistant professor of surgery at Southwestern Medical School of the University of Texas, Dallas. He was a member of the vestry of St. Peter's Episcopal Church, McKinney.

Dr. Carswell is survived by his wife, the former Miss Agnes Chapman; his mother, Schenectady, N. Y.; and two sons, James Carswell, Chicago; and Ross Carswell, serving with the United States Marine Corps in Japan.

President's Page

LIAISON EFFORTS WITH ALLIED HEALTH GROUPS

At the annual session in San Antonio, I pointed out that one of my objectives as president was the improvement of our liaison efforts with allied health groups in Texas.

Several weeks ago a letter of invitation was extended by me in behalf of our Association to allied health organizations through their presidents, asking each of them to meet with us and bring several other officers of their respective associations. The following groups were invited to meet in Austin at our headquarters office: Texas State Department of Health; Texas League for Nursing; Texas Pharmaceutical Association; Chiropody Society of Texas, Inc.; Texas Graduate Nurses' Association; Texas Veterinary Medical Association; Texas Dental Association; Texas Joint Commission for the Improvement of the Care of the Patient; Group Hospital Service; Texas Public Health Association; and Texas Hospital Association. Letters of response were prompt, enthusiastic, and unanimous in accepting.

The meeting was held the evening of September 3. The attendance was excellent. I made a few preliminary remarks of greeting as did Dr. Robert Kimbro for our Board of Trustees and Dr. R. G. Baker for the Board of Councilors. An invitation was extended to all of the organizations to outline their objectives and current problems. A mid-meeting "break" for refreshments offered an opportunity for visiting and informal talk. The latter portion of the meeting was devoted to friendly and constructive discussion and to questions and answers.

It was pointed out that each organization is different in objectives and purposes and that if there were no problems, there would be no real purpose in meeting. The hope was expressed that much could be learned from each other in appreciating our differences. Perhaps one of the greatest benefits potentially is in this area. It would appear wise to talk over sincere conflicts in opinion where frictions are real or impending. Men of good will in an atmosphere of mutual respect can have benefits come out of such discussions.

Representatives at the meeting agreed that several common objectives are apparent, and much effective cooperation can be developed to benefit each of the health professions and the public. For example, at the time of this meeting, there was reported to be an outbreak of

equine encephalitis in one area of the state. Controlling this epidemic went beyond the simple doctor-patient relationship, involving also the State Department of Health, certain physicians, nurses, pharmacists, veterinarians, and perhaps others in the allied health professions.

For the general good, there should be cooperation in the field of legislation. Free discussions of problems may lead to the introduction of needed health legislation. Together, representatives may discuss potential legislative measures or pending bills and decide on a course of action that is mutually beneficial and in the public interest. Acting together, health groups can be felt politically, but in acting separately and without understanding, their legislative efforts may be ineffective and even confusing.

Joint effort in recruitment of personnel into the health professions offers an area of cooperation as do endorsement and encouragement of public health measures and their wider application by the public.

After it was generally agreed that a need exists for closer liaison between the allied health professions in our state, discussion turned to the mechanism of establishing a permanent organization. It was agreed by unanimous vote of those present that I should act as chairman of an interim committee which will consist of a representative of each of the groups. As soon as members of the committee are selected by their respective associations, another meeting will be held and consideration given to the permanent organization. Naturally, any permanent organization cannot be of consequence until it is approved by each of the represented groups.

A name for the proposed organization has been suggested as the Interprofessional Health Council of Texas. The facilities of our central office and staff have been offered such a council.

It is encouraging to note that several other states have found such councils of value. Inquiries are being made of the various councils already functioning as to organizational set-up, fields of service, composition, and limitations. Information thus gathered should be helpful in our planning.

It is hoped that this initial meeting will be the beginning of a permanent and effective liaison between the various health organizations in Texas and that each group and the public will benefit from the effort.

T. J. L. Blassingame, M.D.

PR diagnotes

REPORT OF COMMITTEE ON PUBLIC RELATIONS: The second annual Medical Students' Day project was launched in Dallas on September 10 with program at Southwestern Medical School of the University of Texas. Students, soon to take up a practice of their own, heard addresses aimed at the practical side of medicine.

Following a welcoming address by Dr. R. W. Kimbro, Cleburne, chairman, Board of Trustees, Texas Medical Association, the program included: "Your Practice and Public Opinion," Dr. William M. Crawford, Fort Worth, chairman, Committee on Public Relations, Texas Medical Association; "You and the Medical Society," C. Lincoln Williston, Austin, assistant executive-secretary, Texas Medical Association; "The Legal Aspects of Your Practice," Smith Pettigrew, Dallas, medical counsel; and "The Business Side of Your Practice," Dr. Harvey Renger, Hallettsville, chairman, Council on Medical Economics, Texas Medical Association.

Luncheon address to senior students was delivered by Dr. Hobart O. Deaton, Fort Worth, speaker, House of Delegates, who discussed "Present Legislative Problems of Texas Doctors."

Enthusiastic student response surpassed last year's overwhelming appreciation for program's material.

Medical Students' Day programs will be presented at the Baylor University College of Medicine, Houston, and the University of Texas School of Medicine, Galveston, in December.

High on the agenda for PR Committee meeting in Austin, October 31, will be county medical society attendance. Committee will study attendance-improvement survey results, discuss best approach to problem.

FROM OVER THE STATE: Travis County Medical Society reports present attendance has more than doubled last year's. Believes mass invitations

enlisting outside aid responsible. In addition to invitations alerting membership, the society urged doctors' wives to remind husbands to attend meetings - went step further and asked all doctors' secretaries to enter county society meeting dates in the doctors' calendars and to remind them several days before the meeting.

The Past Presidents of the Association's Woman's Auxiliary have presented the Memorial Library with a complete set of The Practitioner - includes all journals from 1869 to date.

Texas Medical Association's librarian reports average of 170 Texas doctors outside of Austin now using library facilities monthly. Have you used the library recently?

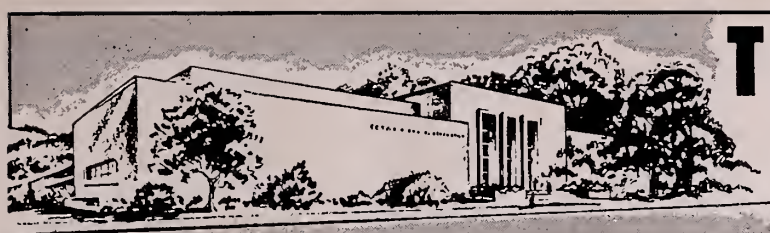
In an effort to bring their senior citizens back into a normal place in community activities, county societies are sponsoring "Senior Citizens' Hobby Shows" - find the shows stimulate community interest in geriatrics problems and revitalize this segment of population.

ON THE NATIONAL FRONT: Macon County Medical Society, Illinois, recognizing ubiquitous complaint that physicians are not interested in making their community a better place to live and that their projects are always keyed to organized medicine, set about short-circuiting such comments by their active participation in a bond issue campaign conducted by the local school board to provide additional schools for the area.

Physicians participated in radio and television programs, discussed the issue with patients, and promoted the campaign at society meetings and public gatherings. To round out the doctors' efforts, a resolution was adopted by the society and this, too, received wide newspaper publicity. Efforts resulted in statements like these: "If the society recommends it, the bond issue must be essential to the welfare of this city." "One of the best things that has happened to this community is the revival of the medical society's interest in public affairs."

TIP OF THE MONTH

Your Senators and Representatives are at home now. This would be a good time to pay them a visit or drop them a note of thanks for listening to medicine's viewpoint. They would appreciate it, and your contact with them would be strengthened.



TEXAS State Journal of Medicine

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HOSPITAL DISTRICTS TO BE VOTED ON

Texans interested in adequate hospital facilities and in the care of indigent patients on a local basis have a job to do before November 2. On that date, as a part of the general election, voters will decide whether or not to amend the state Constitution to permit the establishment of hospital districts in the larger counties.

Submission of the proposed amendment to the electorate was approved overwhelmingly by the Legislature last spring in the adoption of SJR 2. However, the tendency of voters always is to scratch an amendment if they are not fully acquainted with and sold on its provisions. The following points, if called to the attention of citizens before election day, may help secure passage of the amendment:

1. Creation of countywide hospital districts in counties with a population in excess of 190,000 and in Galveston County would be authorized but would not become mandatory.

2. A hospital district would be permitted to issue bonds and to assume bonded indebtedness already incurred for the acquisition, construction, maintenance, and operation of hospitals owned and operated by the county or jointly by the county and a city within the county and also to levy a tax not to exceed 75 cents per $100 valuation on all taxable property within the district provided that taxpaying voters in the county approve.

3. The hospital district would become responsible for providing medical and hospital care to needy inhabitants of the county, and thereafter the county and cities therein would not levy taxes for hospital purposes nor would the state make direct appropriation for the construction, maintenance, or improvement of the hospitals.

Voters face important choices regarding candidates for office and other constitutional proposals on November 2, but the amendment mentioned is especially dear to the thinking of those concerned with health care.

BE SURE TO VOTE NOVEMBER 2

LEGISLATORS AT HOME

Members of the medical profession and their wives are becoming accustomed to writing, wiring, or telephoning their representatives in Congress when measures detrimental to the public health are pending. But how many, expecting their wishes to be reflected in their Congressmen's voting, bother to talk with them when they are home?

United States Senators and Representatives are now in their home districts between sessions. This is the appropriate moment for physicians to introduce themselves personally to their Washington representatives, to thank them for past favors, and to explain the point of view of medicine. It should be remembered, too, that these conversations should be dialogues, not monologues; Congressmen have their questions and comments, their views to air, their problems to point out, and physicians can learn a lot if they will listen.

Although a meeting with a Congressman can be strictly business, it might be a pleasant gesture to converse over a dinner table or after a theater party with the representative and his wife as guests—not all the talk needs to be legislative.

It might be wise to become acquainted also with those who will enact laws in the Texas Legislature next January. Letters to Austin should be more effective if those who receive them can picture the persons behind the signatures.

The public relations "tip of the month" is to get in touch with Senators and Representatives while they are at home. It is a tip which may lead to an enjoyable contact and certainly should lead to a helpful one.

VIEWPOINT IS IMPORTANT

Society is built upon differences—differences in tastes and differences in abilities. Most of us can do one thing better than we can another, and some things we cannot do at all. So it is with the so-called physically handicapped, many of whom cannot do some things but can do others extremely well. Blindness, loss of an extremity, or a damaged heart, although creating more problems than most persons have to overcome, does not mean that a person is a being apart.

The first week in October annually is National Employ the Physically Handicapped Week. This observance is designed to focus attention on the fine job most handicapped persons can do if they are given an opportunity to use their unimpaired faculties.

Physicians are in an enviable position with respect to this nationwide program. It often is their privilege to bring back to near health those who have been stricken with disease or have suffered accident. It is their duty to instill in such persons the will to forget the past and to look forward to a productive and happy future. It is their responsibility to help these patients in overcoming residual physical and emotional barriers by informing them of the many agencies for rehabilitation ready to aid them in their readjustments. First, of course, physicians themselves need to learn what therapeutic, occupational, and financial assistance is available from private or public sources. It is their obligation, because of their understanding of the human body and its ability to be reeducated and to compensate, to interpret to reluctant employers the possibilities for using handicapped employees advantageously. Finally, of course, they may be able to hire a legless bookkeeper or a blind darkroom technician or otherwise heed directly the slogan, "It's good business to hire the handicapped."

The physically handicapped need to be viewed in positive perspective. No longer the subjects for extermination or ridicule as historically they were, these people next door deserve rehabilitation, encouragement, and a place in which they can contribute their fair share to society and in which they can achieve some personal satisfaction.

HEAL THYSELF

"Reason's whole pleasure, all the joys of sense,
Lie in three words—health, peace, and competence."
—Alexander Pope: *Essay on Man.*

For someone who preaches the importance of preventive medicine, the physician habitually is a sorry example. He drives himself too hard, seldom has a physical check-up until something obviously is wrong, and leaves his wife to keep up with her own annual examination and routine checks of their youngsters.

Up-to-the-minute statistics to prove those contentions are not at hand, but between 1938 and 1942, physicians in the United States 45 years of age and older had a slightly shorter life expectancy than the general white population. Physicians had a lower death rate from most infectious diseases, conditions treated surgically, and accidents, but a higher rate from the degenerative diseases and from suicide.*

The age at death of English physicians who died between 1897 and 1916 and who were listed in "Who's Who" averaged 69.5 years, whereas the average age at death of physicians whose obituaries were noted in *The Journal of the American Medical Association* from 1950 to 1952 was only 67.1 years.†

Dr. Merrill Shaw, Seattle general practitioner who was vice-president of the American Academy of General Practice at the time of its annual meeting last March, said he did not remember a single doctor ever coming to him for a physical examination during his twenty years of practice.

These facts are indicative, at least, of the doctor's inclination to look after the other fellow's health and let his own take care of itself.

The Academy of General Practice, sensing that physicians display a singular lack of interest in their patients (who want their doctors to stay alive, alert, and able) and in themselves (who could learn to taste better and longer the fruits of their labors) by ignoring some of the basic principles of staying healthy, are promoting a nationwide campaign to assure "A Family Doctor for Every Doctor's Family." The Woman's Auxiliary of the American Medical Association is cooperating in the project. In fact, the Auxiliary for a long time has been beating the drums for annual physical examinations for each member of the physician's household.

C. S. Lewis aptly pointed out: "The Future is something which everyone reaches at the rate of sixty minutes an hour, whatever he does, whoever he is."‡ What one does with those sixty minutes, however, determines to some degree what the Future may bring. For a long earthly Future as full of good health—physical and mental—as modern medicine can make it, a physician and his family need to take an occasional but appointed sixty minutes for a visit to a colleague and then need to follow his advice.

Dublin, L. I., and Spiegelman, M.: Longevity and Mortality of American Physicians, 1938-1942; Preliminary Report, J.A.M.A. 134: 1211-1215 (Aug. 9) 1947.

†*Poynton, O.: Death and Distinction, J.A.M.A. 153:1379-1380 (Dec. 12) 1953.*

‡*Screwtape Letters, New York, Macmillan Co., 1941.*

CURRENT EDITORIAL COMMENT

ABC'S OF ACCIDENT AND HEALTH INSURANCE

Social purpose combined with free enterprise has produced spectacular results in today's development of voluntary health and accident insurance. One out of every two persons today has some form of surgical insurance; ten years ago it was only one out of fourteen. One out of four today has medical insurance, most commonly to pay for in-hospital calls by doctors for nonsurgical treatment. This amounts to a tenfold increase in ten years. These figures indicate the remarkable growth in protection provided by Blue Cross and Blue Shield and the more than 800 insurance companies that sell accident and health insurance.

This department of the JOURNAL *presents editorial comments on current items pertaining to the science, art, and practice of medicine, contributed by members of the Texas Medical Association and others closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the Texas Medical Association to submit such discussions for this department. The discussions preferably should be between 300 and 500 words in length.*

With all this rapid growth, traditional relationships between doctor and patient have not been disturbed. During the 1930's it was often difficult for a doctor to get more than 60 per cent payment of his outstanding bills, but today an American Medical Association authority estimates doctors receive payment on more than 95 per cent of their patients' medical bills. From information supplied by the AMA and insurance personnel, it is conservatively estimated that on the average each doctor receives $2,500 a year in payments from insurance companies alone.

Payments to doctors as well as to hospitals are derived through three main types of insurance policies currently on the market. They are surgical insurance, which specified scheduled amounts for listed procedures or unlisted ones of like difficulty; medical insurance, which provides funds to help pay for calls made by the doctor or for visits to his office by the patient; and hospital insurance, which at times benefits the doctor indirectly in that it eases the financial load on the patient and thereby makes available for the payment of doctor bills money which the patient otherwise might have spent for hospital care. Hospital expense insurance pays for room and board charges up to a certain amount for a specified number of days, with an additional allowance to pay for other hospital charges.

These policies are often termed the basic coverages. Their purpose is to provide timely benefits in sufficient amounts to prevent financial hardship on the family in case of accident or sickness. Benefit payments, whether to the insured person or to the doctor or hospital by assignment, are running in the neighborhood of $2 billion a year.

Frequency of claims in accident and health is probably greater than in any other line of insurance. In fact, a health or accident benefit payment is made for approximately one out of every ten insured Americans every year. Insurance companies have to rely on doctors to prevent excessive use by the patient, one of the things that will most quickly make the policy too costly to buy.

Accident and health insurance does not manufacture funds to pay the cost of medical care. It allocates, saves, and distributes them. In a sense it is a method of prepayment by a group of policyholders, combined with protection and peace of mind for the insured.

So that one policyholder will not take advantage of the others, individual or family policies contain certain safeguards, including waiting periods, exclusions, and limitations on benefits. With group insurance, however, fewer safeguards of this kind are needed to protect the other policyholders since a reasonable number of healthy persons will be in the group.

From the viewpoint of price to the policyholder, group insurance has the advantage of wholesale merchandising over retail selling. But often a person will find that his benefits under group insurance are not adequate for his individual needs. Or he may not be a member of a group that offers insurance. Sometimes having an individual type policy is the only way he can get health and accident protection since there are certain legal and practical limitations on group insurance.

Through individual policies a person can purchase a selection of coverages closely tailored to meet his own objectives. Guaranteed renewable or noncancellable insurance can carry a policyholder up to a certain age, maybe 60 or 65 years. The company may neither cancel the policy nor refuse to renew it so long as premiums are paid when due or within the grace period. It is more expensive than the cancellable contract. The cancellable type falls into two categories. One type may be cancelled by the insurer without prejudice to any pending claim by written notice to the insured and the return of the pro rata premium. The other type may not be cancelled during the term for

which the premium has been paid and accepted by the company, but the insurer may refuse to renew on any premium due date.

Beyond hospital-medical-surgical insurance there are two additional types of protection that are going a long way toward helping pay the costs of ill health. Income replacement, sometimes called disability or loss-of-income insurance, is available individually or through groups. Funds are provided to help maintain a standard of living and to help meet bills (medical included) when the regular source of income is cut off. Monthly or weekly benefits are given for as long as two or more years when a person cannot work. Lump-sum benefits are provided for loss of sight or limb. Insurance companies are providing income replacement insurance for about 30,000,000 Americans today. The other type is major medical or catastrophe insurance, which provides protection against the huge bills that ordinarily could not be met by a person or family or for those bills that would throw the family budget out of kilter for several years.

Major medical expense insurance is a relatively new kind of protection, the first policies being written in 1949. Today, more than fifty companies are insuring 1,250,000 people under major medical contracts.

There are three important features about major medical expense insurance contracts. First, they are usually written with a $100 or $500 deductible clause, as in automobile collision insurance. Over and above the deductible amount, most policies pay 75 per cent of the bill, with the insured paying the remainder. This feature, called coinsurance, is the second important element of major medical contracts. Found in one form or another in some other types of insurance, it has the effect of keeping the individual from demanding excessive medical treatment and, at the same time, holding the premium at a level the average person can afford. With the increasing demand of patients for medical treatment, this feature becomes highly important. As a third feature, major medical policies have a top limit of payments sometimes as high as $2,500 or even $10,000.

Most major medical expense insurance is geared to over-all medical expense of the policyholder, regardless of whether it results from hospital care, home care, or medical treatment bills. It provides benefits to pay for medical specialists whose services are not now included under the regular medical-surgical policies.

Insurance leaders state that future objectives include programs in which a man with dependents can obtain a policy under which at least three-fourths of his expense for medical care would be covered, except for the minor items which could be provided more efficiently out of his own pocket rather than through insurance.

HEALTH INSURANCE COUNCIL,
Chicago, Illinois.

208 South LaSalle Street.

This is the second in a series of four articles prepared at the request of the Hospital-Insurance-Physicians Joint Advisory Committee of Texas. The final papers will offer suggestions about what to tell patients who ask for advice on buying and using voluntary insurance.

CANCER DEATHS

Persons who survive a cancer operation by several years have an encouraging life expectancy, according to a recently completed study by the Society of Actuaries. Included in a study of 725,000 policies covering persons with some known physical impairment were about 1,000 persons who had been operated on for cancer five years or more prior to acceptance for the insurance. The study covered the period from 1935 to 1950.

Among the cancer group, the ones who had been accepted as standard risks showed a mortality experience during the fifteen years about equal to standard. Those accepted for extra risk policies showed a death rate about twice the normal for standard risks, with all excess mortality due to recurrences of cancer. Analysis of the experience of persons reporting a family history of the disease showed, for all sites of cancer combined, no significant tendency for it to be hereditary.

"The Doctor"

A realistic drama depicting a day in the life of a middle-aged physician will be televised on the December 7 "Cavalcade of America" show. The show, entitled "The Doctor," stars Dean Jagger and is expected to duplicate the drama in every practicing physician's life and to win greater understanding by the public of the job he has to do.

ORIGINAL ARTICLES

A WORD IN FAVOR OF MORE THERAPEUTIC SKEPTICISM

WILLIAM H. GORDON, M. D., F.A.C.P., Lubbock, Texas

MEDICAL philosophies have changed during the past century, and whereas change is necessary for progress, it does not follow that all changes lead to progress. In the field of therapy there have been unbelievable changes. Most of them have been good changes; some of them have not been good. It would appear at times that we have completed a cycle of therapeutic practices, starting with the premise of empiricism, passing through a period of relative nihilism, only to return to more empiricism. We need, as Sir William Osler[1] stated, "a stern iconoclastic spirit which leads not to nihilism, but to an active skepticism—not the passive skepticism born of despair, but the active skepticism born of the knowledge that recognizes its limitations and knows full well that only in this attitude can true progress be made."

Dr. Osler could be regarded as the "father of modern scientific medicine." Before his time clinical medicine was on a shaky footing, not far removed from beliefs firmly entrenched in folklore, superstitions, and at times, quackery. His study of the patient, painstaking attention to details, and correlation of subjective and objective findings with postmortem findings, gave clinical medicine the impetus necessary to establish it on a firm scientific basis. This knowledge excluded the likelihood of benefit from indiscriminate drugging, as was practiced, and it brought about the concept of the difference between the giving of medicine and the treatment of disease.

Osler's death in 1919 occurred on the threshold of modern therapeutic advancement. During the subsequent thirty-five years, we have been deluged with so many alleged specifics—many of them actual—that the adherence to a "spirit of active skepticism" has been difficult. Nevertheless, its need is evident. One needs to view medical therapeutics objectively and to ask several questions. Have we slipped back into the practice of giving medicine rather than treating disease? Have we not, perhaps, stressed the administration of wide spectrum antibiotics to the detriment of accurate diagnosis? Now that we have so many good drugs with which to treat disease, have we not relied on shotgun management of the problem rather than finding which specific drug would do the job best? Finally, is this concept important?

One can cite the decline of the nation's mortality and morbidity figures, which surpasses that of any period in medical history. One can cite also the shortening of the average hospital stay. Is this all there is to the practice of medicine? If this is our only goal, we have been successful. Should we not ask ourselves if, by unrestrained practices of this sort, we are losing some of the scientific approach to treatment that was stressed by our medical forefathers and that is necessary for good medical practice?

Because of our excellent therapeutic agents, drugging is more effective now than it was in Osler's day, but this fact detracts little from his statement,[1] "in the fight which we have to wage incessantly against ignorance and quackery among the masses, and the follies of all sorts among the classes, diagnosis, not drugging, is our chief weapon for offense." Some of us are too prone to administer drugs first and to diagnose later, that is if the first salvo of drugging is ineffective.

Let us review some aims of medical therapy. An old medical axiom expresses the thought that physicians "cure sometimes, benefit often, and give comfort always." There are few of us who have not had our lecturers in therapeutics stress an obvious fact that in treatment if our measures do not benefit, they should do no harm. Every practicing physician is aware of the many patients who seek relief from functional complaints. Office psychotherapy has commonly been accompanied by some medicine that may not be specific in its actions, but it bolsters the belief that active treatment is being instituted. The old family physician brought about many miraculous cures through limitless understanding and bread pills. He was one of the first to use that which is now called psychosomatic medicine. The same philosophy is now practiced, but antibiotics, vitamins, hormones, and many other active and expensive agents are prescribed instead of bread pills. A physician should not lose sight of the fact that these may do harm, and he should wonder if they are always necessary.

Truly, the practicing physician is bombarded daily by requests for treatments of a self-diagnosed ailment, and pressure is put on the doctor to use some new wonder drug reported in the latest Digest of

Read as part of a symposium on therapeutics before Section A (Medical), Texas Medical Association, Annual Session, San Antonio, May 5, 1954.

World Affairs. Is the rationalization that "if I don't give it, someone else will" enough to cause the profession at large to relinquish its right to make medical decisions and to prostitute these expensive and, when properly used, marvelously effective agents? One must remember that when these agents are used without proper indication not only may they be ineffective but they actually may do much harm.

One should not be unreceptive to new ideas, but as Osler suggested, one should hold an active skepticism toward new methods and new agents. Simply because some investigator has made a glowing report of the effectiveness of an agent does not always lead to the fact that others can obtain the same effect. This is no reflection on the writer or his scientific honesty or ability. Rather, it is the recognition that enthusiasm at times may color judgment. It has been said that the effectiveness of the therapeutic agent is often proportionate to the personality of him who gives it.

Despite every attempt being made to the contrary, the fads creep into medical thinking and practice. These fads may pertain to diets, surgery, ambulatory versus bed management, and the use of this or that therapeutic agent. Without detracting from the great good that has been done by the commercial pharmaceutical houses, we should reserve judgment on the effectiveness of a new agent that is presented by a personable and enthusiastic representative until its worth has been well established.

SUGGESTIONS

To be more specific in our dedication of aims, the following suggestions are listed:

More time and more money spent on diagnostic procedures perhaps can shorten an illness and eliminate many expenses stemming from indiscriminate drugging.

A clear understanding of the patient's illness and of the pharmacodynamics of the agent to be used is necessary for proper treatment.

Recognition of uncomfortable side effects or actual dangers attending the use of a drug in comparison with the possible good that can be expected may alter the decision as to what agent is to be used.

Too early and indiscriminate surgery, roentgen-ray therapy, or drugging may cloud an already cloudy picture without benefiting either the clinical course of the patient or the understanding of the clinician.

Our modern philosophy that doing *something* is a step in the right direction does not always hold true. In certain instances, "tincture of time," an effective agent when properly used, might be encouraged.

More time spent in listening to the patient's story or examining him and less time used in writing prescriptions, giving shots, or writing orders on the chart probably will result in better medical practice.

Finally, therapeutic nihilism should not be our aim in this modern era in which we are blessed with so many things with which to do good; rather, we should remain steadfastly against their misuses. By so doing, our patients will be safeguarded, our profession will avoid criticism, and we physicians will gain in stature in the eyes of those who follow us.

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2022 Broadway.

CATASTROPHIC ACCIDENTS

Accidents killing five or more persons took less than half the number of lives in the United States during the first six months of 1954 as during the comparable period the previous year, statisticians of the Metropolitan Life Insurance Company report. There were slightly over 500 deaths during the first half of this year.

The greatest decrease in catastrophic deaths was in civilian aviation and in tornadoes. In general, the trend was toward increases in catastrophic deaths in military aviation and in dwelling and apartment fires.

The largest single catastrophe this year was the flood in Southwest Texas which cost twenty-three lives.

Thyroid Gland Essay

The best essay submitted concerning original work on problems related to the thyroid gland will win the Van Meter award of $300 from the American Goiter Association at its meeting in Oklahoma City, April 28-30, 1955. Two honorable mentions will also be awarded.

The essays, which may cover either clinical or research investigation, must not exceed 3,000 words and must be submitted by January 15, 1955, to Dr. John C. McClintock, Secretary, 149½ Washington Avenue, Albany, N. Y.

VITAMIN C IN ELDERLY PATIENTS

Elderly persons show a low level of vitamin C in their blood, it was noted in a study by three Boston physicians in the August issue of *Geriatrics*. The low vitamin C content in the foods they eat or the losses of the vitamin in food preparation are possible causes. One hundred and forty aged patients were observed in three mixed groups of well and chronically ill persons by Drs. Leo J. Cass, Willem S. Frederik, and J. D. Cohen. They reported the rapid rise in the vitamin C level when the patients received orange juice or ascorbic acid.

"Frozen concentrated orange juice, processed under low temperature evaporation, retains about 98 per cent of its vitamin C content and hence is an excellent source of this vitamin, equal to fresh orange juice," they added.

Industrial Medicine Course

The University of Texas Postgraduate School of Medicine is sponsoring a course in Industrial Medicine, given each Tuesday evening, October 12 through November 16, at the auditorium of the M. D. Anderson Hospital and Tumor Institute. Dr. V. C. Baird, Houston, is instructor in charge, and each program is composed of three thirty-minute speeches plus a question and answer period.

RECENT ADDITIONS TO THE THERAPY OF NEUROLOGIC CONDITIONS

F. KEITH BRADFORD, M. D., Houston, Texas

THE most striking annual progress in therapy in the fields of neurology and neurosurgery has occurred in the increased usefulness of antibiotics in combating infections of or threatening the central nervous system. Although newer antibiotics have increased our armamentarium, the improvement in mortality statistics has largely resulted from increasing and standardizing dosages of the older antibiotics. Sulfadiazine in adequate dosage is used in conjunction with the antibiotics when the organism is sensitive. Results are greatly improved by early diagnosis.

When reasonable probability of meningitis exists, spinal puncture should be used promptly to confirm the diagnosis. Cultures are often negative if antibiotic therapy is undertaken blindly before a specimen of cerebrospinal fluid is taken. Therapy is greatly hampered if the causative organism is not known. When the organism has been isolated, tests of sensitivity to various antibiotics can aid in selecting the most efficacious ones. When such steps are taken promptly, there need be no delay in initiating adequate provisional therapy, which can be altered as subsequent bacteriologic tests indicate.

A serious problem in diagnosis has resulted from the prevalent use of short term antibiotic therapy in treating symptoms of the upper respiratory tract. Among the many patients receiving such short term treatment are significant numbers of patients whose "respiratory symptoms" were prodromes of meningeal infections. Although cure without a diagnosis being made undoubtedly occurs, many other patients later develop a modified clinical picture of meningitis. In such instances the cerebrospinal fluid often will show a predominance of lymphocytes even though a pyogenic organism is responsible for the infection. Often bacteriologic cultures are negative, making sensitivity tests impossible and the choice of antibiotics difficult. Organisms may have developed resistance to antibiotics, and treatment is ineffectual or prolonged. Modified pyogenic infections often resemble tuberculous infections and are differentiated only with the greatest difficulty.

In treating meningeal infections, it is ideal to strike early and hard, usually with antibiotics and sulfonamides. Ideally, the infection is brought under control before any exudates can undergo organization and threaten obstruction of the cerebrospinal fluid pathways or loculation within the subarachnoid space. The response to treatment must be followed by careful, repeated spinal punctures. Unfortunately, there are physicians who have opposed repeated spinal punctures in the course of meningitis, probably as a result of the relatively certain response resulting from the treatment of meningococcic meningitis. Other organisms are not so tractable.

Intrathecal therapy with penicillin or streptomycin is not desirable in infections running a favorable course but may be necessary in others. Catastrophe from intrathecal injection per se is avoided if 10,000 units of penicillin or 0.01 Gm. of streptomycin is injected diluted to 10 cc. with normal saline or cerebrospinal fluid.[2] This, the adult dosage, probably can be doubled safely. Larger amounts, often ten or more times the recommended dosage, have been given as a result of erroneous calculation with death or paralysis resulting. Streptokinase-streptodornase mixtures have been used at times intrathecally with the intention of dissolving exudates to prevent organization. This use is still experimental and cannot be recommended.

Not infrequently there is a period of increased cerebrospinal fluid pressure following an otherwise satisfactory response to therapy. Often this state is due to no more serious complication than a temporary defect in the absorptive mechanism of the cerebrospinal fluid. Repeated spinal drainage usually prevents serious complications in such cases and results in the gradual return of pressure to normal.

Intracranial complications of acute otitis media, mastoiditis, and sinusitis are rare when the primary infection is treated adequately. However, a patient with chronic middle ear infection may develop a brain abscess years after the infection has become relatively dormant. Also, the type of frontal sinus infection which occasionally follows diving may produce osteomyelitis of the frontal bone and intracranial infection before its serious nature is recognized. With modern methods of treatment, acute brain abscesses may be aborted or may be permitted to wall off and become chronic. Although surgical drainage is much less frequently necessary with antibiotic therapy, the indications are unchanged. Mortality is greatly re-

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duced even in acute brain abscess which must be operated upon when a fatal increase in intracranial pressure threatens. Multiple drainage of subdural abscesses, excision of involved bone in osteomyelitis, and other sound surgical methods still must be used and stand a far greater chance of success with the addition of the antibiotic drugs.

Favorable results have been reported in those cases of Guillain-Barré[1, 4, 6] paralysis following the malignant pattern of Landry's ascending paralysis. ACTH and cortisone administered in dosages up to 400 mg. in twenty-four hours have produced marked prompt improvement in paralysis. Relapses have occurred with withdrawal of the hormones, and prompt responses have followed resumption of treatment. Proper precautions and care are essential in administering either of these potent hormones. It appears likely that a fatal march of paralysis may be circumvented with the use of these hormones but that the course of the illness is not shortened. Promising results have been reported also by the early treatment of Bell's palsy with cortisone in similar dosage.[5] Treatment must be instituted within a few days of the onset. Six successive cases, treated early, followed courses much more favorable than would otherwise have been expected. The rationale of treatment is that cortisone reduces the swelling of the facial nerve or geniculate ganglion lying against it in the bony canal within the temporal bone. Neuralgia following herpes zoster has shown no improvement after ACTH or cortisone therapy. There is reason to hope that if such treatment is given early in the course of herpes zoster, post-herpetic neuralgia, which is so disabling in older individuals, might be averted.

The response of patients with trigeminal neuralgia (true tic douloureux) to 1,000 microgram daily doses of vitamin B_{12} administered subcutaneously has been notable enough to make it well worth a trial. Some patients with this condition respond well to oral doses of nicotinic acid sufficient to cause flushing and tingling of the skin (100 to 500 mg.). These two types of medical treatment have lessened the number of cases requiring alcohol injection or posterior root section. Unfortunately, the response of atypical facial neuralgias to either form of medical treatment (or to surgical treatment) is poor.

There is probably reason to be hopeful that the annual scourge of acute anterior poliomyelitis will be mitigated by the use of gamma globulin and vaccination.

There has been progress in the treatment of hydrocephalic children, but the outlook must be guarded. Cases first must be classified as carefully as possible. If the aqueduct of Sylvius is blocked, a tube may be placed connecting one lateral ventricle with the cisterna magna. In communicating hydrocephalus, the lumbar subarachnoid space may be connected to the peritoneal cavity or to one ureter after nephrectomy. In other instances, connection between the lateral ventricle and peritoneal cavity or ureter is elected. The growth factor will necessitate tube-lengthening procedures in the longer anastomotic tubes. Ureteral drainage appears to be the most satisfactory over a period of time. However, it has the disadvantages of sacrifice of one kidney, infections ascending to the meninges, and electrolyte loss, which is often critical in young children, by the free passage of cerebrospinal fluid into the bladder. Subdural accumulations of fluid, easily evacuated or drained, may be only one phase of a complex picture. Spontaneous arrest or unlearned factors may be the essential features leading to recoveries which are attributed to meddlesome procedures that have been performed. The extent of the problem is revealed in a recent article reporting 3 cases of hydrocephalic children who underwent a total of 16 operations with dubious results.[3]

I would like to emphasize tracheotomy, a procedure of great value and little risk which has demonstrated its increasing importance in the treatment of patients with obstruction of the airway, paralysis of the respiratory muscles, or aspiration complications affecting the bronchial tree. In patients with head injuries, brain tumors or abscesses, cerebral vascular accidents, bulbar poliomyelitis, ascending paralysis, or tetanus, tracheotomy is often life-saving. The need for tracheotomy should be anticipated hours before it becomes an immediate, urgent necessity. Local anesthesia is satisfactory. Proper instruments and cannulas are essential. Hemostasis must be complete and the cannula must be properly placed. Adequate suctioning of the cannula and upper respiratory tract must follow tracheotomy to obtain the full value of its use. Certainly, tracheotomy is often an essential part of an all out effort to enable a critically ill patient to survive.

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SOME COMPLICATIONS OF ANTIBIOTIC THERAPY

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THE past decade has witnessed dramatic changes in therapeutics directed against diseases caused by bacteria and rickettsiae. These have followed the isolation and purification of the many presently and widely employed antimicrobial agents.

Prior to the advent of penicillin, pneumococcal pneumonia, acute mastoiditis, syphilis, and the like were seen and treated in large numbers. Now they are seen less frequently, if at all. Pneumococcal pneumonia was once the "captain of death" with a mortality rate of 30 per cent. This rate has fallen below 5 per cent. Acute mastoiditis is now only a medical curiosity. Large clinics and hospitals have difficulty finding even occasional patients with primary and latent syphilis for teaching purposes. The same can be said for many other infectious diseases.

Along with this fall in frequency of important infectious diseases, there is an associated widespread use of antimicrobial agents. More than one-half of all prescriptions written are for antibiotics of various forms. Furthermore, the search for new products and for an understanding of the mechanism of action of these agents continues unabated.

While many problems in the field of infectious diseases have been resolved, the widespread use of antibiotics has created new and perplexing ones. Among these are the side reactions or untoward effects, which may be allergic, toxic, or related to a specific biologic action of one or more of these agents.

The list of undesirable effects actually observed and attributed to antibiotics is long and not at all consistent for the entire group of antimicrobial agents. Penicillin usually provokes a cutaneous allergic or an immunological reaction while the untoward effects of the broad-spectrum antibiotics are rarely evidenced by cutaneous manifestations. Therefore, for convenience, the complications of the antibiotics are discussed in relation to various organ systems which may be affected.

CUTANEOUS MANIFESTATIONS

Systemic administration of antibiotics provokes in the skin a wide variety of reactions. Most of these probably are due to sensitization and often are accompanied by pruritus and fever. Such lesions frequently appearing during or after therapy are transient and disappear. They may increase in severity and may result in serious consequences if therapy is continued.

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Penicillin is capable of causing the widest range of sensitivity and immunological reactions from a mild drug fever or a transient rash to exfoliative dermatitis and acute anaphylaxis. The cutaneous sensitivity eruptions of the mild and moderately severe type are frequently observed; fortunately, exfoliative dermatitis appears infrequently. Other reactions of hypersensitivity and immunological change include angioneurotic edema, serum sickness, and acute anaphylaxis. The severe anaphylactic reaction following penicillin does not occur unless the patient has been previously sensitized to this antibiotic. Use of penicillin in minor respiratory infection should be avoided in order to prevent hypersensitization. Presently penicillin is the most frequent single cause of this dangerous complication. The frequency of anaphylaxis is much higher than is being reported.

Contact dermatitis has been observed with many antimicrobial agents, especially penicillin and streptomycin. Persons who handle these agents but who have not been previously sensitized to them may have a dermatitis of the hands and face. This is usually accompanied by edema and vesiculation or eczema. It has been noted that the highest frequency of local and systemic sensitization occurs when these antibiotics are applied locally to the skin in ointments or oily suspensions. In any clinical situation the local application of these antibiotics in this manner should be considered carefully in order to avoid sensitization to future parenteral therapy.

Sensitization to the sulfonamides and penicillin has been suggested as one of the cardinal reasons for the evident increase in the diagnosis of periarteritis nodosa and acute disseminated lupus erythematosus. These diseases long have been suspected examples of severe diffuse sensitization reactions of the tissues to certain drugs, and the sulfonamides and penicillin are receiving increasing scrutiny as possible causes of some of the so-called acute collagen diseases.

ORAL LESIONS

Among the untoward reactions to the antibacterial agents, thirty-three different oral manifestations have been reported.[4] These are described as ulcerative or vesicular stomatitis and usually are provoked by the broad-spectrum antibiotics as follows: oxytetracycline (Terramycin), chlortetracycline (Aureomycin), tetracycline (Achromycin), and chloramphenicol. The chief symptoms are burning, dryness, soreness, and itching of the mouth and tongue. Examination reveals red and inflamed buccal mucous membranes, with or

without vesicles. The tongue may be red, smooth and shiny, swollen, furred, or denuded. Angular stomatitis (cheilosis) has been ascribed to riboflavin deficiency caused by broad-spectrum antibiotic administration. Yet the parenteral administration of massive doses of this vitamin with others of the B complex has usually failed to cure the lesion so long as the specific therapy was continued.

Distressing oral and gastrointestinal tract reactions are observed with greater frequency following the use of lozenges and troches than following oral or parenteral therapy. There may be some question as to whether treatment with lozenges and troches should be recommended for any purpose. This question is because of the frequency of these oral lesions, the danger of systemic sensitization, and the serious doubt that the antibiotic content in lozenges and troches is sufficient to be effective.

GASTROINTESTINAL DISTURBANCES

The broad-spectrum antibiotics administered orally often are followed by nausea, with or without vomiting, and by diarrhea of varying severity. These usually result from the direct irritating effect these agents have upon the gastrointestinal tract.

Severe diarrhea may present a difficult problem in management. Frequent liquid stools containing mucus and pus and often associated with high fever, weakness, and at times prostration upset the management of any infectious disease. Some cases of diarrhea are caused by coagulase-positive and hemolytic strains of Micrococcus pyogenes var. aureus (Staphylococcus aureus). This entirely new disease entity appeared following the introduction of broad-spectrum antibiotics. When these organisms appear in the stool in pure culture, they probably come from the upper respiratory tract and represent acute staphylococcal enteritis.

Acute colitis or chronic colitis, with the bowel flora consisting exclusively of Proteus, Pseudomonas, Monilia, and other less common organisms, have been recorded following the administration of the broad-spectrum antibiotics. These often resist the reestablishment of the normal bowel flora, even though the antibiotics are discontinued.

Acute monilial stomatitis, pharyngitis, vaginitis, and proctitis may accompany the administration of some of the antibiotics. More severe instances have resulted when these were administered over long periods or to debilitated patients.

Recently Reiner and his associates[5] presented evidence that Aureomycin is responsible for pseudomembranous colitis. Their studies of 49 necropsies indicated that 7 patients died of this specific condition. In many others there was microscopic evidence of the hyperproduction of tenacious mucus in the colon. In no instance could a specific enteric pathogen be cultured from the feces. Kleckner[3] and his coworkers reviewed the incidence of pseudomembranous colitis in a large clinic during the past decade. Since the widespread use of the broad-spectrum antibiotics, there has not been an associated increase in the frequency of this condition. Therefore, the possible relationship between the broad-spectrum antibiotics and pseudomembranous colitis remains undetermined.

EFFECT ON BLOOD FORMING ORGANS

The most serious hematologic reaction is the development of hypoplastic or aplastic anemia. This has occurred primarily in patients who have received repeated and prolonged courses of chloramphenicol. A number of deaths have resulted from this type of anemia, often caused by chloramphenicol used in the treatment of relatively trivial conditions. The bone marrow disclosed hypoplasia of all the marrow elements, and there was a reduction in the red blood cells, polymorphonuclear granulocytes, and platelets in the peripheral blood. The immediate cause of death has usually been hemorrhage, gastrointestinal or intracranial.

In my opinion chloramphenicol has been implicated severely and perhaps unnecessarily as a cause of hypoplastic anemia. The number of proven cases of this blood disease is small and not impressive as compared to the frequency of its successful use in therapy, especially where its employment is strongly indicated. The advantages of this antibiotic have been greatly weakened by the fear of this complication, and to avoid such complications, adequate blood studies should be made at regular intervals during treatment. Its casual use is not justifiable.

BIOLOGIC ACTION

Bacterial antagonism has been recognized since Pasteur first noted that a delicate balance existed in the environmental struggle between microorganisms. There is a constant struggle for survival exemplified best by the organisms in the soil. Bacteria, fungi, and Actinomyces become established when the environmental conditions (organic matter, acidity, physical and chemical properties, and the like) are most favorable to their growth. This established soil flora resists the entrance of other organisms by the production of toxic metabolites (antibiotics) which inhibit or destroy the invader before the new organism can become established. Many of the presently

employed antibiotics have been isolated and purified from these ubiquitous soil organisms.

Man also has an established flora of microorganisms in the skin, mouth, pharynx, vagina, and bowel. The administration of any antibiotic may upset this synergistic balance by depression or elimination of certain groups of organisms. Thus, agents that tend to inhibit gram-positive bacteria will allow the gram-negative microorganisms to flourish;[1] the opposite is also true. Under such circumstances the established flora becomes so altered that the microorganisms insensitive to the drug used become the predominant type. Such changes may not be significant, but occasionally a new or a superinfection results.[2] Whether these occur only because certain organisms normally present as saprophytes increase numerically to the extent that they may become invasive, whether there are tissue changes resulting from certain antibiotics that favor invasion of tissues by bacteria of low pathogenicity, or whether there is bacterial stimulation by the antibiotics remains obscure. It is significant, however, that a small percentage of patients treated by antimicrobial drugs become infected with different organisms from the one for which the therapy was originally given. Locally administered antibiotics, as in the eye or female genital tract, have a greater tendency to provoke new infections than when given for a specific systemic infection.

The organisms that have been observed to increase and occasionally to provoke a superinfection during antibiotic therapy are various species of Proteus, Pseudomonas aeruginosa, Micrococcus pyogenes var. aureus, Candida albicans, and Hemophilus influenzae (in children particularly).

Perhaps the most serious complication resulting from the widespread use of the antibiotics is the emergence of organisms that are becoming increasingly more resistant to most of the agents now commonly used. The great majority of important infectious agents have not become resistant. However, Micrococcus pyogenes var. aureus has developed an increase in resistance to all the antibiotics, including the most recent agent, erythromycin. I have observed this increase in resistance in a patient who was treated for a staphylococcal septicemia. This problem relates not only to the Staphylococci, for many other organisms previously considered less important infectious agents are capable of increasing their resistance to specific antimicrobial therapy. The number of antibiotics yet to be discovered may be limited, at which time the more adaptable pathogens may flourish at will and become capable of increasingly severe infections.

It is remarkable that none of the available antibiotics are free from the potentialities of untoward reactions. The most serious effects are the development of hypersensitivity, the increasing frequency of infections caused by antibiotic-resistant organisms, and, to a lesser extent, the development of superinfections by such resistant organisms.

The onset of untoward reactions to antibiotics during the course of therapy does not always warrant the prompt cessation of therapy. If the agent is the only effective one available for the purpose required, the type and severity of the reaction, its expected course, and the possibility of reducing its severity by proper management must all be weighed on the one hand against the hazard of the infection being treated. If there is a good prospect of favorably influencing that infection by continued therapy with this antibiotic, treatment may continue provided the drug hazard is not significant or can be managed and controlled.

SUMMARY

The untoward effects of antibiotics may appear insignificant compared to their great achievements toward conquering infectious diseases; yet the harmful sequelae of their use (particularly of their abuse) have not been given adequate prominence. The fact that harmful effects appear should not discourage any physician from their use when they are indicated. However, it should be remembered that when used casually for trivial or insignificant infections, severe and occasionally fatal complications may result. The employment of penicillin prophylactically in elective surgery and to treat noninfectious diseases should be strongly discouraged in order to reduce the hazard of hypersensitivity.

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Bulletin on Rheumatic Diseases

The first four volumes of *The Bulletin on Rheumatic Diseases* have been bound and are now available to physicians. *The Bulletin,* issued nine times a year, is available without charge to all physicians and medical students who request it. The bound volume which contains all issues for the past four years is available for $1 from the Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36.

PENICILLIN REACTIONS

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THE introduction of the use of penicillin in 1943 provided the medical profession with a powerful weapon against an innumerable group of infectious diseases. The end of the penicillin decade, in spite of the introduction of many other antibiotics, still found penicillin in wider use than ever before. However, because of this increased usage, more and more allergic reactions have been noted, and it has replaced foreign serums as the most common cause of anaphylactoid shock and anaphylactoid deaths. Our purpose is to discuss these reactions and measures that may reduce their incidence.

The overall incidence of penicillin reactions is not high. It has been estimated at from 2 to 20 per cent by various authors.[1, 2, 3, 8, 9] The incidence is much higher in persons who have a history of allergy, such as asthma, hay fever, atopic dermatitis, and urticaria. Almost every type of toxic drug reaction has been described, encompassing a range in severity from asymptomatic dermatographia and urticaria of transient type to serum sickness type of reactions, exfoliative dermatitis, and anaphylactoid shock.[8, 12, 17] The duration of the reactions may be from a few days up to a year. In general, the more severe the reaction, the less reversible it is, and the reactions of periarteritis nodosa and allergic granulomatosis may proceed for a long time after the initiating allergen, such as penicillin, has been eliminated. Severe anaphylactoid reactions are more common than the published reports would indicate, and we have been given informal reports by six colleagues of 12 anaphylactoid reactions in the past year locally. Welch[19] undertook a survey of 95 large general hospitals, totaling a capacity of 51,000 beds. Over a two year period 59 anaphylactoid reactions to penicillin were reported in this survey, with 19 deaths due to penicillin reactions. Although most of the deaths were due to injections of procaine penicillin, one death followed the oral tablet of dibenzylethylenediamine dipenicillin G (Bicillin). Welch also investigated 25 cases of anaphylactoid reactions to penathamate (Neo-Penil), with 5 deaths. A history of asthma and other allergies was present in 26 of the total group of 84 patients. Two anaphylactoid deaths will be reported in this paper.

The following is a classification of penicillin reactions in order of increasing severity and rarity:

1. Dermatographia
2. Toxic erythemas (morbilliform, scarlatiniform, and so forth)
3. Vesicular dyshidrotic reaction
4. Urticaria
5. Erythema nodosum and erythema multiforme
6. "Serum-sickness" reaction
7. Bullous or pemphigoid reaction
8. Hemorrhagic reaction
9. Purpura and agranulocytosis
10. Periarteritis nodosa
11. Exfoliative dermatitis
12. Allergic granulomatosis
13. Anaphylactoid reaction.

This is admittedly only a partial list of the most common syndromes, and almost twenty other syndromes have been reported.[1, 2, 3, 8]

In all the above reactions the primary shock organ has been the vascular apparatus, in various degrees of severity. Thus in dermatographia exudation of water and electrolytes and probably some plasma occurs after only minor injury to the vessels.

In urticaria, plasma protein, water, and electrolytes pass out of the vessels spontaneously. In erythema multiforme and erythema nodosum the formed elements of the blood leave the vessels into the surrounding tissue, both the red blood cells and white blood cells. In purpura, which may occur with or without depression of the blood platelets, plasma and red blood cells enter the interstitial spaces. In periarteritis nodosa the damage to the blood vessels progresses to a stage of necrotizing arteritis, while in allergic granulomatosis the change is a granulomatous perivascular inflammatory reaction. In anaphylactoid shock, in addition to the smooth muscle of the vessels, the smooth muscle of the bronchioles and probably also the heart muscle are involved in an almost instantaneous reaction. The latter responses either are due to a direct antigen-antibody reaction in the tissue involved or may be secondary to a massive release of a histamine-like substance.

The treatment of these reactions also varies with the severity of the vascular reaction. Thus dermatographia may require no therapy or may respond to antihistamines. Mild urticaria often may be suppressed with the antihistamines. The more severe reactions are usually best treated with ACTH or corti-

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The majority of the case material was obtained from the Dermatology Service of the United States Air Force Base Hospital, Randolph Field, Col. Carl B. Stilson, USAF (MC), Commanding Officer.

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costeroids[5] and are usually very resistant to antihistamine therapy. Anaphylactoid shock may require intravenous epinephrine, intravenous aminophylline to release bronchiolar constriction, and intravenous antihistamines. If time permits, ACTH or cortisone is given, and shock combated with plasma and oxygen therapy.[4, 8] In fatal reactions, actually little time is available, since Collins-Williams[2] in analyzing 16 fatal reactions found death occurred in from five seconds to two and one-half hours, with 10 dying in less than five minutes.

STUDY OF 33 CASES

We have studied in detail cases of penicillin reactions severe enough to warrant hospitalization. More hospital days were spent in treating this group than any other single dermatologic disease. With the exception of one dyshidrotic reaction, all of the cases belonged to the "serum sickness" type of reaction. Most of them had failed to respond to initial medication with various antihistamines. In addition to urticarial lesions of varying size, most of the patients also had swelling of the eyelids, hands, feet, knees, and elbows, with moderate arthralgia, fever, and elevation of the sedimentation rate. One case had hemorrhagic lesions, 1 had bullae, and 1 had electrocardiogram changes with incomplete bundle branch block. Albuminuria was noted in 1 case, and no L.E.-like phenomenon was found in the serum in 10 cases in which the test was performed.

Initial therapy included a vast variety of drugs, including Histadyl, Benadryl, Chlortrimeton, Pyribenzamine, and other antihistamines both orally and intravenously; Adrenalin, sodium salicylate, Pabalate, ephedrine, intravenous procaine, intravenous calcium gluconate, and intravenous Decholin; and sedation with barbiturates (Seconal, Nembutal, and phenobarbital) and analgesics (morphine and Demerol). Of this group 18 cases were satisfactorily relieved with one of the above medications. However, 15 patients continued with severe reactions with little or no response to therapy over a period of two to seven days. Fourteen of these severe cases responded promptly and dramatically to oral cortisone therapy with complete suppression of symptoms and lesions in forty-eight hours or less. One case was treated with ACTH with similar satisfactory results. The average length of therapy with cortisone was five days, with a variation of from two to seven days. Only sufficient cortisone to suppress the symptoms was given, usually not more than 200 mg. the first day, with rapid reduction as improvement occurred. No adverse reactions of any kind were noted to this short course of cortisone therapy. However, we should emphasize these were mostly healthy young men who were not known to have peptic ulcer, tuberculosis, diabetes, or psychotic tendencies.

In this series no recurrences of urticaria were noted. This is not the universal experience, however, as I have observed some cases in private practice in which recurrent reactions have occurred over as long a period as six months, responding only temporarily to corticosteroid therapy. The definite impression is gained, however, that early treatment of severe reactions with ACTH or cortisone not only gives prompt relief of all symptoms, but reduces the incidence of prolonged resistant reactions. As a result of this experience, it is our present policy to initiate cortisteroid therapy in all severe penicillin reactions from the onset, with the aim of both cutting short the reaction and reducing the duration of the reaction and hospitalization.

The indications for the use of penicillin in these cases was tabulated (table 1) and 25 different conditions were encountered. Diseases of the throat and respiratory system predominated. The validity of the indication was impossible to evaluate.

TABLE 1.—*Diagnoses Given as Indications for Penicillin Therapy.*

Diagnosis	No. Cases	Diagnosis	No. Cases
Upper respiratory infection	5	Urinary tract infection	1
Pharyngitis	2	Nonspecific urethritis	1
Acute sinusitis	1	Syphilis	1
Bronchitis	1	Impetigo	1
Acute tonsillitis	1	Carbuncle	1
Otitis media	4	Infected toe	1
Primary atypical pneumonia	1	Ingrown toenail	2
Granuloma of lung (preoperative)	1	Infection of gum	1
Orchitis	1	Sprained wrist	1
Mumps	1	Abrasion	1
Rectal abscess	1	Laceration	1
Anal fistula	1	Pain in side	1
		Infected tooth	1

In many of these cases the trouble with the penicillin reaction was more by far than the trouble with the primary disease.

CASE REPORTS

In addition to this group, I would like to report, with the permission of the physicians concerned, on 2 fatal anaphylactoid reactions which previously have been unreported.

CASE 1.—A 29 year old married woman complained of a cold of several days' duration and an injury to her left leg. She gave a past history of intractable asthma, for a year requiring Adrenalin constantly and almost biweekly visits to the doctor for relief of severe attacks with injection of intravenous aminophylline. She previously had had both penicillin and procaine with no reactions.

On examination the left leg presented a black and blue area 6 by 3 cm., with fluctuation in the center. The fluctuant area was incised and a small quantity of pus was evacuated. The patient was given procaine penicillin 300,000 units intramuscularly because of the abscess. Five minutes later the patient became cyanotic, tremulous, and speechless. She fell to the floor. Blood pressure and pulse could not be obtained, and she ceased breathing. Artificial respiration, oxygen, and intracardiac Adrenalin failed to resuscitate the patient. From the onset of symptoms of reaction to death was apparently only a matter of seconds.

CASE 2.—An infant, aged 6 weeks, had had a draining ear for four days. Examination revealed a profuse purulent discharge. No penicillin had been given previously. The family history was negative for allergies, and the mother had had penicillin without reaction. Procaine penicillin in aqueous suspension 300,000 units was given in the buttocks. No blood returned to the syringe on aspiration before injection. The baby cried for one minute, the breathing stopped, heart beats were not audible on auscultation, and the patient became cyanotic. Adrenalin and caffeine were injected. Within four minutes the chest was opened and cardiac massage started. Artificial respiration with oxygen was given for one and one-half hours. No resuscitation occurred. The father was a military medical technician and stated that he had observed two similar anaphylactoid deaths from penicillin while he was overseas.

Death was almost instantaneous in both cases, once the reaction started, and probably had occurred before treatment was started, prompt as it was. There was no evidence of intravascular injection. There is not absolute proof that penicillin and not procaine was the active antigen. However, the experience of Thomson[18] may be cited. A patient had a severe reaction to procaine penicillin from which he recovered. In the belief that the reaction had been caused by procaine and not penicillin, two months later the physician gave him an intramuscular injection of penicillin G. The patient was dead in fifteen minutes.

PREVENTION OF REACTIONS

Because of this increasing problem, various measures have been proposed to prevent reactions to penicillin. One obvious measure is not to give penicillin injections except for adequate indication. Certainly penicillin therapy has no place in the uncomplicated common cold and various other self-limited diseases on which penicillin has no direct effect. Because of the increased incidence and severity of reactions in persons who have allergies[2] such as hay fever, asthma, and atopic dermatitis, these persons probably are better treated with another antibiotic if possible. However, although the allergic reactions to other antibiotics are much less, they also have disadvantages, and each case must be individualized.

Another obvious preventive measure is a thorough history as to previous reactions on all patients given penicillin. Welch[19] found that in 84 cases of anaphylactoid reactions to penicillin, 16 had a history of penicillin sensitivity. Scratch tests have been proposed to predict sensitivities. However, Collins-Williams[2] found that out of 7 adults known to be penicillin sensitive, only 3 reacted to scratch and intracutaneous tests. At present they cannot be regarded as either practical or accurate and are not generally used. Kern and Wimberly[8] have suggested that the injection be made far enough down the arm or in the fascia lata, so that a tourniquet may be used to delay absorption in case of a severe reaction.

Various attempts have been made to modify penicillin to make the drug less active antigenically. White[20] found that oral penicillin tablets given as venereal prophylaxis were associated with a very low rate of allergic reaction. Out of 45,000 tablets of 500,000 units each, only 3 mild reactions occurred. The Navy has found few reactions to oral penicillin, and uses oral tablets for venereal prophylaxis in areas of high incidence. Various studies in oral penicillin for prophylaxis of rheumatic fever have indicated low reaction rates. For general use in nonfulminating infections, therefore, there is much to be said for the use of oral rather than parenteral penicillin in the prevention of allergic reactions. Penicillin O has been proposed because some penicillin reactors can tolerate this modified penicillin. However, Lyons[10] has stated that in 8 patients known to be sensitive to penicillin G, reactions were obtained in 4 with penicillin O also. Combination of the penicillin with an injectable antihistamine has been investigated. Jenkins[6] reported no reactions from 590 injections in 111 patients when penicillin 300,000 units was given with 10 mg. injectable Chlortrimeton in the same syringe. Simon[16] reported only 3 mild reactions when penicillin was given with pyribenzamine injectable in the same syringe in 1,237 patients, a reaction rate of 0.24 per cent. It would seem then that reactions could be diminished if oral penicillin were given more frequently and if those patients requiring immediate high levels of penicillin were given the drug in combination with an injectable antihistamine in the same syringe. In patients with an allergic tendency, it would be better to use one of the other antibiotics if possible.

To be prepared as fully as possible for any anaphylactoid reaction, an emergency kit should be kept close at hand at all times. This should include a syringe, needle, tourniquet, injectable epinephrine, aminophylline, an antihistamine, and cortisone or ACTH.[8]

The situation has been nicely summarized by Smith and Walker[17] in "Penicillin Decade." They stated that "by desensitization and the considered use of anti-histaminics or other detoxifying agents, surely the great number of reactions recorded in these pages need not be found in the literature of penicillin's second decade. While the actual toxicity of penicillin is almost negligible, its ability to sensitize and to cause serious and even fatal accidents should not be minimized. A grave responsibility rests upon the shoulders of the physician for its wise application in clinical practice."

SUMMARY

The increasing importance of allergic reactions to penicillin, in particular the "serum sickness—like re-

actions" and anaphylactoid reactions are discussed.

Features of 33 penicillin reactions requiring hospitalization are discussed, with favorable emphasis on the early use of ACTH and cortisone in therapy.

Two fatal anaphylactoid deaths due to penicillin are reported.

Preventive measures are presented, including the recommendation for avoidance of penicillin in allergic persons if possible, the increased use of oral penicillin, and the combination of penicillin with injectable antihistamine for parenteral use.

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ABSTRACT OF DISCUSSION

LT. COL. MYLES P. MOURSUND, USA (MC), Fort Sam Houston: I have not seen a case of anaphylactoid shock from penicillin, but probably this is because I have become increasingly reticent and cautious in the administration of penicillin in recent years as a result of seeing innumerable cases of severe urticaria and angioneurotic edema from penicillin in the years from 1949 to 1951. Of course reactions to penicillin varying in degree are still occurring every day in the week, but fortunately the majority of them are mild. However, even a partial review of the literature and conversations on the subject have amazed me as to the number of reported as well as unreported instances of anaphylactoid shock and deaths resulting from penicillin injections. It certainly corroborates the statement by Dr. Strauch and his associates that this type of severe and even fatal reaction to penicillin is definitely on the increase and should be kept in mind when one considers the use of penicillin.

The value and use of penicillin when properly indicated cannot be denied, but the essayists bring out an especially good point, that with reckless abandon and no thought of the possible consequences, penicillin has been given and no doubt still is being given for such things as infection of the upper respiratory tract, sprained wrist, pain in the side, and abrasions. I tried, unsuccessfully I am sure, to convince one of our local general practitioners of the potential danger of indiscriminate use of penicillin, but he insisted it had become "routine treatment for colds and the flu." The large majority of the patients I have seen with a penicillin reaction have received their penicillin for a "cold" or some similar minor condition.

In addition to deciding that the patient has a definite indication for use of penicillin, one should take time to question him about allergy (asthma or hay fever in particular) and about previous penicillin therapy with any possible untoward effects from it. Then if penicillin is given, one should observe the patient closely following each injection for early evidence of anaphylactoid shock, which usually occurs within five to fifteen minutes after the injection. All of this is obviously time consuming but appears necessary in the present day use of penicillin.

Sterling* listed five cardinal symptoms which forewarn of anaphylactoid shock and stated that if any one or several of these symptoms appear, no further penicillin should be given. These symptoms are (1) syncope, mild to severe, at the time of injection, or a feeling of faintness recurring periodically for the following three or four hours; (2) sensation of burning or heat throughout the body, especially in the throat, palms, and soles (similar to sensation during intravenous calcium administration); (3) local or generalized pruritus within a few hours after the injection; (4) choking sensation in the throat; and (5) severe paroxysmal pain varying in location such as precordial, epigastric, or diaphragmatic. In all of the reports of anaphylactoid reaction to penicillin that I reviewed, one or more of these symptoms, especially the severe pain, usually precordial, were initial and more or less immediate symptoms of the reaction.

It is unfortunate that to date we have no simple means of determining penicillin sensitivity. Kern and Wimberley[8] have been strong advocates of skin tests, and Feinberg and others[4] stated, "It is practically a certainty that a skin test will be positive in all those persons who react anaphylactically to penicillin." Other observers have disagreed strongly with the value or efficacy of this test. For example, Capt. Bruno Eisen, resident in internal medicine, and Lt. Col. Arthur J. Berger, chief of the Allergy Service, Brooke Army Hospital, Fort Sam Houston, recently have skin tested (patch, scratch, and intradermal) more than 1,000 persons, including at least 100 known sensitive persons and have yet to see a positive test. Also such skin testing is not without danger. One of the persons tested had an immediate anaphylactoid reaction and required prompt treatment to prevent serious results. Her skin test

**Sterling, A.: Anaphylactic Shock Following Penicillin Therapy in Bronchial Asthma, J. Allergy 24:542-546 (Nov.) 1953.*

was negative. A complete summary of Eisen and Berger's findings will be published in the near future. Other reports of anaphylactoid reaction from penicillin skin tests are to be found in the literature.

Dr. Strauch and his co-workers advocate the use of oral penicillin, and a report by White[20] seems to substantiate the fact that few reactions occur from this method of therapy. However, severe and near fatal reactions have been described from intranasal instillation, aerosol, penicillin troches, and oral administration in other reports.

ACTH and cortisone definitely have proved their worth as adjuncts in the treatment of penicillin or other allergic reactions. However, a word of caution might well be reemphasized. It is a recognized fact that patients who have had steroid therapy within six months or perhaps even a year, and particularly those who have been receiving prolonged maintenance steroid therapy, may die suddenly from acute adrenal insufficiency if subjected to stress such as an injury or an operation unless cortisone is given to them immediately in adequate dosage (30 to 50 cc. aqueous adrenal cortex extract intravenously for immediate adrenal cortical support and 70 to 140 mg. of hydrocortisone per day or 100 to 200 mg. of cortisone per day orally depending on dosage prior to surgery or accident). Drug manufacturers (Upjohn for one) are now furnishing cards with instructions concerning this emergency for physicians to give to patients who have had or currently are receiving steroid therapy.

As for me, except in the treatment of syphilis and gonorrhea or when sensitivity tests reveal that penicillin is the only drug to which the organisms are susceptible, I am relying on the use of Terramycin, Aureomycin, Achromycin, or Erythromycin whenever I think antibiotic therapy is in dicated. But who knows how soon we will begin to see or hear of anaphylactoid reactions and deaths from these also?

HYDROCORTISONE OINTMENT IN THE TREATMENT OF DERMATOLOGIC DISORDERS

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SINCE the recognition of the anti-inflammatory action of the steroids, many dermatologic disorders have been treated with these compounds. Cortisone acetate was found to be relatively ineffective when used locally on the skin. However, hydrocortisone acetate (compound F) has definitely been assigned a role in the treatment of certain skin diseases. Sulzberger[2, 3, 4, 5] has reported the beneficial effects of both hydrocortisone free alcohol and hydrocortisone acetate in a series of 252 cases. The purpose of this paper is to evaluate the merits of topical hydrocortisone in 100 selected cases of dermatoses and to compare the response of these cases to 1 per cent (10 mg. per gram) and 2.5 per cent (25 mg. per gram) hydrocortisone acetate. These concentrations were incorporated into a vanishing cream type base, which we believe is of considerable significance in the therapeutic effect derived from the preparation.

METHOD

Where possible, cases were selected with symmetrical involvement in order that the ointment base could be utilized on one side and the specific preparation on the other. Also an attempt was made to compare the 1 per cent with the 2.5 per cent preparation on several of the same patients. The majority of the cases presented an erythematous weeping dermatitis; however, there were some cases of idiopathic pruritus of the anogenital region with no inflammatory involvement. Initially, the patient was requested to apply a thin film of the ointment four times daily; after definite improvement, the frequency of application was decreased. The nonhospitalized patients were observed at three to four day intervals.

RESULTS

Although the patients on whom we used the hydrocortisone free alcohol are not reported here, the results were not significantly different from those shown in tables 1 and 2.

There was little difference in the 1 per cent (table 1) and 2.5 per cent hydrocortisone acetate (table 2) in regard to the improvement noted in pruritus of the anogenital region. The criteria for improvement in these cases, as well as the subsequent ones, were less weeping, erythema, scaling, and pruritus. The duration of treatment in these cases was somewhat longer when the 1 per cent concentration was utilized; however, in all cases there was marked relief of pruritus within twenty-four to forty-eight hours and objective improvement within three days.

In the 10 cases of atopic dermatitis, the improvement was extremely satisfactory. Perhaps this is related to the duration of the disease as the majority of these cases were in infants and small children. In

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The hydrocortisone acetate used in this study was supplied by the Pfizer Company under the trade name of Cortril Acetate.
**Chairman and Director, Department of Dermatology, University of Texas Medical Branch.*

the cases of lichen simplex chronicus, there was significant improvement in the majority of the patients, especially in the alleviation of itching. However, it was found that the objective response to therapy was much slower than in cases of the remaining diseases and the duration of therapy was usually longer. A number of these patients are still under treatment and are showing progressive improvement.

In the 3 cases of herpes simplex, the response was favorable within a twenty-four hour period. However, the 1 case of herpes zoster was not benefited by this therapy. Localized neurodermatitis, particularly of the eyelid, responded exceedingly well to each concentration of the ointment. Eczematous contact dermatitis responded favorably, as did many cases of eczematous dermatitis associated with vesicular dyshidrosis.

In almost all of these patients there was significant relief of pruritus within forty-eight hours, and the conditions had shown marked clinical improvement by four to six days. The therapy as shown in the tables was carried out for longer periods of time in order not to allow an exacerbation of the condition. In many of the cases of pruritus of the eyelids, pruritus of the anogenital region, and lichen simplex chronicus, it was noted that if therapy was discontinued at the end of six or seven days, frequently there was a recurrence of the disease within three to four days. Many of the patients with pruritus of the anogenital region had been confronted with the disease for one to fifteen years. The therapeutic response seemed to parallel exactly the amount of lichenification present. This was particularly true of lichen simplex chronicus.

In none of these cases was there evidence of primary irritation, sensitization, or untoward systemic absorption effects. However, other investigators have reported distant beneficial effects from treatment of an unrelated site.[3] Infectious eczematoid dermatitis of the ears responded favorably to hydrocortisone acetate, but frequently it was necessary to eradicate the predominantly gram-negative organisms with antibiotic therapy before the administration of hydrocortisone ointment. There is no contraindication to the utilization of hydrocortisone ointment and various antibiotic preparations concomitantly or in combination.[1]

We had an opportunity to use the hydrocortisone acetate in a petrolatum-lanolin type base on approximately 20 patients, but it was believed that the results were less satisfactory, and the greasy base was not as well accepted by the patient as the vanishing cream type. This was particularly true of the thin skinned sites and the mucous membranes.

SUMMARY AND CONCLUSIONS

The results of therapy, following the use of hydrocortisone acetate ointment, in 100 selected, well controlled cases are reported.

Hydrocortisone acetate, 2.5 per cent, was somewhat superior to hydrocortisone acetate, 1 per cent. Each of these concentrations was in a vanishing cream type base.

If a good therapeutic response is to be expected from these preparations, it will be noted within six days. Frequently it is observed within the first twenty-four hours.

TABLE 1.—*Results of Treatment of Various Dermatoses with 1 Per Cent Hydrocortisone Acetate Ointment.*

Diagnosis	No. Cases	Average Duration of Treatment (Days)	Results			
			Marked Improvement	Moderate Improvement	Slight Improvement	No Improvement
Atopic dermatitis	8	15	3	3	2	
Contact dermatitis	7	11	5	2		
Pruritus ani, vulvae, and scroti	7	16	5	2		
Eczematous dermatitis	5	10	4	1		
Lichen simplex chronicus	3	8	1	1	1	
Localized (eyelid) neurodermatitis	2	8	2			
Infectious eczematoid dermatitis	1	30		1		
Pityriasis rosea-like eruption	1	9			1	
Roseola vaccinia	1	9	1			
Seborrheic dermatitis	1	16	1			
Totals	36		22	10	4	

TABLE 2.—*Results of Treatment of Various Dermatoses with 2.5 Per Cent Hydrocortisone Acetate Ointment.*

Diagnosis	No. Cases	Average Duration of Treatment (Days)	Results			
			Marked Improvement	Moderate Improvement	Slight Improvement	No Improvement
Contact dermatitis	11	7	7	2	1	1
Eczema nummulare	9	13	2	4	3	
Lichen simplex chronicus	7	12	3	1	3	
Vesicular dyshidrosis with eczematization	7	14	1	3	3	
Pruritus ani, vulvae, and scroti	6	10	5	1		
Eczematous dermatitis	6	11	3	2		1
Localized (eyelids) neurodermatitis	5	12	3	2		
Infectious eczematoid dermatitis (ears)	3	21	2	1		
Herpes simplex	3	6	3			
Atopic dermatitis	2	8	2			
Seborrheic dermatitis	2	7	1	1		
Herpes zoster	1	4				1
Monilial folliculitis	1	4	1			
Pyogenic granuloma	1	7			1	
Totals	64		33	17	11	3

These agents appear to be much more effective at the sites of the body where the skin is thin, such as the eyelids, the nipple, and the axillary region, as well as the mucous membranes of the anogenital region and lips. This is probably due to the fact that there is better "absorption" at these particular areas.

Hydrocortisone acetate ointment commands a distinct role in the treatment of certain specific dermatologic diseases. It would seem to be the treatment of choice in atopic dermatitis of infancy, neurodermatitis of the eyelids, and essential pruritus of the anogenital region. The ultimate value of this preparation in conjunction with other well accepted therapeutic modalities is yet undetermined.

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ABSTRACT OF DISCUSSION

DR. C. F. LEHMANN, San Antonio: My experience with this product has been limited as compared with other observers, and I have not become as enthusiastic about it. Possibly by further use of it my results will improve. The conditions which seem to respond best are atopic eczema, anogenital pruritus, and localized neurodermatitis. I concur in the reports that it is of value in atopic eczema, but in my experience the benefit in anogenital pruritus and localized neurodermatitis (such as on the nape of the neck or eyelids) has been disappointing. The incidence of improvement or relief of pruritus in these two latter conditions has been roughly 10 per cent.

Possibly three factors explain why I have not seen a high percentage of good results in my experiences with hydrocortisone ointment. First, I prescribed the ointment without in any way using the power of suggestion. It was just another prescription, not one that gave a lot of relief. (There was one exception. A stingy patient who could well afford to buy sufficient quantities of the ointment disappointed me after a two weeks' trial. He stated that it did not give his scrotal pruritus as much relief as carbolated Vaseline. In this case, I had lauded the product to the skies, hoping to impress upon him in some way the wonderful virtues of this new ointment.) I do not believe that many of us need go back very far long Memory's Lane to recall the value of suggestive psychotherapy in prescribing something new. I can recall the wonderfully high percentage of satisfactory antipruritic results from Thephorin Ointment when I first used it.

But I do not believe the poor responses to hydrocortisone ointment have been due to lack of salesmanship. I am more inclined to believe that it is due to paucity of its use. Until recently, I have instructed patients to massage it into the skin twice a day. (I note, however, that Rein's reports* are based on twice a day instructions when using it on large areas.) Massaging the ointment into the skin four times a day, as Dr. Mullins, Dr. Hicks, and others have have advised, is a fairer test of the product. The paucity in its use is no doubt also explained by the expense of the product. At the price charged for a 5 Gm. tube, we could not have expected many patients to agree to using enough of the ointment nor continuing its use for long. With the recent drop in price, I would expect better results if paucity of usage explains why I have not been enthusiastic about this product. I have considered having an ointment compounded by the pharmacist. If a patient can buy 20 Gm. now for $6, I hardly think that any pharmacist would compound the ointment from the hydrocortisone tablets for less.

It is gratifying to know from the presentation by Dr. Mullins and Dr. Hicks, as well as from other reports, that no case of sensitivity to hydrocortisone has been seen and also that no constitutional effect has been noticed from absorption of it through the epidermis. In this respect it promises to be a safe medicament.

Like every other new drug it is going to be applied to all sorts of conditions with and without any rationale. For instance, just a few days ago I saw a child with a wool irritation on a congenital keratosis pilaris (a mild ichthyosis) who had been using hydrocortisone ointment for three months without enough relief to justify the expense of the ointment. I predict that after another year or so we all will be better acquainted with its indications and limitations, and I anticipate that my enthusiasm will increase.

I do not mean to infer that I have not seen any good results from this preparation. I have seen it given a severe test, as in a case of long standing neurodermatitis on temple areas and upper eyelids, with a markedly lichenified skin. This case had received an array of various treatments. The itching was promptly relieved with hydrocortisone and the lichenification left after the rubbing and scratching stopped. However, from a limited experience I am not convinced that this ointment deserves the position of *sine qua non.* To justify such a position at the price of the ointment there should be 100 per cent marked improvement from its use. Until I am convinced that hydrocortisone ointment will give the patient an 80 per cent or better chance of marked, prompt benefit, in my hands it will be resorted to when other conventional medicaments have failed.

**Rein, C. R.: Present Status of Hydrocortisone Acetate Ointment in Dermatologic Therapy, Arch. Dermat. & Syph. 68:452-456 (Oct.) 1953; Report on Topical Hydrocortisone in Dermatologic Therapy, Merck Report 63:20-22 (April) 1954.*

Accidental Falls Fatality

Accidental falls take approximately as many lives each year in the United States as tuberculosis; falls rank second only to motor vehicles as a cause of accidental death, the Metropolitan Life Insurance Company statisticians report.

Of the approximately 21,000 fatal falls each year, about two-thirds take place in and around the home. The death rate from accidental falls is higher among males at ages under 75 and higher in females after that time. More than half of all fatal falls occur at 75 years of age and over, a big proportion occurring while the victims are walking about the house. Below the age of 15 years, falls from porches, roofs, windows, and trees account for most of the deaths. Falls on stairs account for nearly a fourth of the deaths in the 25-44 group and close to a third in the 45-74 range.

SCREENING METHODS IN HEMATOLOGY
A Comparative Study

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THE comparative inaccuracy of standard hematologic screening procedures has been well known for many years, yet clinicians and even some clinical pathologists have been reluctant to alter the time-honored methods used almost universally for admission hematologic studies. It was a realization of the fallacies of these procedures that prompted this investigation. Since many of the "normal values" in hematology are based on inherently inaccurate methods, we have directed our efforts toward study of the ease and simplicity and of the reproducibility of certain hematologic procedures rather than attempting to determine the degree of accuracy of each.

In a survey of admission hematology methods used in 21 hospitals throughout the state (table 1), it was found that in 13 of these, studies consisted of an erythrocyte count, leukocyte count, hemoglobin determination, and differential white cell count. A hematocrit determination was included as an additional procedure in 1 case. The erythrocyte count had been eliminated in 7 hospitals, being replaced by a hematocrit in 4 of these. In 1 hospital, no routine admission hematology work was done. Four pathologists indicated appreciable experience with photometric methods for erythrocyte counts; however, only one of these had had significant experience with the scatter photometric method. The direct erythrocyte count was considered to be an ideal screening procedure in only 7 instances, while the majority of pathologists preferred to substitute a hematocrit for the erythrocyte count. It immediately becomes apparent that not only is there a striking lack of uniformity of hematologic screening methods, but also an equally striking lack of uniformity of what various clinical pathologists consider to be ideal procedures for this purpose.

TABLE 1.—*Screening Methods in Hematology Used in 21 Texas Hospitals.*

Methods Currently in Use	
RBC, Hgb., WBC, and Diff.	13
(Photometric RBC 1)	
RBC, Hgb., WBC, Diff., and Hematocrit	1
Hgb., WBC, and Diff.	6
(Plus Hematocrit 2)	
(Plus Hematocrit and Sed. Rate 2)	
No admission hematology studies	1
	21
Methods Considered Ideal	
RBC, Hgb., WBC, and Diff.	4
RBC, Hgb., WBC, Diff., and Hematocrit	3
Hgb., WBC, and Diff.	4
Hgb., WBC, Diff., and Hematocrit	6
WBC, Diff., and Hematocrit	3
Hematocrit and Hgb.	1
	21
Experience with Photometric Erythrocyte Counts	4
Favorable 3	
Unfavorable 1	

The various procedures considered in this investigation were the erythrocyte count by both direct and scatter photometric methods; hemoglobin concentration by Leitz and Haemoscope* instruments; packed cell volume by Wintrobe and capillary methods; and whole blood specific gravity by the Barbour-Hamilton "falling drop" method.

ERYTHROCYTE COUNTS

During the past few years an increasing interest in the possibility of photoelectric determinations of erythrocyte counts has become manifest. The basic principles, clinical application, and limitations of this method were outlined by Blum[2, 3] in 1945, and since that time many additional papers have appeared on this subject.

The photoelectric method involves the principle of turbidimetry and basically measures the amount of parallel light rays transmitted through a suspension of erythrocytes, but does not compensate for the influence of the size and shape of cells on the transmitted light. A novel method to eliminate partially this effect was described in the German literature in 1951, and was appraised by Brackett, Mattern, and Olson[4] in 1953. The principles of the instrument

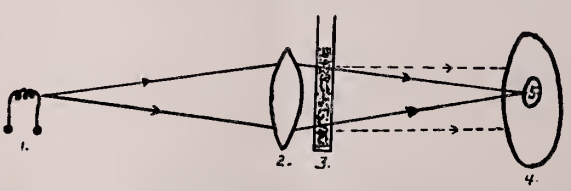

FIG. 1. Diagram showing the principle of the Haemoscope (scatterphotometer). A beam of light from the source (*1*) passes through the lens (*2*) and cuvette (*3*). The light rays are converged on the photoelectric cell (*4*) to the focal point (*5*); however, the photoelement has an aperture at that point so that no photoelectric current is produced by the focused image. Light striking the edges of the erythrocytes is diffracted from its original path to strike the sensitive portion of the element, and the current thus produced is measured.

Read before the Texas Society of Pathologists, San Antonio, May 3, 1954.

*Haemoscope Corporation, 230 Park Avenue, New York 17.

are quite simple even though the diffraction effect of anisocytosis and poikilocytosis on the light rays is poorly understood. The fundamental principle of the Haemoscope is based on measuring light diffraction as illustrated in figure 1.

The inherent errors of the direct erythrocyte counting method are well known and generally are considered to be as great as plus or minus 16 per cent.[1]

The results of a comparative study of erythrocyte counts done by direct and scatter photometric methods in 350 consecutive hospital admissions are shown in figure 2. It is apparent that most of the values fall within the normal range and that the majority of values obtained by the two methods are correlated within plus or minus 10 per cent. Although several low counts are represented in the scattergram, additional studies were made in the form of erythrocyte counts done on progressive saline dilutions of a single blood sample. The results shown in table 2 indicate satisfactory correlation, even in those bloods with especially low red cell counts. Comparable results were obtained on progressive concentrations of a single blood specimen.

TABLE 2.—*Comparison of Haemoscope and Direct Erythrocyte Counts on Progressive Saline Dilutions of a Single Blood Sample.*

Example	Haemoscope RBC Count (millions/cu. mm.)	Chamber RBC Count (millions/cu. mm.)
1	3.45	3.50
2	2.80	2.49
3	2.30	2.29
4	2.20	2.65
5	2.00	1.99
6	1.94	2.00
7	1.30	1.38

TABLE 3.—*Comparison of Haemoscope and Direct Erythrocyte Counts in Cases with Color Index 0.85 or Less and with Hemoglobin 11.0 Gm. per 100 cc. or Less.*

Case	Direct RBC (millions /cu. mm.)	Haemoscope RBC (millions /cu. mm.)	Variation of Haemoscope RBC from Direct RBC: millions /cu. mm.	Variation of Haemoscope RBC from Direct RBC: %	Color Index (Direct RBC)	Color Index (Haemoscope RBC)
8	3.87	3.9	+0.03	+ 0.8	0.85	0.85
9	3.96	3.9	—0.06	— 1.5	0.80	0.82
10	4.17	4.07	—0.10	— 2.5	0.81	0.83
11	3.91	3.23	—0.68	—18.0	0.80	0.95
12	4.22	4.10	—0.12	— 3.0	0.80	0.82
13	4.18	4.10	—0.08	— 2.0	0.85	0.85
14	4.06	3.34	—0.72	—18.0	0.65	0.76
15	3.99	3.33	—0.66	—16.0	0.85	0.98
16	3.92	3.82	—0.10	— 2.5	0.85	0.86
17	3.60	3.27	—0.33	—10.0	0.85	0.92
18	3.56	3.38	—0.18	— 5.0	0.83	0.86
19	3.41	3.25	—0.16	— 5.0	0.85	0.89
20	3.95	3.47	—0.48	—12.0	0.80	0.88
21	4.20	3.98	—0.22	— 5.0	0.84	0.86
			Average error: 7.2%			

Although numerous bloods showing a marked degree of microcytosis and macrocytosis were not available for this study, comparison of the two methods was made in 14 selected cases having a low color index (table 3). It is evident that in these cases values obtained by the photometric method are almost uniformly lower than those derived by the direct count with a maximum of 18 per cent deviation. Since the degree of error inherent in direct erythro-

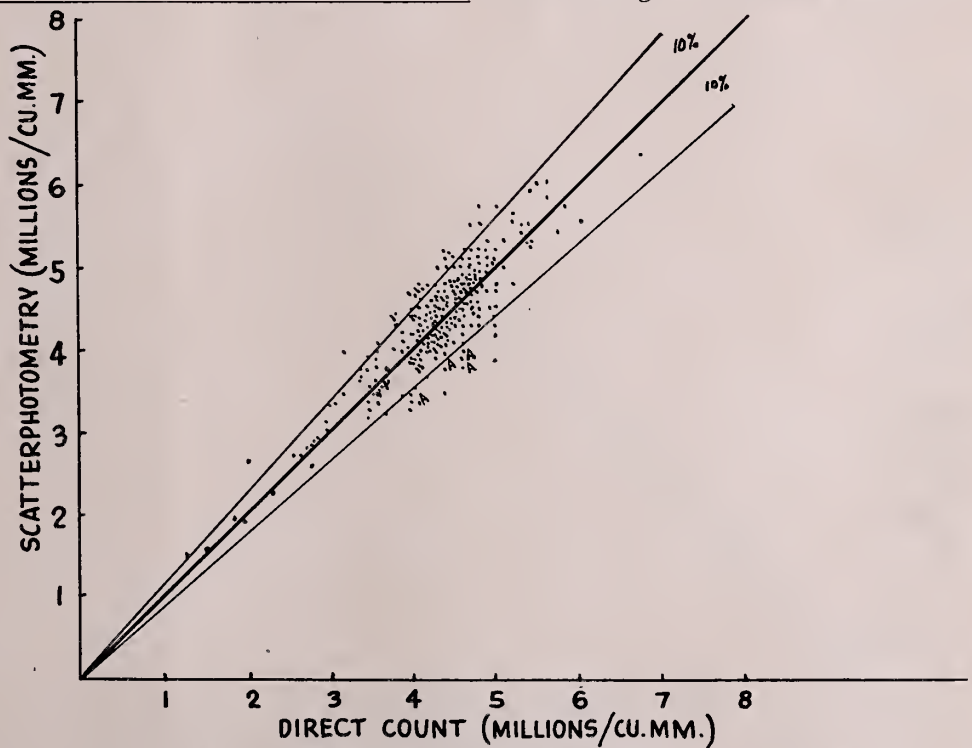

FIG. 2. A scattergram showing correlation between Haemoscope and direct erythrocyte counts in 350 consecutive hospital admissions. The points indicated by *A* represent cases in which marked anisocytosis was noted on examination of the stained smears.

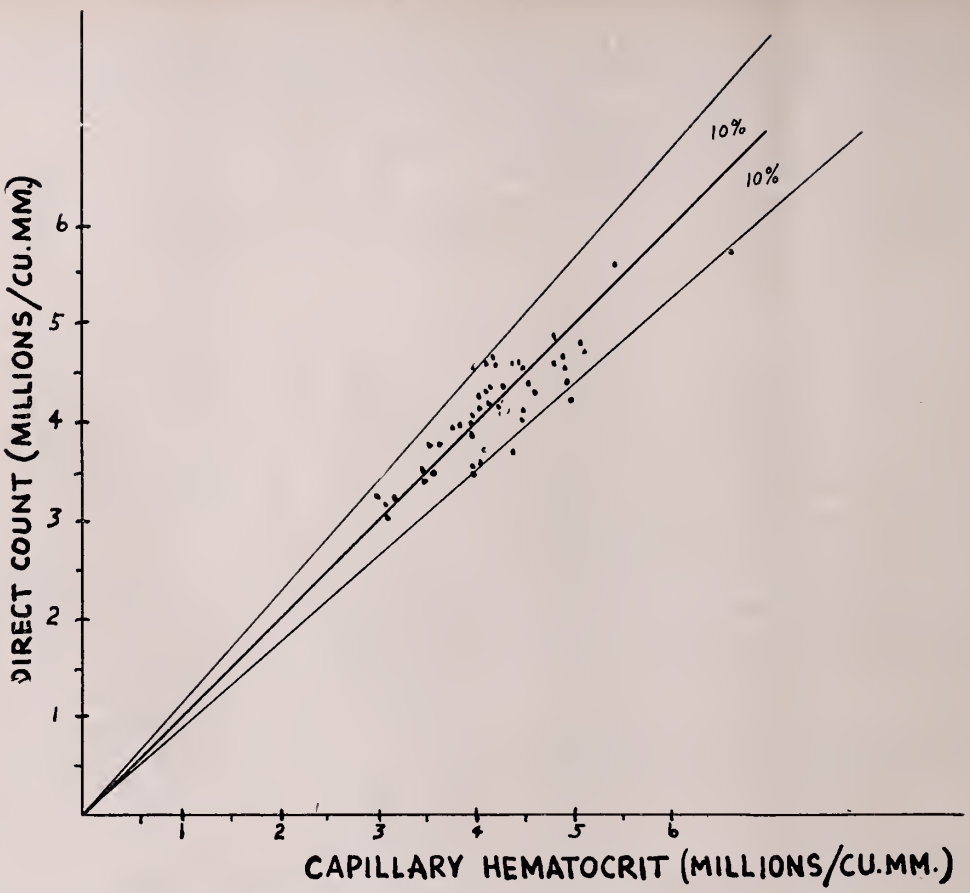

FIG. 3. A scattergram showing correlation between direct erythrocyte counts and erythrocyte estimations from capillary hematocrit determinations.

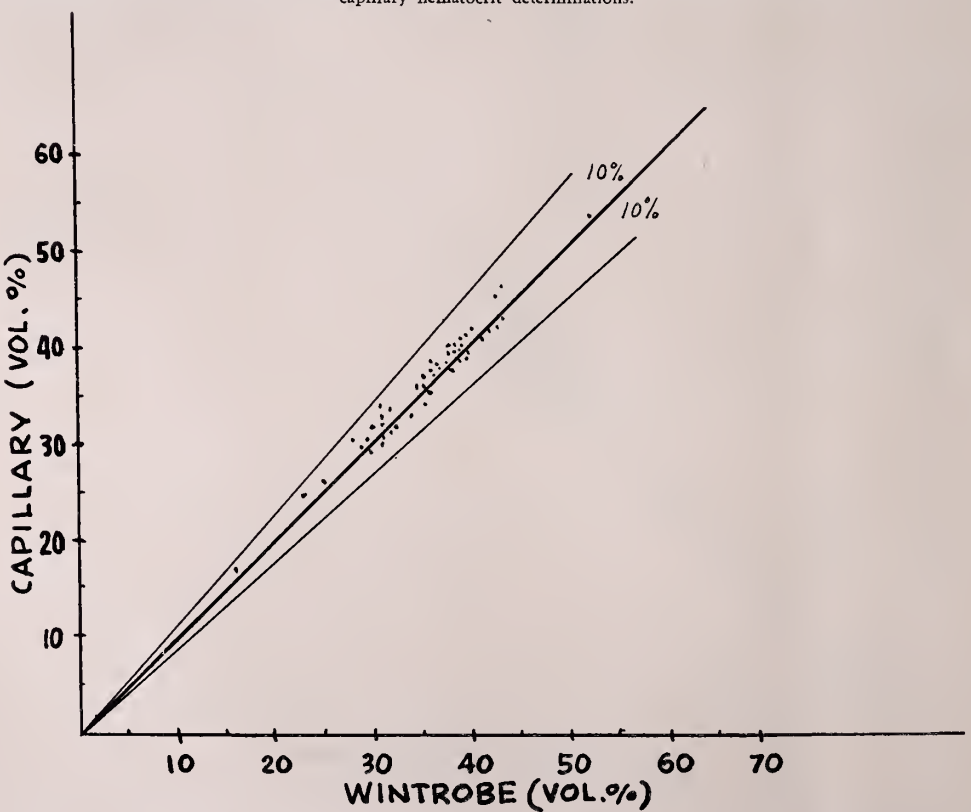

FIG. 4. A scattergram showing correlation between capillary and Wintrobe methods of hematocrit determination.

TABLE 4.—*Comparison of Time Factor of Erythrocyte Counts by Haemoscope and Direct Methods.*

No. Cases	Direct				Haemoscope			
	Dilute	Shake	Count	Total	Dilute	Calibrate	Count	Total
1	1 min. 3 sec.	2 min. 23 sec.	3 min.	6 min. 26 sec.	1 min. 27 sec.	1 min. 30 sec.	47 sec.	3 min. 44 sec.
80	1 hr. 24 min.	31 min. 40 sec.	4 hr.	5 hr. 26 min.	1 hr. 57 min.	1 min. 30 sec.	1 hr. 4 min.	3 hr. 3 min.

cyte counts may be as much as 16 per cent, however, the magnitude of this variation becomes less alarming. It will be noted also that the average variation between the two methods was only 7.2 per cent, a figure that certainly falls within accepted limits and indicates a certain degree of compensation by the instrument. Nevertheless, the fact that the Haemoscope values were lower than those obtained by the direct method indicates an incomplete compensation by the instrument for reduced cell size and hemoglobin content.

The time factor involved in erythrocyte counts is of importance, although certainly less important than the accuracy and reproducibility of the procedures. A comparison of the time involved in photometric and direct erythrocyte counting methods is shown in table 4. Although less than three minutes per count are saved by use of the photometric method, this represents a 44 per cent saving and amounts to approximately two and one-half technician hours per day in an average sized hospital laboratory. Technologists using the instrument were favorably impressed with its adaptability to routine hematologic work and with the ease and simplicity of its operation.

As direct erythrocyte counts, in addition to inherent inaccuracies, are time consuming and since so many clinicians are reluctant to accept hematocrit values in lieu of actual cell counts, an attempt was made to estimate red cell counts from capillary hematocrit determinations and to correlate the values obtained

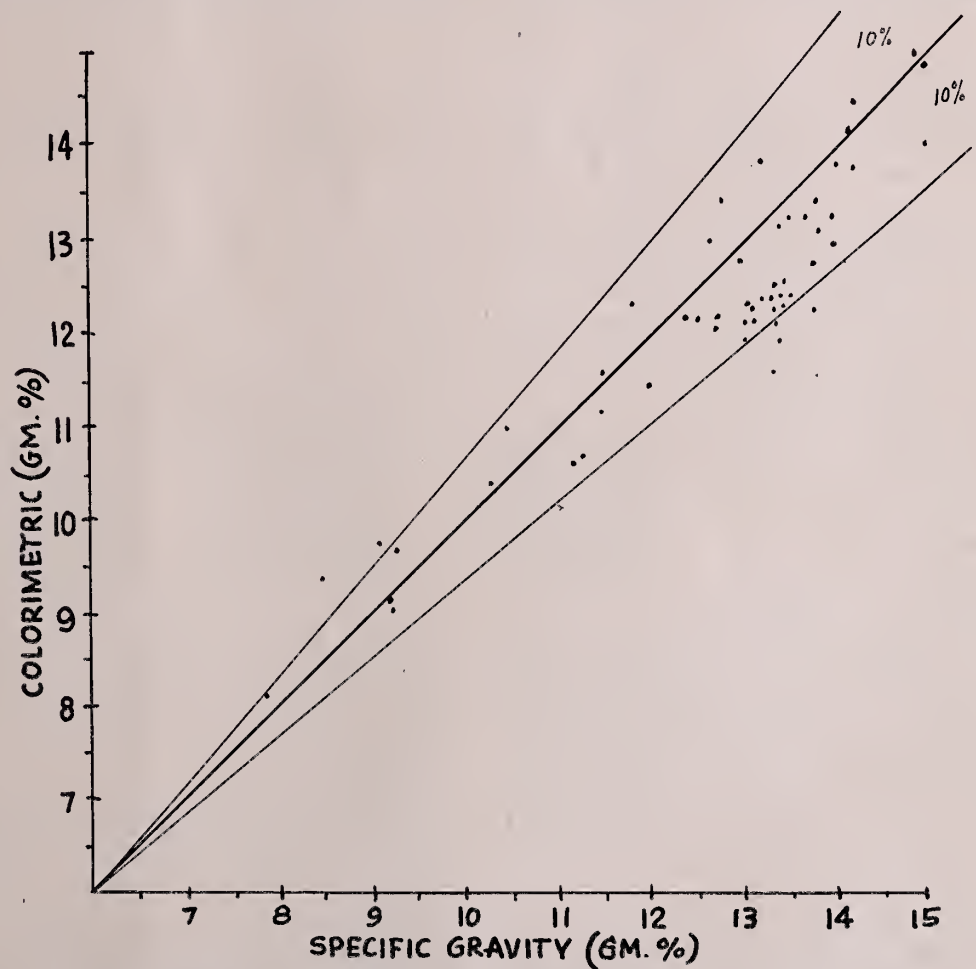

FIG. 5. A scattergram showing correlation between colorimetric (Leitz) and specific gravity (Barbour-Hamilton) hemoglobin determinations.

with those derived by the direct chamber method (fig. 3). It will be noted that nearly all of the values obtained by these methods showed a deviation of less than 10 per cent, indicating that an adequate estimation of the red cell count can be made, if desired, from the hematocrit. A comparison of results obtained by the Wintrobe and capillary methods of hematocrit determination indicates that estimation of the erythrocyte count by either method would be satisfactory as a routine screening procedure (fig. 4).

HEMOGLOBINOMETRY

In clinical hemoglobinometry, as in all other laboratory procedures, errors may be classified as instrumental and personal. The sources of instrumental errors are the colorimeter and the pipettes. The intrinsic error in well calibrated colorimeters is relatively small. The Sahli pipette, however, may be the source of large error as Sunderman has reported as much as minus 30 to plus 20 per cent error due to inaccurate calibration.[5]

Colorimetric hemoglobin determinations, using the Leitz-Rouy photometer, were compared with those done by the Barbour-Hamilton specific gravity method (fig. 5). It is noted that lower values were obtained in most cases by the colorimetric method, although most of the determinations showed a deviation of less than plus or minus 10 per cent. The hemoglobin values derived from whole blood specific gravity, however, were based on an arbitrary conversion factor which may not have been accurate.

REPRODUCIBILITY

In an attempt to evaluate the reproducibility of each of the procedures under consideration, six blood samples were subjected to repeated study by each procedure with determination of the range and standard deviation of the results (table 5). The direct chamber erythrocyte count showed a maximum range of 17 per cent with an average standard deviation of 169,000 cells per cubic millimeter. On the other hand, results obtained by the Wintrobe hematocrit showed only 1.8 per cent maximum range with an average standard deviation of 0.164 per cent.

Oxyhemoglobin determinations by the Leitz colorimeter showed a surprising failure of reproducibility, although pipettes were checked by the mercury-gravimetric method. Satisfactory hemoglobin reproducibility was obtained with the Haemoscope.

Concerning the relative accuracy of each procedure, we believe that they should be listed in the order indicated in table 6. It should be emphasized that this represents purely a personal impression and is not supported by any specific data, although it will be readily accepted, we are sure, that the routine direct red blood cell count is the least accurate of all the procedures considered.

The Wintrobe hematocrit method shows the greatest degree of reproducibility followed closely in order by the specific gravity, Haemoscope hemoglobin, Haemoscope red cell count, and capillary hematocrit procedures. Here again, the direct chamber erythrocyte counting method shows the least promising results.

TABLE 5.—*Reproducibility of Screening Methods.*

	Hgb. Leitz (Gm. /100 cc.)	Hgb. Haemoscope (Gm. /100 cc.)	RBC Direct (millions /cu. mm.)	RBC Haemoscope (millions /cu. mm.)	Hematocrit Wintrobe (%)	Hematocrit Capillary (%)	Specific Gravity
Range	0.50	0.50	0.57	0.25	1.00	1.00	0.0010
Std. Dev.	0.18	0.19	0.21	0.11	0.43	0.41	0.00043
Range	1.40	0.10	0.20	0.13	0.00	1.50	0.0000
Std. Dev.	0.36	0.05	0.09	0.04	0.00	0.59	0.00000
Range	0.45	0.20	0.12	0.16	0.00	1.00	0.0011
Std. Dev.	0.14	0.09	0.04	0.08	0.00	0.41	0.00043
Range	1.00	0.50	0.47	0.15	0.00	1.50	0.0015
Std. Dev.	0.31	0.22	0.14	0.06	0.00	0.54	0.00060
Range	0.70	0.30	0.82	0.05	1.00	1.00	0.0008
Std. Dev.	0.25	0.11	0.37	0.02	0.50	0.41	0.00033
Range	1.05	0.10	0.46	0.14	1.00	1.50	0.0007
Std. Dev.	0.33	0.05	0.15	0.07	0.50	0.65	0.00027
Max. Range	8.4%	3.0%	17.0%	4.0%	1.8%	4.2%	2.5%
Average Std. Dev.	0.206	0.118	0.169	0.063	0.164	0.50	0.00034

TABLE 6.—*Comparison of Hematologic Methods.*
(Listings from best to worst.)

Accuracy	Ease and Simplicity	Reproducibility
Hematocrit, Wintrobe	Hematocrit, Capillary	Hematocrit, Wintrobe
Hematocrit, Capillary	Hemoglobin, Leitz	Specific Gravity, B-H
Specific Gravity, B-H	Hemoglobin, Haemoscope	Hemoglobin, Haemoscope
Hemoglobin, Haemoscope	RBC, Haemoscope	RBC, Haemoscope
Hemoglobin, Leitz	Hematocrit, Wintrobe	Hematocrit, Capillary
RBC, Haemoscope	Specific Gravity, B-H	Hemoglobin, Leitz
RBC, Direct	RBC, Direct	RBC, Direct

Regarding the ease and simplicity of the procedures, the capillary hematocrit determination seems to be the easiest to perform. Certainly the direct red cell count technically is the most tedious and time consuming of all.

In following patients through the course of an illness, as a guide to possible blood loss, or to determine changes resulting from transfusion, the accuracy with which these measures of red cell and hemoglobin contents of the blood can be duplicated is a matter of as much importance as the inherent accuracy of the procedures. Hematocrit or whole blood specific gravity determinations appear to be the most accepta-

ble procedures from this standpoint, although it is doubtful that specific gravity determinations could be adapted to routine laboratory use.

CONCLUSIONS

It is thought that the relatively greater reproducibility of the Haemoscope red cell count, as well as its ease and simplicity of operation, certainly would justify the substitution of this type of procedure for the direct chamber count in routine admission work. It is recommended, however, that in detailed hematologic studies, in cases where there is evidence of pronounced microcytosis or macrocytosis in the stained smear, careful direct chamber counts be done in duplicate or triplicate using certified counting chambers and pipettes.

We believe that, in comparison, it would be no more costly nor time consuming to use a capillary hematocrit determination, Haemoscope erythrocyte count, Haemoscope hemoglobin determination, white cell count, and differential than to do the standard, accepted, and time-honored complete blood count, composed of a direct red blood cell count, photometric hemoglobin determination, white blood cell count, and differential. Certainly the former procedures would yield more accurate and reproducible results. The danger of overlooking significant alterations in cell size and hemoglobin content probably would be eliminated if direct chamber red cell counts were performed in those cases in which the stained smear showed a significant degree of microcytosis or macrocytosis. In 350 routine admission cases, we found 4 per cent to fall within this group.

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Harris Hospital.

Further Comments on Cobalt-Iron Therapy of Anemia of Prematurity

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IN THE May issue of the TEXAS STATE JOURNAL OF MEDICINE an article entitled "Effect of a Cobalt-Iron Mixture on the Anemia of Prematurity"[2] indicated that the use of a cobalt-iron mixture given to premature infants resulted in slightly higher hematocrit and hemoglobin values than in a control group. The 16 infants who received the cobalt-iron mixture were reported as showing no harmful effects despite the large doses. A somewhat similar study reported by Coles and James in the *Archives of Diseases of Childhood*[1] gave approximately the same results in 20 prematures. They were able to show that the administration of a cobalt-iron mixture for a very short period was able to keep such a treated group at a higher hemoglobin level than other control babies. They made no mention of harmful effects of the cobalt-iron preparations used.

Gross, Kriss, and Spaet from San Francisco, at the May, 1954, meeting of the American Pediatric Society reported the occurrence of thyroid hyperplasia in children with sickle cell anemia who were being treated with a cobalt-iron mixture. At the time of the presentation of this material before the pediatric group other physicians commented that they too had seen thyroid enlargement in patients receiving cobalt-iron mixtures. A recent experience here in Dallas has led me to concur in the belief that cobalt-iron mixtures can result in thyroid enlargement and consequently that whenever such medications are used such an effect should be looked for. A 4 month old baby who had received a cobalt-iron mixture since its premature birth developed a disease of the upper respiratory tract and then episodes of choking and cyanosis and had an enlarged thyroid gland; biopsy showed hyperplasia. In view of this finding plus the observations of others as noted earlier it is felt that cobalt-iron mixtures if given over a sufficiently long period may well result in enlarged thyroids.

However, the results of the group from England reported previously suggested that cobalt-iron mixtures need not be given for long periods. These authors were of the opinion that in the young infant, even more so than in the adult, cobalt is stored efficiently for long periods of time and that a small dose of cobalt, for perhaps no longer than three weeks, may give as beneficial an effect as cobalt administered over long periods.

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Renal Hemodynamic Response to Acute Alterations of Blood Pressure with Vasopressor and Vasodepressor Agents

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AT PRESENT in clinical medicine there are available potent drugs which are capable of causing acute alterations of the blood pressure. Norepinephrine is one of the most potent agents for raising the blood pressure, and the ganglionic blocking agents are effective in lowering it. Although the blood pressure effects of these drugs are well known, it is of great clinical importance to observe the renal hemodynamic response to these agents which accompany sudden alterations in blood pressure. This presentation, which is divided into two parts, is a consideration of the renal hemodynamic effects of these drugs. In the first part we consider the effects accompanying the changes in blood pressure due to the use of the vasopressor agent norepinephrine for the treatment of shock. In the second part we consider some aspects of the renal hemodynamic responses accompanying the treatment of hypertension with ganglionic blocking drugs.

VASOPRESSOR AGENTS

In the treatment of acute clinical shock one should consider not only the restoration of blood pressure but also improvement of the circulation to special vascular beds such as the kidney. In the kidney, this is reflected in improvement of impaired renal function which may have been manifested clinically by oliguria or anuria. It has been observed that pressor agents such as norepinephrine are effective in restoring blood pressure to normal, but the effect of this agent on renal function is more obscure and has not been completely evaluated heretofore.

Methods

Studies were performed in both dogs and human beings in which norepinephrine was administered intravenously. The effect of this pressor agent on glomerular filtration rate and renal plasma flow was determined when normotensive dogs and humans were rendered hypertensive and when dogs previously rendered hypotensive by phlebotomy and humans in acute clinical shock were rendered normotensive.

Glomerular filtration rate was determined in the dogs by the creatinine clearance method and in the humans by the inulin clearance method. Renal plasma flow was determined by the use of para-aminohippurate. Methods and techniques have been described previously.[1, 2, 3]

Results and Discussion

It was demonstrated that when normotensive dogs were rendered hypertensive by the intravenous administration of norepinephrine, a significant reduction in glomerular filtration rate and renal plasma flow occurred. This effect can be seen in table 1. As the blood pressure increases to hypertensive levels, there is an initial reduction in renal plasma flow but not in glomerular filtration rate. As the rate of the norepinephrine infusion is increased and the blood pressure is raised further, both glomerular filtration rate and renal plasma flow are depressed.

TABLE 1.—*Effect of Blood Pressure Elevation to Hypertensive Levels with Norepinephrine in Normal Dogs.*

	Urine Volume cc./min.	Blood Pressure mm. Hg.	Glomerular Filtration Rate cc./min.	Renal Plasma Flow cc./min.
Control	5.0	115	52	348
Norepinephrine ...	6.0	140	53	248
Norepinephrine ...	2.0	170	16	118

TABLE 2.—*Response in Renal Blood Flow When Blood Pressure Is Increased to Hypertensive Levels in Human Beings.*

	Control	Norepinephrine	% Control
Mean blood pressure	97	132	136
Urine volume (cc./min.) ..	7.6	7.9	104
Glomerular filtration rate (cc./min.)	105	98	94
Renal plasma flow (cc./min.)	706	417	60

Comparable studies were done in 9 normotensive humans using norepinephrine (table 2). Here, too, a reduction in renal plasma flow occurred when these patients were rendered hypertensive, but glomerular filtration rate was not similarly reduced. It appears that vasoconstriction in the human kidney is not as prominent a response as it is in the canine kidney. If marked renal vasoconstriction occurred in patients in shock when the blood pressure was raised to normal by norepinephrine, it would tend to preclude its use since impaired renal function already exists in the shock state. However, clinical observations indicate that such an effect does not occur, for numerous oliguric and anuric patients in shock have been ob-

Presented before the Texas Heart Association, San Antonio, May 3, 1954.

served to have improved renal function as manifested by the onset of adequate urinary output following elevation of the blood pressure toward normal by means of the administration of one of the pressor drugs.

Coinciding with this clinical observation, it has been determined that in moderate controlled hypotension brought about by the use of the ganglionic blocking drug Arfonad,* the resultant depression of glomerular filtration rate and renal plasma flow can be elevated toward normal by the use of norepinephrine. However, since this is not comparable to acute clinical shock, a study was undertaken to determine if a similar effect could be produced in typical shock from various causes.

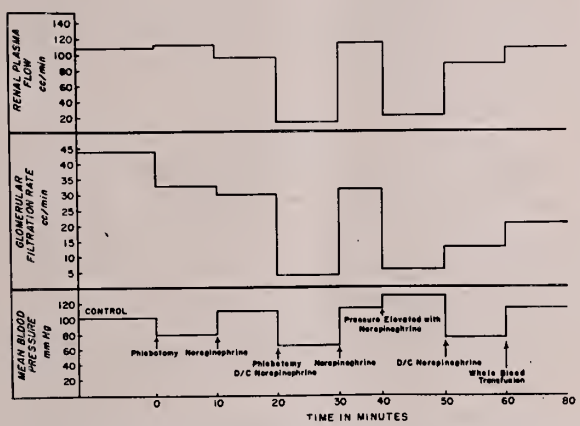

FIG. 1. The chart shows the renal hemodynamic response with the use of norepinephrine in a dog which has been rendered hypotensive by phlebotomy.

Preliminary studies were performed in dogs which were rendered hypotensive by means of phlebotomy. Figure 1 illustrates the response in 1 of these dogs.

TABLE 3.—*Renal Effects of Norepinephrine in Dogs Rendered Hypotensive by Phlebotomy.*

	Mean Blood Pressure mm. Hg.	Glomerular Filtration Rate cc./min.	Renal Plasma Flow cc./min.	Urine Volume cc./min.
Control	134	50	142	2.0
Phlebotomy	78	36	125	1.0
Phlebotomy	57	20	62	0.7
Norepinephrine	108	34	104	1.2
Norepinephrine	157	12	34	0.6

Following hemorrhage in the experimental animal, both glomerular filtration rate and renal plasma flow were depressed as the blood pressure fell. When the blood pressure was increased back to normotensive levels with norepinephrine, glomerular filtration rate and renal plasma flow increased. However, when the rate of infusion was too rapid and the blood pressure increased to hypertensive levels, glomerular filtration rate was depressed again as was the renal plasma flow.

Table 3 summarizes the mean values in this series of animal experiments. It can be seen that as the mean blood pressure is restored toward normal, there is considerable improvement in renal function. Also, as previously demonstrated in normal subjects, elevation of the mean blood pressure to hypertensive levels results in uniform reduction in glomerular filtration rate, renal plasma flow, and urine volume.

Following the preliminary animal studies, similar investigations were carried out in 9 patients in clinical shock. The etiology of the shock varied and included both normovolemic and hemorrhagic types. The effect produced in shock following myocardial infarction is depicted in figure 2. Following severe hypotension resulting from a myocardial infarction, glomerular filtration rate was depressed. When the blood pressure was increased toward normotensive levels, the glomerular filtration rate returned toward normal.

Although renal hemodynamics were frequently improved in hemorrhagic shock when pressor agents were used, if hemorrhage was too great, a similar degree of improvement was not observed. Under the latter circumstances, it was necessary to restore partially the blood volume before improvement of renal function was noted with norepinephrine.

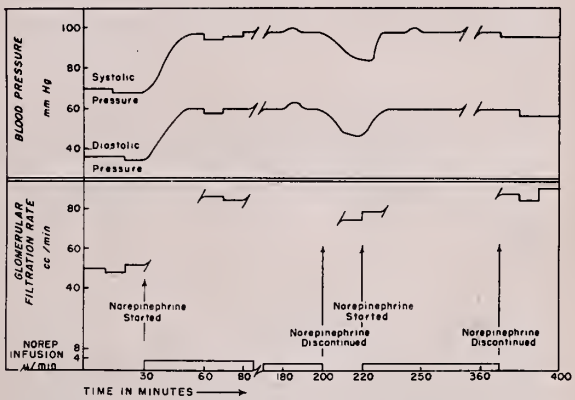

FIG. 2. The renal response to norepinephrine in shock accompanying myocardial infarction (recovery) is shown in the chart.

Figure 3 shows the effect of partial blood replacement on the response to norepinephrine. Although the blood pressure is initially raised by means of the vasopressor agent, there is no significant increase in the glomerular filtration rate and little increase in renal blood flow. However, after the administration of 350 cc. of whole blood, the subsequent administration of norepinephrine results in a significant improvement in renal blood flow and glomerular filtration rate.

Table 4 summarizes the mean values in the 9 shock

**Arfonad is d–3,4 (1',3'–dibenzyl–2'–keto–imidazolido)–1,2–trimethylene thiophonium d–camphor, which was furnished by Hoffman-LaRoche, Inc.*

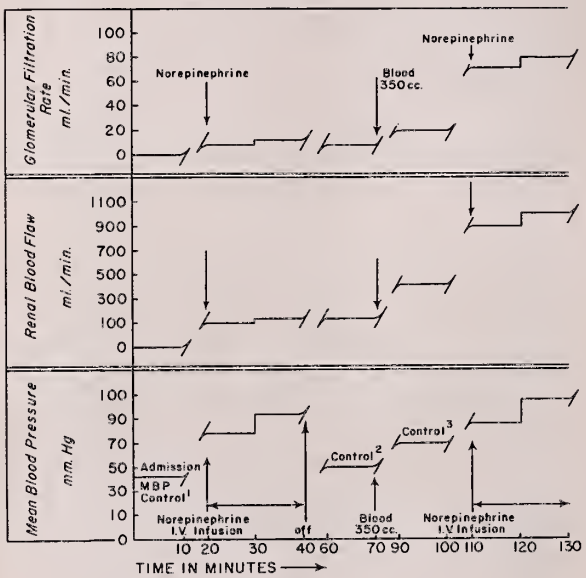

FIG. 3. Chart showing the effect of partial blood replacement on the renal response to norepinephrine in hemorrhagic shock.

patients studied. It is well to note again the improved glomerular filtration rate and renal plasma flow as the blood pressure is restored to normal levels. Following treatment, both glomerular filtration rate and renal plasma flow remain low for the group because some of the patients studied had primary renal disease.

TABLE 4.—*Renal Effects of Vasopressor Agents on Patients in Shock, Mean Values in 9 Patients.*

	Mean Blood Pressure mm. Hg.	Glomerular Filtration Rate cc./min.	Renal Plasma Flow cc./min.	Urine Volume cc./min.
Control	54	8	73	0.40
Vasopressor	73	53	404	1.40
Vasopressor	91	60	562	4.00

Comment

These observations appear to indicate that norepinephrine is effective in improving renal function in normovolemic shock and in some cases of hemorrhagic shock. There appears to be a fundamental difference between the renal response in normotensive patients when rendered hypertensive as compared to the response seen when patients in shock are rendered normotensive. In the former renal function is compromised, whereas in the latter it is improved.

VASODEPRESSOR AGENTS

In the treatment of hypertension with ganglionic blockade, it is desirable to provide sufficient blood pressure reduction to bring about improvement in cerebral and cardiac hemodynamics. At the same time renal effects of blood pressure reduction must be kept in mind since it is known that glomerular filtration rate and renal excretory capacity are dependent upon systemic blood pressure. If blood pressure reduction is excessive, renal decompensation can result. Because of this problem confronting the clinician, an attempt was made to see how far blood pressure could be reduced before producing significant reduction in glomerular filtration rate. If this could be ascertained, it would reveal a general range of blood pressure reduction which could be used clinically in the treatment of hypertension without further impairment of renal function by the therapeutic procedure.

Methods

Determination of glomerular filtration rate as related to mean blood pressure reduction was accomplished in 17 patients with untreated hypertension. Blood pressure reduction was achieved by the intravenous administration of the ganglionic blocking agent Pendiomide.* Glomerular filtration rate was determined in all patients by the inulin clearance method, and mean blood pressure was determined by intra-arterial femoral manometry. The ganglionic blocking drug was administered after three consecutive control periods in which determination of mean blood pressure and glomerular filtration rate was obtained. The mean blood pressure was reduced gradually in step-wise fashion, approximately 20 mm. of mercury at a time. With each reduction in the mean blood pressure, two terminations of glomerular filtration rate were made. After maximum mean blood pressure reduction was reached, the blood pressure was kept at this level for at least one hour, after which two additional determinations of glomerular filtration rate were made. The same study was performed in an additional 8 patients with the use of the ganglionic blocking drug Arfonad (table 5).

For comparison, a similar study was performed in 9 patients with normal blood pressure in whom Pendiomide was used to lower the blood pressure to hypotensive levels, and the resultant effect on glomerular filtration rate was determined.

Results and Discussion

It was noted that in both the hypertensive and the normotensive patients there was an initial decrease in glomerular filtration rate as the blood pressure was reduced. Following this, there was a rise in glomerular filtration rate in spite of continued reduction of the mean blood pressure and then a second decline in glomerular filtration rate which persisted

**Pendiomide is pentamethyl—diethyl—3—aza—pentane—1,5—diammonium—dibromide, which was furnished by Ciba Pharmaceutical Products, Inc.*

as the mean blood pressure was kept at the maximum reduction level.

Table 5 shows a comparison of the results obtained in the hypertensive patients and the normotensive patients. These average values show that in patients with hypertension when the blood pressure is lowered with Pendiomide into a normal range (mean blood pressure of 95 mm. of mercury) amounting to a 38 per cent reduction, the glomerular filtration rate is depressed far below the control value, amounting to a 26 per cent reduction. Similar results were obtained in the 8 hypertensive patients in whom blood pressure was reduced by means of Arfonad. When the mean blood pressure was lowered to 91 mm. of mercury, the glomerular filtration rate showed a 25 per cent reduction. In comparison, when the blood pressure of the normotensive group is reduced to a hypotensive range (mean blood pressure of 71 mm. of mercury), which amounts to a 28 per cent reduction, the glomerular filtration rate remains well within the range of normal and shows only a 14 per cent reduction from the control value. Of course, in terms of absolute decrease in mean blood pressure, it is more than twice as much in the hypertensive patients as it is in the normal ones. The mean control glomerular filtration rate for the hypertensive group is at the lower limit of normal because of the inclusion of a number of patients with secondary renal damage.

TABLE 5.—*Comparison of Results in Hypertensive and Normotensive Patients Showing the Effect of Reduction of Mean Blood Pressure on Glomerular Filtration Rate.*

	MBP_c	MBP_1	% Decrease	MBP_2	% Decrease	GFR_c	GFR_1	% Decrease	GFR_2	% Decrease
Average in 17 hypertensive patients after Pendiomide	153	100	35	95	38	91	61	33	67	26
Average in 8 hypertensive patients after Arfonad	143	103	28	91	36	88	63	28	66	25
Average in 9 normotensive patients after Pendiomide	97	77	21	71	28	134	111	17	115	14

MBP_c—Mean blood pressure in millimeters of mercury before Pendiomide or Arfonad (control values).
MBP_1—Value after maximum reduction in blood pressure.
MBP_2—Value after maximum reduction in mean blood pressure for one hour or more.
GFR_c—Glomerular filtration rate in cubic centimeters per minute before Pendiomide or Arfonad (control values).
GFR_1—Value after maximum reduction in blood pressure.
GFR_2—Value after maximum reduction in mean blood pressure for one hour or more.

Comment

Although a clearly defined critical blood pressure level for the maintenance of glomerular filtration rate was not found in patients with hypertension when the blood pressure was reduced by a ganglionic blocking drug, there was a significant decrease in glomerular filtration rate when blood pressure was lowered maximally. This reduction in glomerular filtration rate occurs within the normal blood pressure range. In normotensive persons, the changes in glomerular filtration rate are qualitatively similar and less marked and occur only after the blood pressure is reduced to hypotensive levels.

CONCLUSIONS

Vasopressor agents are effective in improving renal function in normovolemic shock and in some cases of hemorrhagic shock.

In contrast to the effect in shock, vasopressor agents compromise renal function when normotensive patients are rendered hypertensive.

In hypertensive patients, glomerular filtration rate is significantly depressed when the blood pressure is maximally reduced by a ganglionic blocking drug, and this reduction in glomerular filtration rate occurs within the normal blood pressure range.

A clearly defined critical blood pressure level for the maintenance of glomerular filtration rate in hypertensive patients was not found in this study.

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LEPROSY CASE CITED

What appears to be the first reported case of leprosy acquired during World War II military duty is described by a California physician in the September 11 *Journal of the American Medical Association*. Although some cases had been expected in servicemen stationed in regions such as the Philippines and this is the first reported, Dr. Norman E. Levan, Bakersfield, said that some instances of the disease may be anticipated during the next thirty years or more in veterans of World War II and the Korean campaign who served in such regions.

A PROGRAM FOR ROENTGEN EXAMINATION OF HOSPITAL ADMISSIONS

CAROLINE W. ROWE, M. D., Galveston, Texas

PRIOR to 1949 the Texas Tuberculosis Association had wished to see a program established whereby routine hospital admissions could receive a chest roentgen-ray examination. Consequently, the group proposed to lend a 70 mm. photofluorographic unit to the University of Texas Medical Branch at Galveston so that such a program might be initiated. This offer was accepted and by December, 1949, the project was started.

This presentation includes the result of this program to date.

First, let us consider the trend of thought throughout the country concerning the use of the miniature film. The need for survey chest photofluorograms is well established. All doctors will agree that in the field of chest diseases many potentially serious conditions show no symptoms during a considerable part of their course and that these may be detected at a much earlier stage with the use of the photofluorogram than was hitherto possible. Also, there are many conditions which in themselves may not be important but which complicate the management of other diseases.

Furthermore, photofluorography may be the first step in evaluation of the cardiovascular system. Most physicians value the visualization of the heart and great vessels as an adjunct to the management of their cases and consider the miniature film a worth-while investment from this viewpoint.

Mass chest surveys are fully twenty years old and have been studied at length. They did not reach statistically significant size, however, until the use of the photofluorogram. There is no doubt that they have served their purpose in detecting unsuspected tuberculosis, and recent studies show a gratifying decline in the tuberculosis death rate. As a result of this decline a smaller percentage of active cases are currently being detected by this method. Therefore, in recent years more emphasis has been placed on the use of hospital surveys in place of mass surveys, since hospitals and clinics are thought to contain a higher percentage of cases of undiagnosed tuberculosis and a more fruitful yield of the disease is expected from a hospital survey.

Coincident with the decline in the tuberculosis death rate, there is an increase in the death rate from lung cancer. In males bronchogenic carcinoma is replacing gastric carcinoma as the most frequent cause of death from cancer. Thus chest surveys are now being studied in respect to their role in detecting early bronchogenic carcinoma. Much emphasis is placed on the treatment of bronchogenic carcinoma while it is in a presymptomatic stage as it is only in this stage that anything approaching curative treatment can be expected.

Overholt[3, 4] recently has reported that when prompt treatment has followed discovery by roentgen-ray survey of lung cancer in the silent phase, all lesions were resectable and 75 per cent of the patients are still living. In contrast, however, in the symptomatic group approximately 90 per cent of the lesions extended beyond the lungs, and there was a possibility of cure in less than 10 per cent. Since carcinoma of the lungs can be discovered in the asymptomatic phase by photofluorography, it is a challenge to the medical profession to utilize the simple expedient of routine photofluorographic examinations of the chest to accomplish this.

PRESENT PROCEDURE

At the John Sealy Hospital the photofluorographic unit is utilized as follows on (1) all new admissions except stretcher cases, children under 6 years, and a group of pay patients; (2) personnel; (3) students; (4) food handlers every six months; (5) all obstetric patients every six months; and (6) patients from a State Department of Health prenatal clinic.

When projects are begun at the hospital such as the workmen's compensation program, a 70 mm. film is taken of all new persons entering this program. This takes a tremendous load off the main Radiology Department.

To illustrate the method of obtaining the 70 mm. film on new patients, let us follow a patient whom we shall call Miss X through the procedure. Miss X appears at the registration office as a new patient. The necessary data are recorded on the initial registration sheet to which is attached the request for a 70 mm. film. Therefore, the vital statistics are recorded by means of carbon paper on the roentgen-ray request. After the patient has registered, the clinic worker tears off the request and directs the patient to the photofluorographic unit. This unit is not

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Presented before the Texas Tuberculosis Association, Dallas, April 9, 1954.

situated in the Radiology Department but is adjoining the out patient clinic.

The patient presents herself to the technician who gives her a gown to wear, the film is made in a short time, and the patient goes directly to the clinic. At 6 a. m. the following day the technician develops the film, which is dried and processed by 8 a. m. It is reported and typed up that morning, and by the end of the day the report should be in the record room. It is not brought directly to the attention of the doctor, and this is a deficiency in the system which will be discussed later.

EARLY DIFFICULTIES

When this program was started in 1949, there was not as widespread use of this unit as there is today. As is frequently the case with a new idea, it was not received with enthusiasm. The education of the staff to the use of the photofluorographic unit was not an easy or rapid procedure, and considerable initial resistance was met. It had not been a routine procedure to obtain chest films on all new cases, and when the use of the 70 mm. film was proposed, even though for routine examinations, the staff believed the patients were being cheated by having a small film made instead of the conventional size radiograph.

The general opinion was that one could not see sufficient detail on a 70 mm. film to make them worth while. However, with the idea that the 70 mm. film should be tried as a screening process on new patients to separate negative from positive cases, the Department of Radiology was able to increase the number of examinations during a twelve month period by eight times. For example, in December, 1949, only 74 films were made, but in the following December 561 examinations were made. The number of examinations each year is listed in table 1. After the

TABLE 1.—*The Number of Roentgen Examinations of Chests per Year at John Sealy Hospital.*

Year	No. Examinations
1949 to 1950	2,573
1950 to 1951	7,581
1951 to 1952	6,615
1952 to 1953	8,648
1953 to 1954	8,744
Total	34,161

first year the percentage of the 70 mm. films made on new clinic and hospital admissions remained about the same from year to year. It was 86.4 per cent in 1953. The remaining 13 per cent included stretcher cases, small children, and private patients.

There were also initial difficulties in film interpretation. The radiologists had to learn to read the miniature film. There was a tendency to interpret normal markings as possible infiltration and many cases were returned for follow-up examination which proved to be normal. The duty of interpreting these films is still rotated among the staff and residents, and each new reader commits the same error until he becomes aware of the difficulty. Inevitably a number of lesions were missed. The most frequent error was failure to see a soft lesion behind the first rib and clavicle. I cannot give accurate statistics on the number of errors of omissions made by the radiologists because cases which were called normal naturally were not returned for follow-up examination. The only way to obtain reliable statistics on errors of omission would be to run a series in which the same group of patients received a 70 mm. film and a 14 by 17 inch film so that the results could be compared. This has not been done at John Sealy Hospital.

In spite of the fact that miniature films have much less resolving power than full size radiographs and hence give less detail, small lesions usually could be seen in review of the 70 mm. film after being demonstrated on a 14 by 17 inch film. It is my impression that our known errors were based more on a personal factor than on inherent differences between the miniature and conventional size film.

RESULTS

The procedure of having the registration office fill out the request has increased the number to have photofluorograms by approximately 2,000 per year. This system has been used at the John Sealy Hospital

TABLE 2.—*Positive Results Found on 70 mm. Films During an Eighteen Month Period.*

Major Groups	No. Cases	%
Cardiovascular disease	251	33
Lung disease	337	45
Miscellaneous	74	10
Errors (follow-up normal)	85	12
Total	747	

for nearly two years. Therefore, I have taken the statistics for a late eighteen month period as an example of the results the survey is now obtaining.

All radiographs at John Sealy Hospital are coded and a card is punched for I.B.M. use by the statistical clerk. All positive 70 mm. cases were listed and submitted to me for this study. On surveying the positive reports, I find that the hospital has an average of 5.6 per cent positive cases, which is essentially the same average shown in the statistics from other institutions which are carrying on similar surveys. Table 2 indicates the number of positive cases divided into major groups. This 5 per cent positive group includes cardiovascular disease, which comprises about 33 per cent of the group; lung disease, which makes up about 45 per cent of the group; and a miscellaneous group, which comprises 10 per cent of the positive group. The miscellaneous group includes all other

conditions from a fractured rib to more serious conditions such as mediastinal tumor. It is necessary to include in the group of positive cases a number of errors, which comprise 12 per cent of it. These were errors in which a 14 by 17 inch film was requested without a reason given, and the follow-up film was proved to be normal.

I made no attempt to evaluate the cardiovascular group but studied the charts of every positive lung case. I found in this eighteen month period 337 positive lung cases as reported on the 70 mm. film; 141 of these were proved to have lung disease; 196 lung disease suspects were lost to follow-up study, a point on which I shall elaborate further.

There were 86 cases of proven tuberculosis in this group, 46 of which were found to be active cases and 40 considered inactive on subsequent study in the clinic. There were 10 cases of proven bronchogenic carcinoma in the group.

Because of lack of follow-up facilities and lack of interest of physicians in special clinics, 196 lung disease suspects were lost. Of these 196 cases, there were 37 that seemed so typical on the 70 mm. film that they were reported as probable tuberculosis so that it might stimulate the physician to obtain follow-up examination quickly, but the recommendation was not heeded. This is a distressing fact, and it was noted that this took place repeatedly in special clinics such as genitourinary; ear, nose, and throat; orthopedics; eye; and psychiatry. Also, there were a number of patients who made only one visit to the clinic, and a lack of follow-up facilities allowed them to slip through our fingers without being notified that they had positive chest films.

ANALYSIS OF STATISTICS

The customary figures have been presented for a project such as this. In reporting mass surveys, such figures would be significant without further analysis. However, on reporting a hospital survey, I believe a more critical analysis is needed for true evaluation of the project.

There is a definite difference between patients who have photofluorograms made in a mass survey and in a hospital survey in that, theoretically, those positive cases discovered in a mass chest survey would not have been discovered except by that method. On the other hand, a hospital survey is comprised of patients who have come to the hospital because they are ill or believe they are ill; therefore, many of them must have signs or symptoms of a chest disease or knowledge that they have a chest disease. For this reason I believe that the chart on each of the positive cases should be studied, and it should be determined whether the condition was actually discovered by means of the miniature chest film or whether the patient came to the hospital with symptoms or knowledge that would have warranted obtaining a regular chest film anyway.

The following facts were revealed: of the 141 proven lung cases, 69 had presented themselves with chest symptoms or a knowledge that they had disease and only 72 cases were asymptomatic and unsuspected. The results should read that out of 13,157 cases, 72 unsuspected lung disease cases were discovered. Out of 86 proven tuberculosis cases, 66 had presented themselves with symptoms of a chest condition or a knowledge that they had had tuberculosis; therefore, only 20 unsuspected tuberculosis cases were actually discovered. The same situation applied to the cases of bronchogenic carcinoma. Ten of the lung disease cases proved to have bronchogenic carcinoma, but only 1 was unsuspected.

COMPARATIVE COSTS

It is obvious that the previously mentioned figures should be used if one is to attempt to estimate the cost of a hospital survey.

It is not difficult to determine unit cost. Our unit cost is essentially the same as that from other institutions; that is 75 cents per person having a photofluorogram. Results show that each asymptomatic lung case or unsuspected lung disease case costs $137. The cost of detecting each unsuspected case of tuberculosis is $465.13. Although there is much current interest in detecting bronchogenic carcinoma by the survey method, if this survey had been conducted for this purpose alone, it would have cost $9,767 for each discovery of asymptomatic bronchogenic carcinoma.

These figures tally closely with those presented by Guiss[1] in reporting the value of the chest photofluorogram in the control of lung cancer from a study of 1,867,201 examinations at Los Angeles County Hospital. This is the largest survey of its kind in the nation. This study was made with the use of a medical board and adequate secretarial and social service help in order to obtain the necessary follow-up data. They found 1.9 per cent of these patients were tumor suspects, but only .08 per cent proved to have bronchogenic carcinoma. It cost $396 each to discover a chest tumor suspect, and each proven carcinoma cost $9,625.

DISCUSSION

In spite of the small percentage of proven cases from the suspects of the Los Angeles group, Guiss believed that there is no question that the mass chest survey was an effective method of discovering chest neoplasms, although it was expensive. However, he thought that only by this means could one detect lung cancer still in the asymptomatic phase. He em-

phasized that the mere screening is useless unless this lead is properly exploited and a prompt clinical investigation and surgical intervention accomplished. Also, there is a difference between the problems of tuberculosis and of cancer.

In discovering unsuspected cases of tuberculosis the population is definitely benefited, and there is a sustained effect on the extent of the problem if the patient is given proper treatment. But in attempting to control lung cancer, surveys must be repeated every six months since cancer may develop during an interval of a few months in cases which were negative at the time of the initial survey. This raises another problem, but it is believed that if, for example, all males over 40 years of age could be surveyed every six months, it might prove worth while in the control of lung cancer.

On the other hand, in a report by McNulty[2] from the *New England Journal of Medicine* early this year one finds a more depressing viewpoint. He reported on a survey centered on bronchogenic carcinoma. In this survey the incidence of bronchogenic carcinoma was 1 to 14,000 cases. He thought that this is a discouragingly low figure and that more than one-half of the lesions which were discovered were not resectable at operation. This again emphasizes the point made by the Los Angeles group that bronchogenic carcinoma must be detected early. The only way to approach this problem would be through surveys at a minimum of every six months, or much of the effort and money is wasted.

In spite of the low percentage of cases from which the patients and community benefit by the discovery of disease, it appears to be the only approach to these problems, and I believe that the physician and the interested layman desire the continuation of such a project. Most physicians today agree that the 70 mm. chest film discloses more important information than the much longer established routine of obtaining complete blood counts, urinalysis, and serologic tests for syphilis on new patients. It cannot be disputed that the detection and control of syphilis has resulted largely from obtaining compulsory routine serologic tests for syphilis on all patients seen. Therefore, I think that if we are to progress in the field of early detection of disease and in the control of disease, it is worth while to carry on these projects. They must be carried to completion in an efficient manner so that the value is not lost.

CONCLUSION

As a result of compiling this report, I see that this survey has not been carried on with maximum efficiency and economy, and it is hoped that the following suggestions will be helpful to other hospitals that might be interested in starting chest surveys:

Requests for the 70 mm. examination filled out by the registration clerk are found to expedite this matter and aid in obtaining a high percentage of examinations on new patients.

The photofluorographic unit should be adjacent to the clinic or registration office and not in the main Radiology Department.

The report must be in the hands of the doctor within twenty-four hours in order for this project to serve its purpose. This will aid in preventing unnecessary exposure to staff and other patients of unsuspected tuberculosis cases. It will also allow patients who make only one visit to the clinic to be informed of the need for further chest investigation. It will encourage the doctors in special clinics to obtain further study on the chest before they become absorbed in treating the original complaint.

A social service worker or clerk should be responsible for following up all positive 70 mm. reports and corresponding with those patients who do not return.

Education of the staff doctors to the objectives of the program should be accomplished before it is started, for without their cooperation the project becomes a costly and useless procedure.

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Ratio of Doctors to Population

The graduation of the largest class of physicians in history has brought a record ratio of one doctor for every 730 persons in the United States. The ratio is expected to be lowered even more in the next few years as the number of medical graduates rises more rapidly than the general population.

The record graduation of 6,861 doctors during 1953-1954 brings the physician population in the United States to approximately 220,100.

AMA EXHIBIT EXPOSES QUACKS

The American Medical Association's newest exhibit, titled "The Modern Medicine Show," exposes quack healers and food faddists and presents the facts as to how "medicine men" have duped the public into spending thousands of dollars for "would-be cures."

After being shown at the annual meeting of the AMA in San Francisco, the exhibit is now available from the Bureau of Exhibits for use at medical meetings, fairs, and public gatherings.

CASE REPORTS

Dissecting Aneurysm of the Thoracic Aorta Due to Trauma

FREDERICK P. BORNSTEIN,* M. D., El Paso, Texas

WITH the advent of the automobile, stresses of a magnitude previously unknown have been imposed upon the human organism. Consequently traumas and associated diseases which had not been known in previous years have developed. The case to be reported here is so unusual that I have been able to find only 1 similar case in literature.[1]

Of all the various types of aneurysms formed by the aorta, the dissecting aneurysm is the rarest and most unusual. In dissecting aneurysm there is a break of the wall. Blood digs itself a new tract between the layers of the aorta either between the intima and the media or more commonly between the media and adventitia.

Such a condition frequently causes sudden and dramatic termination of the life of the afflicted person. It is no wonder, therefore, that the older literature[2] contains numerous references to so-called traumatic dissecting aneurysms. However, study of these reports always shows that the trauma referred to consists of a relatively small effort such as sudden lifting or a rash movement. In all these cases on autopsy a previously existing disease of the aortic wall has been demonstrated. Therefore, we should accept as traumatic dissecting aneurysm only cases in which there is a clear connection between a heavy injury and the aneurysm and in which gross and histopathologic examinations of the aorta reveal the absence of preexisting diseases.

CASE REPORT

A 21 year old white man was admitted to El Paso General Hospital after an automobile accident. He was sitting next to the driver when the car went out of control and hit an iron telephone pole with sufficient impact to bend the pole. He was found by the police lying on the seat, but apparently not seriously injured, and was able to walk into the hospital under his own power. Because of a broken rib, a chest roentgenogram was made three hours after the accident; it revealed a chest which was essentially normal. At this time the man appeared to be in good condition. One hour later he went into shock, became pale, and died within ten minutes.

On autopsy 3,000 cc. of partially clotted blood was found in the left pleural cavity. The organs of the chest and abdomen were removed en bloc, and upon inspection of the aorta posteriorly, a layer of blood was located between the adventitia and the media. This bloody infiltration extended to the level of the renal arteries. In following the aorta upward, there was found in the adventitia a tear from which the hemorrhage had broken into the left pleural cavity. When the aorta was opened, a transverse tear was seen in the intima of the aorta slightly above the level of the origin of the first intercostal artery (fig. 1a).

Important findings of microscopic examination were limited to the aorta. Sections taken a considerable distance from the intimal tear, namely, in the abdominal aorta, showed a hemorrhage existing between the adventitia and the media. This established the dissecting character of the lesion. In addition, histologic examination of the wall of the aorta with hematoxylin and eosin and with Verhoeff's elastic stain proved the absence of previously existing disease of the aorta. A section taken directly from the tear showed the splintering of the medial layer and the rolling up of the intima, evidently under the impact of the injury (fig. 1b).

DISCUSSION

From the autopsy and clinical findings, it can be established that this man suffered a tear in the intima and media at the time of accident and that a dissecting aneurysm developed in the following four hours. Upon rupture of this aneurysm death occurred.

This case is similar to the one described by Leonard.[1] The location of the tear was at approximately the same place in our case and in Leonard's case,[1] whereas in Stryker's saccular aneurysms[3] the tears were found in the first part of the ascending aorta. In Leonard's case the dissecting tract extended in an upward direction; in our case it extended downward. In Leonard's case there was a survival of four days. This is important; the interval between the original injury and death in some of these cases may give the physician an opportunity for treatment after more is learned about this condition.

It is unfortunate that in neither Leonard's case, nor our case, nor in the more common cases of complete traumatic rupture of the aorta any adequate data are available to explain the mechanism involved. In traffic accidents, one would like to know the rate of deceleration, the probable direction of the travel of the body, and similar items which would permit an estimation of the magnitude of the impact sustained by the body. Without quantitive data it always will be difficult to explain the sequence of events.

Presented at the annual meeting of the Academy of Forensic Sciences, Chicago, February 27, 1954.

*Pathologist, El Paso General Hospital.

SUMMARY

A case of a partial traumatic rupture of the aorta followed by a dissecting aneurysm is presented. This is the second case in literature so reported.

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Providence Memorial Hospital, 2001 N. Oregon.

FIG. 1a. Transverse tear in the intima of the aorta slightly above the level of the origin of the first intercostal artery.

b. Photomicrograph of a section taken from the tear and showing splintering of the medial layer and rolling up of the intima.

Radiological Physics Course

Beginning October 7 and continuing for twenty-four weeks each Thursday afternoon for an hour, a course in radiological physics is being offered in Houston by the University of Texas Postgraduate School of Medicine in cooperation with the Texas Medical Association, the Texas State Department of Health, and the Texas Academy of General Practice. W. K. Sinclair, Ph. D., is the instructor in charge, and A. Cole, Dr. G. H. Fletcher, Dr. J. E. Richardson, and Dr. R. J. Shalek assist. Twenty-four hours' credit is given for the course, the tuition for which is $10.

Some of the lectures to be presented include physical principles of the diagnostic use of roentgen rays, the measurement of radioactive isotopes, dosimetry, physical aspects of radiobiology, applications of electronics in radiology, and radiological protection. A complete schedule of weekly lectures may be obtained from the postgraduate school, Texas Medical Center, Houston.

INDUSTRIAL POLICYHOLDERS MORTALITY

Mortality among industrial policyholders of the Metropolitan Life Insurance Company set a new low record during the first half of 1954. According to the company's statisticians, 650 per 100,000 policyholders compares with 667 per 100,000 for the first six months of 1950, which was previously the lowest registered mortality rate.

Among the males the death rate for all ages under 75 years combined was about the same as in 1953, when the rate was 670 per 100,000. Female policyholders recorded a lower death rate this year than last in every age group.

Cancer and allied conditions were the only major causes of death to show a rise in mortality over last year. The rate rose from 124.8 to 129.5 per 100,000 for the first half of 1954. The cardiovascular-renal diseases, diabetes, and tuberculosis death rate was lower than that for the same period last year.

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, Fort Worth, April 24-27, 1955. Dr. F. J. L. Blasingame, Pres.; Mr. N. C. Forrester, 1801 North Lamar Blvd., Austin, Executive Secy.

American Medical Association, Miami, Fla., Nov. 30-Dec. 3, 1954. Dr. Walter B. Martin, Norfolk, Va., Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice, Los Angeles, March 28-31, 1955. Dr. W. B. Hildebrand, Menasha, Wis., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. Bayard Carter, Durham, N. C., Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology, New York, Sept. 14-24, 1955. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 4-7, 1954. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Atlantic City, N. J., April 24-26, 1955. Dr. Edward S. Welles, Saranac Lake, N. Y., Pres.; Dr. Paul C. Samson, 3959 Happy Valley Rd., Lafayette, Calif., Secy.

American Association of Genito-Urinary Surgeons, Monterey, Calif., May 22-25, 1955. Dr. Fletcher H. Colby, Boston, Pres.; Dr. John A. Taylor, 2 E. 45th St., New York 22, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons. Dr. Herbert F. Schmitz, Chicago, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Chicago, April 25-30, 1955. Dr. Homer Prince, Houston, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, Atlantic City, N. J., June 2-5, 1955. Dr. William A. Hudson, Detroit, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Philadelphia, April 25-29, 1955. Dr. C. C. Sturgis, Ann Arbor, Mich., Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 4, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-19, 1954. Dr. Fred W. Rankin, Lexington, Ky., Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress on Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chairman.

American Congress of Physical Medicine and Rehabilitation. Dr. William D. Paul, Iowa City, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Belleair, Fla., April 17-21, 1955. Dr. Richard S. Weiss, St. Louis, Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, Atlantic City, N. J., June 4-5, 1955. Dr. Dwight L. Wilbur, San Francisco, Pres.; Dr. H. Marvin Pollard, University Hosp., Ann Arbor, Mich., Secy.

American Gynecological Society, Quebec, Canada, May 23-25, 1955. Dr. Philip F. Williams, Philadelphia, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, New Orleans, Oct. 26-30, 1955. Dr. E. Cowles Andrus, Baltimore, Pres.; Mr. Irving Hexter, 44 E. 23rd St., New York 10, Secy.

American Hospital Association. Mr. Ritz E. Heerman, Los Angeles, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Hollywood, Fla., March 15-17, 1955. Dr. Kenneth M. Day, Pittsburgh, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Chicago, June 13-15, 1955. Dr. Percival Bailey, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, W. Sulphur Springs, W. Va., June 2-4, 1955. Dr. Everett L. Goar, Houston, Tex., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, W. Sulphur Springs, W. Va., June 19-22, 1955. Dr. J. Warren White, Honolulu, Hawaii, Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Quebec, Canada, June 13-17, 1955. Dr. Alfred H. Washburn, Denver, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, New York, June 1-4, 1955. Dr. A. W. Martin Marino, Brooklyn, N. Y., Pres.; Dr. Karl Zimmerman, 3500 Fifth Ave., Pittsburgh 13, Secy.

American Psychiatric Association, Atlantic City, N. J., May, 1955. Dr. Alfred P. Noyes, Norristown, Pa., Pres.; Dr. William Malamud, 80 E. Concord St., Boston 18, Secy.

American Public Health Association, Buffalo, N. Y., Oct. 11-15, 1954. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Cincinnati, Oct. 25-30, 1954. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Philadelphia, April 27-29, 1955. Dr. John H. Gibbon, Jr., Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, Los Angeles, May 16-19, 1955. Dr. W. Joseph McMartin, Omaha, Neb., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Delegates Interim Meeting, Chicago, Oct. 1-2, 1954. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 360 N. Michigan Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Milwaukee, May 23-27, 1955. Dr. John H. Skavlem, Cincinnati, Pres.; Mrs. Morrell DeReign, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association, Louisville, October, 1954. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nashville, Pres.; Dr. George Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth, Oct. 21, 1954. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, Nov. 17-19, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secy.

Tri-State Medical Society, Texarkana, September, 1955. Dr. William B. Harrell, Texarkana, Pres.; Dr. Karlton Kemp, 408 Hazel, Texarkana, Ark., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas, Corpus Christi, Dec. 4-5, 1954. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice. Dr. C. Forrest Jorns, Houston, Pres.; Dr. Woodson W. Harris, 1410 Nickerson, Austin, Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 11-12, 1954. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association. Dr. J. S. Minnett, Dallas, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, Fort Worth, April 24, 1955. Dr. Howard E. Smith, Austin, Pres.; Dr. John Wiggins, 1707 Medical Arts Bldg., Fort Worth, Secy.

Texas Club of Internists. Victor E. Schulze, San Angelo, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, Fort Worth, April 24, 1955. Dr. Paul H. Power, Waco, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, Fort Worth, April 24, 1955. Dr. George M. Jones, Dallas, Pres.; Dr. Hugo Engelhardt, P. O. Box 2180, Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas, Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Geriatric Society, Fall, 1954. Dr. Henry H. Niehuss, Longview, Pres.; Dr. Frank V. Mondrik, 214 Bramlette Bldg., Longview, Secy.

Texas Heart Association, Fort Worth, April 25, 1955. Dr. George R. Herrmann, Galveston, Pres.; Mr. Edgar M. Brown, Jesse H. Jones Library Bldg., 1133 M. D. Anderson Blvd., Houston, Executive Director.

Texas Hospital Association, Houston, April 12-14, 1955. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association, Galveston, Oct. 24-25, 1954. Dr. Edgar S. Ezell, Fort Worth, Pres.; Dr. Bruce H. Beard, 1519 Pennsylvania, Fort Worth, Secy.

Texas Orthopedic Association, Fort Worth, April 25, 1955. Dr. Brandon Carrell, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Fort Worth, Oct. 22-23, 1954. Dr. Robert L. Moore, Dallas, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society. Dr. Jack Kerr, Dallas, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 13-16, 1955. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Houston, Jan. 21-22, 1955. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, Fort Worth, April 25, 1955. Dr. Raleigh White, Temple, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred W. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Mineral Wells, 1955. Dr. Charles N. Burrows, San Antonio, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 3, Executive Secy.

Texas Society of Anesthesiologists, Fort Worth, April 24, 1955. Dr. Frank O. Barrett, El Paso, Pres.; Dr. Milton M. Rosenzweig, 200 Wildwood Dr. E., San Antonio, Secy.

Texas Society of Gastroenterologists and Proctologists, Fort Worth, April 25, 1955. Dr. Charles Hardwicke, Austin, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, Dallas, Jan. 30, 1955. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Galveston, April 15-16, 1955. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 2406 Manor Rd., Austin, Executive Secy.

Texas Urological Society, Corpus Christi, 1954. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg., Corpus Christi, Secy.

West Texas Surgical Society, Dec. 8, 1954. Dr. J. A. Shapira, Midland, Pres.; Dr. Milton J. Loring, 304 North N St., Midland, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society. Dr. John R. Mast, Midland, Pres.; Dr. M. J. Loring, 304 North N St., Midland, Secy.

Third District Society, Borger, April, 1955. Dr. M. C. Overton, Jr., Pampa, Pres.; Dr. William Klingensmith, 215 Fisk Bldg., Amarillo, Secy.

Fourth District Society, San Angelo, Oct. 21, 1954. Dr. P. M. Wheelis, Brownwood, Pres.; Dr. James N. White, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi. Dr. John J. Sloan, Corpus Christi, Pres.; Dr. E. Jackson Giles, 705 Medical-Professional Bldg., Corpus Christi, Secy.

Seventh District Society. Dr. William McLean, Austin, Pres.; Dr. John Rainey, 1709 San Antonio, Austin, Secy.

Eighth District Society, Galveston, 1955. Dr. George E. Glover, Jr., Victoria, Pres.; Dr. York Lancaster, Port Lavaca, Secy.

Ninth District Society, Houston, March 17, 1955. Dr. Thomas H. Giddings, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. John M. White, Port Arthur, Pres.; Dr. Rider Stockdale, Jasper, Secy.

Eleventh District Society, Jacksonville, Oct. 27, 1954. Dr. John Dean, Crockett, Pres.; Dr. Marlin T. Braswell, Henderson, Secy.

Twelfth District Society. Dr. Neil Buie, Marlin, Pres.; Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society, Abilene, March 2, 1955. Dr. Mal Rumph, Fort Worth, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society. Dr. J. David Thomas, Denton, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Mount Pleasant, 1955. Dr. R. L. Johnson, Mount Pleasant, Pres.; Dr. R. L. Hardman, Mount Pleasant, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 14-17, 1955. Dr. Lawrence B. Sheldon, Dallas, Pres.; Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco. Dr. Ross Shipp, Waco, Pres.; Dr. Milton Spark, 3805 Herwal, Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 7-10, 1955. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City, Oct. 25-28, 1954. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls, April, 1955. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences, Austin, Oct. 22-23, 1954. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, Dec. 2-4, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

Southwestern Begins Postgraduate Series With Obstetrics and Gynecology Course

The Southwestern Medical School of the University of Texas, in association with the Dallas Southern Clinical Society and under the auspices of the Postgraduate School of Medicine of the University of Texas, the Texas Medical Association, and the Texas Academy of General Practice, is offering a three-day course in obstetrics and gynecology, November 15-17, at the new Parkland Hospital, 5201 Harry Hines Boulevard, Dallas.

The course, to be taught by members of the full-time and clinical faculty of Southwestern Medical School, will give twenty hours' credit to members of the Academy of General Practice.

Those teaching will be Drs. William F. Guerriero, Mary A. Jennings, Douglas M. Haynes, J. R. Jordan, William F. Mengert, Jules W. Vieaux, Stewart A. Fish, G. C. Nabors, A. R. Shapiro, William P. Devereux, Oran V. Prejean, V. A. Davidson, and William G. Langston.

In addition to individual papers, four panels will be offered. They are "Caesarian Section," "Obstetrical Analgesia and Anesthesia," "Newer Drugs in Relation to Obstetrics and Gynecology," and "Genital Cancer."

The course, which is limited to fifty, will cost $5 for registration and $25 for tuition.

The tentative schedule for postgraduate courses to be presented during the school year 1954-1955, in addition to the course on obstetrics and gynecology for general practitioners, includes recent advances in special surgery for general prac-

titioners, December 2-4; pediatrics for general practitioners, January 7-9; surgical cardiac disease for internists and thoracic surgeons, February 7-9; seminar for dietitians, February 18-19; seminar for medical technologists, March 4-5; fluids and electrolytes, April 4-6; and seminar in tuberculosis for physicians sponsored jointly with the Dallas Tuberculosis Association, late May.

The annual spring conference of the Dallas Southern Clinical Society, to be held March 14-17, is jointly sponsored by the medical school, and a number of courses will be scheduled one night a week for six to ten weeks.

Further information and application forms may be obtained from Dr. John S. Chapman, assistant dean for graduate and postgraduate education of the school, 2211 Oak Lawn Avenue, Dallas 19.

Courses already presented this year were a seminar in current development in medicine for medical social workers September 9-11 and a discussion of recent advances in internal medicine October 4-6.

TRI-STATE SOCIETY CONVENES

Seven guests presented the major portion of the scientific program when the Tri-State Medical Society met September 29 and 30 in Longview. Dr. Joe Nichols, Atlanta, presided over the organization as its president.

Featured as the speakers were Dr. C. T. Ashworth, chief of pathology at Harris Memorial Hospital, Fort Worth; Dr. Arthur Grollman, professor of internal medicine at Southwestern Medical School of the University of Texas, Dallas; Dr. Ellery C. Gay, professor of plastic surgery at the University of Arkansas, Little Rock; Dr. Curtice Rosser, professor of proctology at Southwestern Medical School, Dallas; Dr. Joe Shuffield, chairman of the Division of Traumatic Surgery, American College of Surgeons, Little Rock; Dr. Jack B. Trunnell, chief of the Department of Endocrinology and Cancer Research, M. D. Anderson Hospital, Houston; and Dr. Robert Watson, professor of neurosurgery at the University of Arkansas, Little Rock.

The program was as follows:

SEPTEMBER 28

Whitehead Operation—Dr. J. R. Stamper, Shreveport.
Pathologic Physiology of Hemorrhoids—Dr. Ashworth.
Office Management of Minor Anal Condition, Including Early Hemorrhoids—Dr. Rosser.
Physiology of Hypertension—Dr. Grollman.
Nature of Cancer—Dr. Trunnell.
Proctoscopic Examination with Differential Diagnosis—Dr. Rosser.
Newer Drugs in Treatment of Hypertension—Dr. Grollman.
Pathologic Physiology of Cancer of Prostate—Dr. Ashworth.
Treatment of Cancer of Prostate—Dr. Trunnell.

SEPTEMBER 29

Burns—Dr. Gay.
Compound Fractures—Dr. Shuffield.
Terminal Phase of Hypertension—Dr. Grollman.
Present Management of Diverticulitis—Dr. Rosser.
Pathologic Physiology of Cancer of Thyroid—Dr. Ashworth.
Treatment of Cancer of Thyroid—Dr. Trunnell.
Head Injuries—Dr. Watson.
Fluid Balance—Dr. Grollman.
Pruritus Ani—Dr. Rosser.
Pathologic Physiology of Cancer of Breast—Dr. Ashworth.
Treatment of Cancer of Breast—Dr. Trunnell.

Drs. Winston C. Holman, Shreveport; W. S. Terry, Jefferson; and Frank G. Thibault, El Dorado, Ark., vice-presidents, presided over parts of the scientific sessions. Dr. V. R. Hurst, Longview, was general chairman for the convention.

Luncheons, one of them jointly with visiting wives, a dinner, and a golf tournament rounded out the two day meeting.

Dr. William B. Harrell, Texarkana, was elected president; Dr. Karlton Kemp, Texarkana, secretary-treasurer. The 1955 meeting will be in September in Texarkana.

Southwestern Medical School

Dr. George N. Aagaard has resigned as dean of Southwestern Medical School of the University of Texas, Dallas, to assume the same position at the University of Washington School of Medicine, Seattle. He will also have charge of all other medical activities centering around the university. Dr. A. J. Gill, assistant dean of buildings and development, has been appointed acting dean.

Other resignations include that of Dr. J. J. Quilligan, associate professor of pediatrics, who joins the faculty of the College of Medical Evangelists at Los Angeles, and Dr. Louis Tobian, assistant professor of medicine, who is to be associate professor of medicine at the University of Minnesota Medical School, Minneapolis.

New staff members include Dr. Harlow Ades, professor of anatomy; Dr. Edward Pratt, professor and chairman of the Department of Pediatrics; Dr. James Hamilton, assistant professor of experimental medicine; and Drs. Marvin Siperstein and James P. Lillehei, on the Department of Medicine faculty.

Dr. J. Harold Cheek, Dallas, recently has been elected by circular vote vice-president and consequently president-elect of the alumni group; Dr. James Holman, Dallas, is the new secretary-treasurer. Dr. Ern C. Mooney, Victoria, was elected president at the group's May meeting in San Antonio.

Southern Medical Association

The forty-eighth annual meeting of the Southern Medical Association will be November 8-11 in St. Louis with the St. Louis Medical Society as host.

The meeting, which opens with a general public session on Monday afternoon, will be held at Keil Municipal Auditorium. Included in the program are scientific and technical exhibits, section meetings, Woman's Auxiliary meetings, and entertainment. The scientific sections will have half-day sessions beginning Monday afternoon and extending through Thursday. The Doctor's Day luncheon planned by the Woman's Auxiliary is scheduled for Tuesday, and the Association dinner will be held Wednesday evening.

The Southern Medical Association has provided for twenty-one sections to meet, enabling each physician present to find something in his field. The sections are general practice, medicine, gastroenterology, neurology and psychiatry, pediatrics, pathology, radiology, dermatology and syphilology, allergy, physical medicine and rehabilitation, industrial medicine and surgery, surgery, and orthopedic and traumatic surgery. Other sections are gynecology, obstetrics, urology, proctology, ophthalmology and otolaryngology, anesthesiology, public health, and medical education and hospital training.

Dr. Alphonse McMahon, St. Louis, is president of the Association, and Dr. Robert L. Sanders, Memphis, Tenn., will be installed as president during the four-day session. Dr. R. O. Muether is president of the St. Louis Medical Society, and Dr. Daniel L. Sexton is serving as general chairman of the Committee on Arrangements.

Meeting with the Association are the American College of Chest Physicians, Southern Chapter; Southern Gynecological and Obstetrical Society; Southern Society of Cancer Cytology; Southern Electroencephalographic Society; Association for Research in Ophthalmology, Southern Section; and American Therapeutic Society.

Requests for hotel accommodations should be sent to the Housing Bureau, Southern Medical Association, 911 Locust Street, Room 406, St. Louis 1.

JESSE JONES LIBRARY DEDICATED

The $1,250,000 Jesse H. Jones Library Building, Houston, was dedicated on September 9 in a program in which Dr. M. D. Levy, president of the Houston Academy of Medicine, gave the address of welcome. John T. Jones, Jr., gave an address which was followed by a speech on "The Medical Library in a Medical Center and Community" by Chauncey D. Leake, Ph. D., Galveston, dean of the University of Texas School of Medicine. Dr. C. C. Cody, Jr., Houston, gave the dedication address, and Dr. C. A. Dwyer, Houston, presented a plaque to Jesse H. Jones.

The four-story building was paid for entirely through contributions. Mr. and Mrs. Jesse H. Jones gave $600,000 to the building through the Houston Endowment, Inc.; The M. D. Anderson Foundation, $300,000; the oil companies of the Houston area, $75,000; and doctors and laymen, the other $275,000. The Texas Medical Center provided the land on which the building stands.

The library is housed on the first two floors with stacks for 140,000 volumes. In addition to a Fellows Room, which is furnished as an informal reading room where doctors may discuss their professional interests and problems, are a reading room and thirty carrells. Also on the second floor are a Rare Books Room, a small auditorium, a microfilm room, two seminar rooms, and ten individual study rooms.

JESSE H. JONES LIBRARY BUILDING

On the third floor is an auditorium with a seating capacity of 516; with its high ceiling it also occupies one section of the fourth floor. A doctors' club also is included on the third floor.

The fourth floor houses the executive offices of the Harris County Medical Society, the Texas Medical Center, University of Texas Postgraduate School of Medicine, Postgraduate Medical Assembly of South Texas, Houston Heart Association, Texas Heart Association, and the Woman's Auxiliary to the Harris County Medical Society; administrative office of the Houston Committee on Alcoholism; and a branch of the Medical and Dental Service Bureau.

The color scheme throughout the building is of cocoa and various tones of green, the interior being planned to complement the exterior. The auditorium is so constructed that no amplification system is needed.

A portrait of Mr. Jones hangs in the front lobby, as do portraits of Dr. C. C. Cody, Jr., chairman of the Library Committee, and Dr. M. D. Levy in the Fellows Room.

ANDERSON HOSPITAL OPENS OFFICIALLY

Clinical conferences and symposiums on basic problems in cancer research for Texas physicians will precede the formal opening of the University of Texas M. D. Anderson Hospital and Tumor Institute to be held October 23.

One unit of credit for each hour of attendance at the scientific sessions October 21 and 22 will be certified by the University of Texas Postgraduate School of Medicine to the Academy of General Practice for physicians who wish it.

Following registration and a welcome at 9 a. m. from Dr. R. E. Clark, Jr., director and surgeon in chief, four successive panel discussions lasting an hour and a half each will be held October 21. Dr. David A. Karnofsky of the Sloan-Kettering Institute in New York will lead the panel on "The Chemotherapy of Cancer"; Dr. F. A. D. Alexander of the Veterans Administration Hospital at McKinney will lead that on "The Control of Pain"; Dr. Alexander and Dr. William Brewster of Massachusetts General Hospital at Boston will be panelists in a discussion of "The Anesthesiology of Cancer Surgery"; and Dr. Herbert C. Allen of the Veterans Administration Hospital in Houston will be a member of the panel on "Studies of Thyroid Tumors."

A fifth panel, "The Team Approach to Gynecologic Cancer" with Dr. A. N. Arneson of Washington University at St. Louis as chairman, will be presented the morning of October 22 after a review of "Admission Policies of the M. D. Anderson Hospital" by Dr. Clifton D. Howe, chief of clinics. A series of four clinical conferences with presentation of patients will be held the same day with the first beginning at 11 a. m. Conducted by members of the medical staff of the hospital, these conferences will be on "The Recognition and Treatment of Cancer," "Medical Malignancies," "Head and Neck Malignancies," and "General Surgery Malignancies." Simultaneously during the afternoon will be three symposiums on basic problems of cancer research: "Biologic Effects of Radiation," "Cancer Diagnostic Tests," and "Proteins and Cancer." The first of these will be participated in by Edgar Altenberg, Ph. D., of Rice Institute, Houston, and Wilson S. Stone, Ph. D., Orville Wyss, Ph. D., and A. B. Schrank, Ph. D., of the University of Texas, Austin.

M. D. ANDERSON HOSPITAL AND TUMOR INSTITUTE

Formal dedication ceremonies for the $10,000,000 building in the Texas Medical Center will be held at 10:30 a. m. October 23. The public will be invited to a program the afternoon before.

The new hospital, occupied last March, has 310 beds and facilities to serve 300 out patients per day. Research in biochemistry, biology, pathology, radiology, physics, surgery, experimental medicine, and epidemiology has been allotted about 80,000 square feet of space. One operating room has been equipped with color television equipment so that operations can be televised to an auditorium and staff rooms elsewhere in the building. A library on the first floor is supplemented by departmental collections. A cafeteria and a coffee shop serve staff and visitors.

LIBRARY OF THE
COLLEGE OF PHYSICIANS

With exterior finish in pink marble, the hospital was financed by private philanthropy (notably from the M. D. Anderson Foundation), state funds, and a federal grant.

PERSONALS

Dr. Curtice Rosser, Dallas, was named president-elect of the International College of Surgeons at the group's September meeting in Chicago. Dr. Rosser will serve as president-elect for two years prior to taking the office of president in 1956.

Dr. Odon F. von Werssowetz, Gonzales, was awarded a gold medal and first prize for the scientific exhibit, "Supportive Assists in the Rehabilitation of Paralytic Hand," which he and his staff presented at the annual session of the American Congress of Physical Medicine and Rehabilitation September 6-11 in Washington, D. C. Dr. von Werssowetz also participated in the scientific program.

Dr. Weldon O. Murphy, Amarillo, presented a paper at the Pan-American Association of Ophthalmology, which met during the summer in Sao Paulo, Brazil.

Dr. K. J. Kemp, Corpus Christi, is quoted in the Congressional Record of July 27. His comments on the Children's Hospital Medical Center of Corpus Christi, a physical medicine center with emphasis on cerebral palsy, were included as an extension of remarks by Representative John E. Lyle, Jr., of Texas.

Dr. Morris D. Mann, Coleman, was presented a special award of appreciation by Boy Scout Troop 31 of Coleman at its August 10 meeting. Dr. Mann received an honorary membership in the troop and a statuette for his contribution to the troop in its health program.

Dr. Ralph Homan has been named to fill a vacancy on the El Paso school board.

Mrs. W. L. Brown of El Paso, widow of the late bone surgeon and past president of the Woman's Auxiliary to the El Paso County Medical Society, died the latter part of September at the age of 70 years. An active Catholic layman, Mrs. Brown also was interested especially in the Pan-American Round Table program locally, statewide and nationally.

Dr. Juanita Thacker Hart, Bellaire, and Mr. Cecil Robertson were married in Houston on August 1.

The *Bulletin* of the Alumni Association of the University of Texas Medical Branch lists *Dr. and Mrs. V. A. Stembridge,* Galveston, as parents of a girl, born on June 20. The *Bulletin* reports that boys were born to *Dr. and Mrs. Charles B. Sadler,* Amarillo, on July 12; *Dr. Worth Walton and Dr. Ida K. Walton,* Galveston, July 1; and *Dr. and Mrs. Robert J. Ulmer,* Galveston.

University of Texas Medical Branch

C. M. Pomerat, Ph. D., director of the Tissue Culture Laboratory at the University of Texas Medical Branch, Galveston, acted as moderator of a symposium at the eighth International Congress for Cell Biology in Leiden during the first week in September and later that month attended the fifth International Congress of Hematology in Paris, where he displayed the exhibit, "Cultures of Human Vascular Tissue." *John Finnerty, Ph. D.,* Department of Anatomy, also attended this congress.

Dr. C. R. Allen and Dr. Truman G. Blocker, Jr., participated in a week's lectures and demonstrations of anesthesiology and plastic surgery at the ninth annual summer program of the Medical School, University of Nuevo Leon, Monterrey, Mexico.

C. D. Leake, Ph. D., director of the Medical Branch; *Dr. Titus Harris;* and *Dr. E. I. Bruce, Jr.,* recently attended a meeting in Atlanta on mental health training and research sponsored by the Southern Regional Educational Board.

The Medical Branch has been given $45,000 by the Josiah Macy, Jr., Foundation of New York for a five year study and survey of personality factors among medical students. The money is to be used by the Student Health Service, the Department of Neuropsychiatry, and the Dean of Students.

William Verwey, Ph. D., director of Bacteriological Research of Sharp and Dohme, spoke on tools of modern research on September 21 at the Medical Branch.

Heart Disease Conference

The third annual Western Cardiac Conference will be held in Denver, November 8-13, with seven out-of-state speakers and Colorado teachers participating in the combined conference on "Clinical Electrocardiography and Recent Advances in Cardiovascular Diseases." This is sponsored by the Colorado Heart Association, Colorado State Department of Public Health, Fitzsimons Army Hospital, Denver Veterans Administration Hospital, and the University of Colorado School of Medicine. Those serving on the guest faculty are Dr. M. M. Best, Louisville, Ky.; Dr. William H. Bunn, Youngstown, Ohio; Dr. George C. Griffith, Pasadena, Calif.; Dr. Gordon B. Myers, Detroit; Dr. Myron Prinzmetal, Beverly Hills, Calif.; Dr. Henry A. Schroeder, St. Louis; and Dr. Paul Dudley White, Boston.

A three-day clinical electrocardiography course is being conducted by Colonel Edwin M. Goyette, Medical Corps, on November 8-10 at the Veterans Administration Hospital Auditorium. Lectures, panel discussions, a clinical-pathological conference, and scientific exhibits will be at the Cosmopolitan Hotel November 11-13. Additional information may be obtained from the Colorado Heart Association, 901 East Seventeenth Avenue, Denver.

Greater Longevity Achieved in Spinal Surgery

A study of 58 patients with verified intrinsic tumors of the spinal cord shows that when immediate postoperative radiation therapy is applied, patients with intrinsic tumors of the spinal cord achieve greater average longevity than those patients with surgery alone, three New York radiologists reported in the July issue of *Radiology.* The physicians, from the Department of Radiology, Columbia University College of Physicians and Surgeons, are Dr. Ernest H. Wood, Dr. Alfred S. Berne, and Dr. Juan M. Taveras.

They report that 36 of the 58 patients can be evaluated on the basis of survival beyond the average of six years assumed for the effect of surgery alone. Twenty-five of the 36 survived beyond six years, and 22 others are alive but as yet have not been followed for the full six years. Seven of these 22 patients have been followed five years.

CIVIL SERVICE EXAMINATIONS

The United States Civil Service Commission has announced new examinations for filling medical officer positions in the following Federal agencies: medical officer, paying $5,940 and $7,040 a year, and medical officer (specialist), paying $8,360 to $10,800 a year. These positions will be filled in agencies in Washington, D. C., and vicinity, and in the Public Health Service and the Children's Bureau, located throughout the United States. Positions of medical officer paying $7,425 to $10,450 a year will be filled in the Panama Canal Company-Canal Zone Government Organization. No written test is required. A physician must be a graduate of a medical school, and for most positions as medical officer must have completed an internship. For specialists, applicants must have completed appropriate study or residency training; professional medical experience is required for the higher-paying positions.

Institute on Epilepsy

The sixth Western Institute on Epilepsy will be held October 22-23 at the Jack Tar Hotel in Galveston. The sixth Institute, which is being sponsored jointly by the Hogg Foundation of the University of Texas, the Baylor University College of Medicine, and the University of Texas School of Medicine, will have Dr. Howard D. Fabing, Cincinnati, president of the American Academy of Neurology, as its honored guest. The theme of the meeting is the psychosomatic aspects of epilepsy with a portion of the program devoted to research in the disease.

Chauncey D. Leake, Ph. D., Galveston, will give the welcoming address; speakers from New York, California, Arizona, and Colorado as well as many Texas physicians will be on the program. President of the organization and chairman of the sixth Institute is Dr. John L. Otto, Galveston; vice-president, Dr. John R. Green, Phoenix; and secretary-treasurer, Dr. Madison H. Thomas, Salt Lake City, Utah.

The Institute was organized six years ago in Denver by Dr. Jerry Price of New York, Dr. Harriot Hunter of Denver, Dr. Otto, and others to create interest in epilepsy in the western part of the United States. It is aimed to appeal to both lay persons and physicians as a means of coordinating their efforts toward the eventual betterment of the epileptic. The program is open to any doctor of medicine, social worker, psychologist, or properly qualified person officially connected with an accredited agency, association, or society interested in the problem of epilepsy. The registration fee is $3, except for medical students and teachers, for whom there is no fee. The Western Institute on Epilepsy has offices at 112 North Boulevard, Galveston.

Fellowships Offered

A limited number of clinical fellowships in the fields of physical medicine and rehabilitation are being offered by the National Foundation for Infantile Paralysis to physicians who wish to become eligible for certification by the American Board of Physical Medicine and Rehabilitation.

Each recipient of a fellowship must agree to practice as a specialist in physical medicine and rehabilitation for at least two years following the completion of his fellowship and must practice in the United States or its territories. Applicants, who must be licensed to practice medicine in one or more states and be graduates of an approved school of medicine with a year of internship in an approved hospital, must be citizens of the United States (or applicants for citizenship) and must be in sound health. Fellows receive $300 to $400 per month, depending on marital status and number of dependents.

RADIATION THERAPY

A North Carolina radiologist, Dr. Robert J. Reeves, discusses the value of roentgen therapy and its nearly universal selection as the treatment of choice in lymphoid hyperplasia of the nasopharynx in the August issue of the *American Journal of Roentgenology*. Dr. Reeves, from the Department of Radiology, Duke University Hospital, Durham, outlines the value of roentgen therapy in preference to radium in treating this condition and reviews histories of more than 1,200 patients.

His survey shows that roentgen therapy produced marked improvement in 70 per cent of the more than 700 patients who suffered persistent and recurrent colds; that postnasal drip due to the infection was improved in 72 per cent of more than 300 cases and 28 per cent of the patients were relieved completely; and that impaired hearing was relieved in approximately 30 of nearly 40 patients, with the other 10 persons improved.

AMERICAN COLLEGE OF SURGEONS

The fortieth annual Clinical Congress of the American College of Surgeons, November 15-19, is expected to bring more than 10,000 fellows of the College and their guests to Atlantic City, N. J. The postgraduate education meeting will present recent surgical developments through programs including panel discussions, symposia, surgical forums, motion pictures, cine clinics, color television, and exhibits.

Dr. Charles deT. Shivers, Atlantic City, is chairman of the Atlantic City Advisory Committee on Arrangements. Dr. Alfred Blalock, Baltimore, will be installed as president for the coming year.

PHYSICIAN AND MINISTER LECTURE-CLINIC

The director's committee on religious activity of the Methodist Hospital, Lubbock, presented a lecture-clinic for physicians and ministers, "Serving the Suffering," on October 7 and 8. Speakers were Dr. Gilbert H. Marquardt, associate professor of medicine, Northwestern University Medical School, Chicago, and Russell L. Dicks, D. D. The first day they discussed the role of the physician and the minister, respectively, in helping persons suffering from the feelings of anxiety, hostility, and guilt. They spoke on how ministers or physicians hurt the other dealing with the sick, giving suggestions for closer cooperation. They also discussed work with alcoholics and each one's role in caring for the dying.

ALIEN PHYSICIANS

A survey in the September 4 issue of *The Journal of the American Medical Association* showed that a large increase in alien physicians taking postgraduate work in the United States had helped fill gaps left by young doctors now on active military duty.

During the 1953-1954 school year, 5,589 foreign physicians held appointments as interns, residents, or fellows on house staffs of the 800 civilian hospitals approved for such training by the Department of State. The states of Mississippi, North Dakota, and Arkansas had no alien physicians in training.

This program began in 1949 under the United States Information and Educational Exchange Act of 1948.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next scheduled Part I examination for the American Board of Obstetrics and Gynecology will be held on February 4, 1955. The written examination and review of case histories for all candidates will be held in various cities in the United States and Canada and in military centers outside the United States. Twenty case abstracts are to be sent by the candidate to the secretary as soon as possible after receiving notification of eligibility to the Part I written examination.

TV Postgraduate Education

A closed circuit television program broadcast by the American College of Physicians on September 23 was the first nationwide closed circuit hookup for postgraduate medical education. The program, "A Symposium on the Management of Hypertension," was received at two Texas stations, Dallas and Houston, out of the twenty-three receiving stations.

New Tuberculosis Association Headquarters

The Texas Tuberculosis Association has moved into a new headquarters building at 2406 Manor Road, Austin. Built especially for the organization, the new structure replaces a converted residence into which the tuberculosis offices were moved in 1948.

Muscular Dystrophy Research

The National Muscular Dystrophy Research Foundation, the only national charitable health organization chartered by Texas, has as its new president F. R. C. Brown, Houston. Mr. Brown has appointed several new directors with whom he will plan a fund raising and educational campaign, including Coffee Day and the annual national Prayer Crusade, which are among those successful drives conducted previously by the foundation.

An additional grant of $1,500 from the research fund was given to the Southwest Foundation for Research and Education at San Antonio for a project conducted by Roy B. Mefferd, Jr., associate research biochemist, under the supervision of N. T. Werthessen, director of the Biological Division. The study is on "Individual Metabolic Patterns for Members of Families Having a History of Muscular Dystrophy."

The organization was founded in 1950 by two Liberty sisters, Sallie and Nadine Woods, who are victims of the disease.

New March of Medicine Show

The March of Medicine television show will have a program on schizophrenia on the National Broadcasting Company network October 31, 6:30 p. m. The show, sponsored by Smith, Kline, and French Laboratories in cooperation with the American Medical Association, will be broadcast over sixty-three television stations.

LIBRARY SECTION

RECENT PUBLICATIONS BY TEXAS PHYSICIANS

Following is a list of recent articles published by Texas physicians and available at the Memorial Library of the Texas Medical Association. Articles appearing in the TEXAS STATE JOURNAL OF MEDICINE are not included. If a physician who has had a paper printed in the past six months is not named below, the Library would appreciate being notified. Also, the Library would like to have two reprints of each article.

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Bloxsom, Allan: Use of New Apparatus for Continuous Nebulization Therapy, South. M. J. *47:*819-824 (Sept.) 1954.

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Creech, Oscar; Overton, Robert C.; and DeBakey, Michael: Deep Venous Thrombosis and Pulmonary Infarction Occurring as Premonitory Symptoms of Thromboangiitis Obliterans, Surgery *36:*52-64 (July) 1954.

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DeBakey, M. E., and Cooley, D. A.: Successful Resection of Aneurysm of Distal Aortic Arch and Replacement by Graft, J.A.M.A. *155:*1398-1403 (Aug. 14) 1954.

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Dunlap, J. C., and Brown, W. W.: Oxygenation in Obstetrics, Obst. & Gynec. *3:*498-503 (May) 1954.

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BOOK NOTICES

[1]Motion of the Heart

BLAKE CABOT, *New York. 173 pages. $2. New York, Harper and Brothers, 1954.*

Sponsored by the American Heart Association, this book was written by a layman primarily for laymen. It is an absorbing and enlightening survey of the main fields of cardiovascular research from Harvey to the present, with projections into the future. Such a project is admittedly difficult—especially for its intended audience, yet the book can be recommended to patients and lay friends without reservation.

[2]Pelvic Relaxations and Herniations

JAMES M. WILSON, M. D., *Assistant Professor of Gynecology and Obstetrics, Medical College of South Carolina, Charleston. Illustrations by* ELON HENRY CLARK, *Artist and Professor of Medical Art and Illustration, Duke University School of Medicine, Durham, N. C. Edited by* E. C. HAMBLEN, M. D., F.A. C.S., *Professor of Endocrinology and Associate Professor of Obstetrics and Gynecology, Duke University School of Medicine. 64 pages. $2.75. Springfield, Ill., Charles C Thomas, 1954.*

This monograph in the American Lectures in Gynecology and Obstetrics Series continues to present an interesting subject in easily readable form. It is well illustrated, on good paper, and nicely bound. The subject matter is well organized.

The normal pelvic anatomy from the clinical rather than from the academic aspect is presented, and the changes from normal that occur with pelvic relaxations are pointed out. The monograph gives the indication for surgical interference and principles of repair without giving a lengthy detailed operative technique. It not only presents the common varieties of pelvic relaxation such as prolapse, rectocele, cystocele, and urethrocele with and without incontinence but also the frequent (but frequently misunderstood) posterior vaginal hernia and the rare obturator hernia, sciatic hernia, and herniation into the broad ligament. The description of the normal pelvic fascia and supportive structures is easily readable and understood with excellent illustrations. The various changes that occur with pelvic relaxation are likewise well presented. In discussing the frequently overlooked or misunderstood problem of posterior vaginal hernia or enterocele, the author presents the anatomic variations from normal and principles of repair so that anyone doing pelvic surgery should be able to recognize and correct this condition.

His presentation of the episiotomy should be read by every physician who does obstetrics. He includes in this monograph descriptions of all, even the rarest, pelvic herniations with adequate bibliography for further study.

This volume should be required reading by every medical student during his obstetrics and gynecology courses and available to every physician doing obstetrics and/or gynecology.

[3]Coal Tar and Cutaneous Carcinogenesis in Industry

FRANK C. COMBES, M. D., *Professor of Dermatology and Syphilology, New York University Post-Graduate Medical School; Director of Dermatology and Syphilology, Bellevue Hospital, New York. 76 pages. $2.75. Springfield, Ill., Charles C Thomas, 1954.*

In this short volume Dr. Combes presents a readable, concise, and good survey of the basic considerations of coal tar and the various factors related in its carcinogenesity. For the most part he uses common sense in presenting suggestions as to protective procedures to be used in industrial processes to protect workers from carcinogenic or possibly carcinogenic materials.

His discussion of the consideration of carcinogenic agents in the petroleum industry I believe should be construed as a consideration of possibilities in large degree until epidemiologic and animal research programs now in progress have been completed and confirm such considerations.

[4]Amebiasis

ERNEST CARROLL FAUST, A. B., M. A., Ph. D., *The William Vincent Professor of Tropical Diseases and Hygiene, Head of the Division of Parasitology, Department of Tropical Medicine and Public Health, Tulane University of Louisiana School of Medicine, New Orleans, La. 154 pages. $4.75. Springfield, Ill., Charles C Thomas, 1954.*

Amebiasis is an important disease not only because of soldiers returning from heavily infested areas but because of the proximity of Texas to Mexico. In that country actual statistics are difficult to compile, but most authorities feel that the incidence is somewhere between 25 and 50 per cent. Americans are traveling more in foreign lands, and short vacations in Mexico are becoming popular with people in Texas. A knowledge and awareness, therefore, of amebiasis seems to be imperative.

The author has stated well in his preface the purpose of this book, "to provide a concise, comprehensive picture of amebiasis as a present day clinical and public health problem. In no sense is it an exhaustive treatise of the subject." Dr. Faust is a renowned authority on this subject and accomplishes his purpose with ease. He has stripped the subject of nonessentials and gives a clear picture of the disease and the problems essential to its control.

Because an exhaustive treatise was not planned, the subject matter is presented factually with no attempt made to cover controversial points. This does not in the least detract from the book.

The monograph can be recommended to all physicians and surgeons, particularly those who see amebiasis rarely. For those physicians in intimate contact with the disease, the book may be elementary. It is, however, thought provoking and presents well a subject which should be recognized as a major public health problem.

[1]*Wylie F. Creel, M. D., Austin.*
[2]*H. O. Padgett, M. D., Marshall.*
[3]*L. R. Byrd, Jr., M. D., Port Arthur.*
[4]*George E. Clark, Jr., M. D., Austin.*

[5]An Atlas of Congenital Anomalies of the Heart and Great Vessels

JESSE E. EDWARDS, M. D., *Consulting Physician in Section of Pathologic Anatomy, Mayo Clinic;* THOMAS J. DRY, M. D., Ch. B., M. S. in Med., F.A.C.P., *Consulting Physician in Division of Medicine, Mayo Clinic;* ROBERT L. PARKER, M. D., M. S. in Med., F.A.C.P., *Consulting Physician in Division of Medicine, Mayo Clinic;* HOWARD B. BURCHELL, M. D., Ph. D. in Med., *Consulting Physician in Division of Medicine, Mayo Clinic;* EARL H. WOOD, M. D., Ph. D. in Physiol., *Consulting Physician in Section of Physiology, Mayo Clinic;* ARTHUR H. BULBULIAN, D.D.S., F.A.C.D., *Director, Museum of Hygiene and Medicine, Mayo Foundation for Medical Education and Research, Rochester, Minn. 202 pages. $13.50. Springfield, Ill., Charles C Thomas, 1954.*

This atlas contains 30 anomalies of the heart and great vessels. There is a brief description of the principal clinical features of each anomaly accompanied by a case history. In most instances a photograph and drawings of the anomalous heart are shown. Models of the heart are illustrated in the form of color plates. A chest roentgenogram and an electrocardiogram are usually shown with each case. Catheterization data, oximetry, dye-dilution methods, and intra-arterial pressure studies are given in some cases. The surgical techniques for correction of the anomalies amenable to surgery are not included.

This atlas is brief and easily read. It is recommended for students or physicians interested in becoming familiar with the various types of anomalies of the heart and great vessels.

[6]Children for the Childless

Edited by MORRIS FISHBEIN, M. D., *with chapters by Sidonie Matsner Gruenberg; Edward Weiss, M. D.; I. C. Rubin, M. D.; Nicholson J. Eastman, M. D.; J. P. Greenhill, M. D.; Fred B. Kyger, M. D.; Richard L. Jenkins, M. D.; Benjamin C. Gruenberg, Ph. D., and Dr. Fishbein. 223 pages. $2.95. New York, Doubleday and Company, Inc., 1954.*

This book is an interesting and readable presentation covering a considerable range of material. From a layman's viewpoint this should be an enjoyable and informative source of medically accepted facts. The subject matter is not covered in detail, but the high points are reviewed from the angle of both children and parents.

[7]Arthritis and Rheumatism

CHARLES LEROY STEINBERG, M. D., *Director of Arthritis Clinic and Senior Attending Physician in Medicine, Rochester General Hospital, N. Y. 326 pages. $10. New York, Springer Publishing Company, Inc., 1954.*

This book will be intensely interesting to any physician who sees arthritic patients. The beginning of the book with the physiology of the joints is one filled with an absorbing amount of information, and it offers a more complete understanding of what goes on in the joints and of the structures that make them up. The illustrations in this treatise are well done, with the color ones well balanced and presented.

The photography and the quality of editing in the book are excellent.

The chapter on pathology of rheumatoid and collagen diseases ties together the many conditions that are somewhat interwoven and related. The chapters on rheumatic fever and rheumatoid conditions are dealt with as to history, incidence and mortality, geographic and climatic factors, etiology, clinical manifestations, and laboratory with treatment. The author takes up bed rest, salicylates, digitalis, corticotropin, and cortisone with the comment that it will take a number of years to evaluate properly the latter two drugs mentioned. Finally, prevention and prophylaxis are discussed. The use of gold, phenylbutazone, vaccines, and other drugs is extensively discussed in connection with rheumatoid arthritis. The color and radiograph reproductions in this section are exceedingly good.

Gout and the malignant collagen diseases are also well discussed. The orthopedic and physical medical handling of these rheumatic and arthritic conditions and the place of hydrotherapy is brought out. The section with illustrations for self help by the arthritic patients themselves is a real contribution.

Although this book has only 326 pages, it contains a wealth of information and helps in the evaluation of these conditions.

[8]Music Therapy

Edited by EDWARD PODOLSKY, M. D., *Department of Psychiatry, Kings County Hospital, Brooklyn, N. Y. 335 pages. $6. New York, Philosophical Library, 1954.*

A compilation of present day information regarding music therapy, this book is done in thirty-two parts by thirty-nine contributors. History, physiological and psychological effects, uses, and future of music in medicine are discussed. It is probably the only such symposium to date. It particularly delves into the value of music therapy in specific psychological entities. For anyone applying total push therapy, this book will be of aid; for study and research in music therapy, the book is a must.

[9]The Thyroid

T. LEVITT, F.R.C.S. (Eng.), F.R.C.S. (Edin.), F.R.C.S.I., *Hunterian Professor of the Royal College of Surgeons of England, London; First Surgical Assistant, Thyroid Clinic, New End Hospital, London; and Demonstrator in Anatomy, Middlesex Hospital, University of London. 606 pages. $20. Baltimore, Williams and Wilkins Co., 1954.*

This rather large volume on a limited subject is well organized, concisely written, and replete with illustrations, charts, and references. It represents twenty-five years' experience in all phases of thyroid disease and attempts not only to present the latest advances in the field but also to correlate in a strictly original manner the natural history of thyroid disease. A new classification and nomenclature are presented to fit with the author's concept of unity and evolution among previously accepted separate entities of the toxic gland. An exhausting clinical and histologic study of more than 2,000 consecutive thyroidectomies is presented as the foundation of this idea. The volume also includes an excellent section on exophthalmos and localized myxedema and critical reviews of Hashimoto's and Reidel's original work. It will be of particular interest to those pathologists, surgeons, and internists who encounter more than an occasional thyroid problem.

[10]Copying and Duplicating Medical Subjects and Radiographs

H. LOU GIBSON, *Technical Editor, Eastman Kodak Company, Rochester, N. Y. 75 pages. $5. Springfield, Ill., Charles C Thomas, 1953.*

This book is well suited for those persons who have a reflex camera and will enable the owners of such equipment to obtain the best lighting procedures for copying of their

[5]*Roy L. Smith, M. D., Lubbock.*
[6]*R. W. Loveless, M. D., Bastrop.*
[7]*Joe C. Rude, M. D., Austin.*
[8]*Lee F. Scarborough, M. D., Austin.*
[9]*E. Ross Kyger, Jr., M. D., Fort Worth.*
[10]*J. C. Rude, M. D., and Gary Henry, R. T., Austin.*

subjects, whether they be patients, photographs, books, or radiographs. It gives a simple equation for figuring exposures at a new distance when the exposure at a known distance has already been established. All other factors such as film, lens opening, and lighting must remain the same.

It has a good section on the use of filters as well as the selection of the proper type of film for the purpose at hand. The duplicating of color transparencies in black and white is well handled and described, including both negatives and slides. The process of the duplicating of roentgen-ray film is taken up separately and is valuable reading for those who have much of this type of work to do. It also gives good tips on getting the most out of radiographs that are overexposed and underexposed but explains that in the final analysis there is no real substitute for well balanced film to copy.

The book is small, written in an attractive style, and easy to read. It can be recommended for those who have reflex cameras at their disposal. The book was not written or designed for those who use miniature cameras such as the Leica, but there are some good tips on lighting, background, composition, and the proper selection of both film and the type of paper to be used for printing and enlarging to make it a useful reference.

[11]Endocrinology in Clinical Practice

Edited by GILBERT S. GORDAN, M. D., Ph. D., *Assistant Professor of Medicine, University of California School of Medicine; and* H. LISSER, M. D., *Clinical Professor of Medicine and Endocrinology and Chief, The Endocrine Clinic, University of California School of Medicine, Berkeley-San Francisco. 407 pages. $10.50. Chicago, The Year Book Publishers, Inc., 1953.*

The rapid progress and numerous discoveries in this field in recent years make the need for this work evident. Subject matter is presented in a lucid style making easy, pleasant reading. The entire field of endocrinology is touched on, and this probably lends toward making the book particularly appealing to the general practitioner. However, most specialties are involved; internists, pediatricians, and gynecologists particularly should be attracted.

It would be unfair to single out certain sections for special comment in that it is difficult to compare a presentation on a subject that holds fresh appeal, like the section on the adrenal, for example, to the section on carbohydrate metabolism. In every instance the authors have apparently weighed and digested the most recent literature as well as depended on personal experiences. An additional attraction is an appendix that presents a large number of endocrine pharmaceutical preparations with trade names and dosages clarified. The purpose of this book is to furnish practical material for the practicing physician, and it succeeds in accomplishing this end.

Primer of Allergy

WARREN T. VAUGHAN, M. S., M. D., *Richmond, Va. Illustrations by* JOHN P. TILLERY. *Fourth edition, revised by* J. HARVEY BLACK, M. D., *Dallas. 191 pages. $4.25. St. Louis, C. V. Mosby Company, 1954.*

"Primer of Allergy," a guidebook for those physicians who must find their way through the mazes of this strange and tantalizing state, has been revised by Dr. Black. The changes in the fourth edition are more extensive than in the last, the new material being necessary because of new knowledge. The aim of the book is to inform better the patient as to his condition so as to get better results from his treatment. Foods are not stressed.

[11]*Jerome O. Ravel, M. D., Austin.*

Acute Renal Failure

ARTHUR GROLLMAN, Ph. D., M. D., F.A.C.P., *Professor and Chairman, Department of Experimental Medicine, Lecturer in Pharmacology and Toxicology, Southwestern Medical School of the University of Texas; Attending Physician, Parkland Hospital; Consultant in Internal Medicine, Baylor University Hospital; Consultant in Biochemistry and Physiology, Veterans Administration Hospital, Dallas. 92 pages. $4. Springfield, Ill., Charles C Thomas, 1954.*

This short monograph attempts to bring together the material available from many sources on acute renal failure. The etiology, pathology, physiology, clinical course, and treatment are presented in a practical manner.

The book is highly recommended for the general practitioner's library because it is a compact summary of the subject. The bibliography contains more than 100 references arranged in alphabetical order; the book is well indexed, making it easy to use.

Thoracic Surgery

RICHARD H. SWEET, M. D., *Associate Clinical Professor of Surgery, Harvard Medical School, Boston. Illustrations by* JORGE RODRIGUEZ ARROYO, M. D., *formerly Assistant in Surgical Therapeutics, University of Mexico Medical School. Second edition. 381 pages. $10. Philadelphia, W. B. Saunders Company, 1954.*

The first edition of this work was well received by surgeons in 1950. A complete revision was required to include the new techniques which have been accepted and alterations in others since they were first described. Only the operations that were found useful in everyday practice are given thorough consideration; many methods which are still in the trial period are mentioned. Any surgeon interested in thoracic surgery will find this up-to-the-minute text a valuable addition to his library. The illustrations are excellent.

A list of the subject headings will show the coverage of this book. Surgical anatomy of the thorax, general technical considerations, thoracic incisions, operations on the thoracic wall, operations concerning the pleural cavity, operations on the lungs, operations within the mediastinum, operations on the esophagus, abdominal operations performed through thoracic incisions, and surgery of the diaphragm are included.

The Book of Health

Compiled and edited by RANDOLPH LEE CLARK, JR., M. D., M. Sc. (Surg.), F.A.C.S., *Director and Surgeon-in-Chief, The University of Texas M. D. Anderson Hospital for Cancer Research; Professor of Surgery, The University of Texas Postgraduate School of Medicine, Houston; and National Consultant in Surgery, United States Air Force; and* RUSSELL W. CUMLEY, M. A., Ph. D., *Director of Publications, The University of Texas M. D. Anderson Hospital for Cancer Research; Professor of Medical Journalism, The University of Texas Postgraduate School of Medicine, Houston. 768 pages. $10. Houston-New York, Elsevier Press Inc., 1953.*

This one volume is a compilation by 242 doctors of what they think the average lay person should know about the body, how to keep it healthy, and what to do in case of illness. The work has been well done, and the subjects have been handled by experts who can speak with authority in their fields. There are 1,400 illustrations which add to the value of the book in beauty and delineation.

An answer to the increasing interest in medicine by the average man, this book is recommended to the layman as well as to medical students and medical personnel. It is also a valuable reference for students taking related courses in college and high school. Particularly interesting are the chapters on medicine and the law, medical history, and the medical profession.

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION

AMA Begins Law Department

Beginning August 1 all requests for legal opinions and advice were directed to the newly established Law Department of the American Medical Association. The Bureau of Legal Medicine and Legislation and the headquarters staff of the Committee on Legislation have been transferred to the new department. The director is C. Joseph Stetler, secretary of the Council on National Emergency Medicine Service since 1951, and J. W. Holloway, Jr., who has headed the Bureau of Legal Medicine for many years, is serving as consultant for the new office.

MENTAL HEALTH COMMITTEE

A meeting of mental health representatives of state medical associations was held in Chicago September 17-18 under the sponsorship of the American Medical Association Committee on Mental Health. Special speakers for the meeting were Dr. Elmer Hess, Erie, Pa., President-Elect of the AMA, and Dr. Leo H. Bartemeier, Detroit, Chairman of the AMA Committee on Mental Health. Descriptions of the mental health programs of the state medical associations of Virginia, Texas, and Connecticut were presented by their respective committee chairman. Dr. Hamilton F. Ford, Galveston, represented the Texas committee. Mrs. George Turner, El Paso, President of the Woman's Auxiliary to the American Medical Association, spoke to the group at the September 18 morning meeting.

RADIO SHOWS AVAILABLE

Five more fifteen-minute radio shows of the Help Yourself to Health series are ready for shipment to county societies by the American Medical Association Bureau of Health Education. These shows, produced by the Rocky Mountain Radio Council are entitled "Rural Community Receives a New Doctor," "A New Doctor in a Rural Community," "Success of a Health Council Survey," "How to Build a Hospital," and "Nursing." Also available through the Bureau are five new fifteen-minute panel discussion programs for radio. They include "Medical Pre-Payment Plans," "New Fields of Medical Research," "Hope for Your Heart," "Advancement Against Polio," and "Superstition and Chicanery."

TEXAS MEDICAL ASSOCIATION

ASSOCIATION COMMITTEE CHANGES

Several appointments were made recently to councils and committees of the Texas Medical Association by Dr. F. J. L. Blasingame, Wharton, President.

Dr. John S. Chapman, Dallas, was appointed September 7 to fill the vacancy on the Council on Medical Education and Hospitals created by the resignation of Dr. George N. Aagaard, who has moved from Dallas to become dean of the University of Washington School of Medicine, Seattle.

Dr. Charles P. Hawkins, Fort Worth, became a member on October 1 of the Committee on Maternal Mortality; and Dr. J. W. Birdwell, Tyler, has been serving on the State Committee for American Medical Education Foundation as of August 31.

PAPERS FOR ANNUAL SESSION STILL NEEDED

Officers of some of the scientific sections of the Texas Medical Association have indicated that openings still exist on their tentative programs for the annual session next spring and that papers from members of the Association will be welcomed for review. Any physician interested in submitting a presentation in Fort Worth who has not been in touch with the appropriate section officers will find a list of the officers with their mailing addresses on page 458 of the July JOURNAL. If a completed paper is not now ready, the topic and some indication of how the author proposes to develop the subject should be forwarded to the section officers as promptly as possible.

NOVEMBER VISITATIONS

Visits to eight county societies and one district society are scheduled by officers and members of the central office staff of the Texas Medical Association during November. The county societies which will be visited are Lubbock-Crosby Counties, November 2; Lamar County (Delta County physicians will attend), November 4; Kerr-Kendall-Gillespie-Bandera Counties, November 8; Wichita County, November 9; Hill County, November 9; Jefferson County, November 16; Pecos-Jeff Davis-Presidio-Brewster, November 17; and Reeves-Ward-Winkler-Loving-Culberson-Hudspeth, November 18.

COUNTY SOCIETIES

Angelina County Society

September 16, 1954

(Reported by Forrest C. Orman, Secretary)

The Angelina County Medical Society met on September 16 in Lufkin for a social hour and a program given by two officers and a member of the central office staff of the Texas Medical Association. Denton Kerr, Houston, member of the Board of Trustees, told the group about the facilities available through the Texas Medical Association and about the function of the Board of Trustees. Milford O. Rouse, Dallas, delegate to the American Medical Association, spoke on the recent AMA meeting and discussed recent legislation affecting the medical profession. Mr. C. Lincoln Williston, Austin, assistant executive secretary, explained the aims for the coming year to better coordinate the work of the county society with that of the state organization.

Bell County Society

August 4, 1954

(Reported by F. M. Hammond, Secretary)

At the August 4 meeting of the Bell County Medical Society in Temple, R. A. Murray, Temple, and H. H. Brindley, Temple, presented a film on "Replacement of Proximal Humerus and Distal Radius with Fibular Graft." Raleigh R. Curtis, Temple, gave a report on the function and purpose of the American Medical Education Foundation and urged members to support it. He also emphasized the importance of the county medical society and announced that Mr. Philip R. Overton, Austin, legal counsel of the Texas Medical Association, and Mr. C. Lincoln Williston, Austin, assistant executive secretary, would be present at the October meeting of the group.

Bosque County Society

July 7, 1954

The Bosque County Medical Society and its woman's auxiliary met on July 7 at the home of Dr. and Mrs. Van D. Goodall, Clifton. Tom Lyles, Clifton, presented a case report of a surgical patient, using colored slides. Special guests for the program were M. O. Rouse, Dallas, who spoke on medical jurisprudence; Mr. N. C. Forrester, Austin, executive secretary of the Texas Medical Association, who spoke on topics pertaining to his work with the Association; and Mr. R. V. Voyer, Dallas, general director of the David Graham Hall Foundation for the betterment of Texas health, who spoke on pending legislation concerning Texas hospital districts.

Mrs. S. L. Witcher, Clifton, president of the local woman's auxiliary, told of the group's proposed projects.

Eastlond-Collohon-Stephens-Shockelford-Throckmorton Counties Society

September 21, 1954

(Reported by M. A. Treadwell, Secretary)

Roentgen-Ray Diagnosis of Cervical Spine—V. H. Shoultz, Abilene.

The Eastland-Callahan-Stephens-Shackelford-Throckmorton Counties Medical Society met in Cisco on September 21 for a dinner and scientific program. Dr. Shoultz presented the above paper with films, after which a business meeting was held.

El Poso County Society

The El Paso County Medical Society and the auxiliary cosponsored the observance of September as Child Safety Month in El Paso with the police department, El Paso Safety Council, parent-teacher organizations, Boy Scouts, business firms, and other groups cooperating. Designation of the special month was proclaimed by the mayor; and radio, television, and newspaper publicity called attention to the need for safety in relation to children. The society and auxiliary are cooperating in the preparation of a booklet on first aid for distribution to public school children as a gift of the medical society.

Hale-Floyd-Briscoe-Swisher Counties Society

September 14, 1954

(Reported by John C. Long, Jr., Secretary)

The Hale-Floyd-Briscoe-Swisher Counties Medical Society met in Plainview on September 14 and heard Randall Heye, Plainview, director of the West Texas Poliomyelitis Center, discuss the western equine encephalitis epidemic. Plans were made for Diabetes Detection Week by the drive chairman.

Lomor County Society

September 2, 1954

(Reported by Harold E. Hunt, Secretary)

Discussion of Three Current Clinical Diagnostic Problems—O. W. Robinson, J. A. Stephens, and D. R. Lewis, Paris.

The Lamar County Medical Society had three guests present when it met in Paris on September 2. After dinner, a short business meeting was held and the above scientific program presented. It was announced that the October program was to be on tuberculosis.

Lubbock-Crosby Counties Society

July 6, 1954

(Reported by Richard K. O'Loughlin, Secretary)

Collagen Diseases—William Ishmael and Richard Payne, Oklahoma City.

Members of Lubbock-Crosby Counties Medical Society heard the above discussion presented at the July 6 meeting in Lubbock. It was followed with a discussion by Sam C. Arnett, William H. Gordon, Frank C. Goodwin, R. K. O'Loughlin, all of Lubbock, and Jay McSween, Slaton.

At the business meeting a student who plans to enter medical school this fall was given a loan of $400.

August 3, 1954

(Reported by Richard K. O'Loughlin, Secretary)

The Lubbock-Crosby Counties Medical Society met at Lubbock on August 3 and approved a request that Garza County be included in the schedule of the mobile unit x-ray for tuberculosis. O. W. English, Lubbock, spoke on his recent visit to Europe, giving his impressions of the socialistic trends in the practice of medicine there. A discussion by Sam C. Arnett, O. B. Hull, J. T. Krueger, Howard Hancock, William H. Gordon, Frank Goodwin, L. B. Smith, Roy Riddel, and Roy Sheffield, all of Lubbock, followed.

Nueces County Society

August 10, 1954

(Reported by Gerald S. Ahern, Secretary)

Management of Uterine Fibroids—G. Cooley Nabors, Dallas.

The Nueces County Medical Society met on August 10 in Corpus Christi for a short business meeting and to hear the above paper by Dr. Nabors. Elected to membership in the society were Stephen Ware, Jr., John Kohlhaas, and Mary McCaskey, all of Corpus Christi. A resolution expressing the sympathy of the society to the family of Harry Heaney was read.

September 14, 1954

(Reported by Gerald S. Ahern, Secretary)

Treatment of Cancer of Prostate with Radioactive Gold—Cecil M. Crigler, Houston.

The Nueces County Medical Society met at Corpus Christi on September 14 and elected seven physicians to membership. Those elected were Vance J. Maloney, Harold Ross Garza, John D. Reeve, John P. Moran, Ernesto Sierra, John J. DeLaney, and Robert C. Wood.

The president of the local chamber of commerce addressed the group, encouraging them to join the chamber of commerce. George Schuster, Corpus Christi, was elected to the Tumor Clinic Committee, and an amendment to the by-laws requiring a probationary period of two years for new members was approved.

Pecos-Jeff Dovis-Presidio-Brewster Counties Society

July 6, 1954

Professional Public Relations—D. J. Sibley, Fort Stockton.

The Pecos-Jeff Davis-Presidio-Brewster Counties Medical Society met in Fort Stockton on July 6 to hear the above program. Prior to the meeting the society members and members of the auxiliary had dinner together.

Torront County Society

July 6, 1954

(Reported by S. W. Wilson, Secretary)

Symposium on Impotence—Grant F. Begley, Nealie E. Ross, W. W. Moorman, and F. C. Rehfeldt, Fort Worth.

The Tarrant County Medical Society met on July 6 in Fort Worth and heard the above scientific program. Ralph E. Campbell, Fort Worth; and William J. Nelson, Jr., Fort Worth, were elected to membership.

August 3, 1954

(Reported by S. W. Wilson, Secretary)

A film on "Glaucoma—What General Practitioners Should Know" was shown at the August 3 meeting of the Tarrant

County Medical Society by C. Harold Beasley, Fort Worth. Prior to showing the film, Dr. Beasley told members that it was prepared by the National Society for the Prevention of Blindness, and he gave some statistical information about blindness.

John J. Boluch, Fort Worth, and William B. McLeroy, Azle, were elected to membership in the society.

September 7, 1954

(Reported by S. W. Wilson, Secretary)

Tarrant County Medical Society was host to the Dallas County Medical Society at the Godfrey Ranch, east of Grapevine, on September 7. F. E. Wilson, Washington, D. C., director of the Washington office of the American Medical Association, was guest speaker.

Tom Green-Eight County Society

September 13, 1954

(Reported by Joe L. Cornelison, Secretary)

The Tom Green-Eight County Medical Society met in San Angelo on September 13 and heard a speech by the guest, William MacComb, Houston.

At the business meeting prior to the program, a Crippled Children's Committee composed of R. M. Arledge, E. C. Winkelmann, Perry J. C. Byars, Charles F. Engleking, and Henry N. Ricci, all of San Angelo, was appointed.

The society decided to provide district prizes of $100, $50, and $25 for winners of this year's essay contest, sponsored nationally by the Association of American Physicians and Surgeons.

Wilbarger County Society

July 6, 1954

Symposium on Surgery

Development and Management of Shock—J. A. Stirman, Dallas.
Emergencies During Anesthesia—M. T. Jenkins, Dallas.
Minor Incompatible Blood Transfusions—E. E. Muirhead, Dallas.

The Wilbarger County Medical Society met on July 6 in Vernon to hear the above outlined program presented by members of the faculty of Southwestern Medical School of the University of Texas. There were fifteen guests present for the dinner and scientific meeting.

DISTRICT SOCIETIES

Eighth District Society

September 23, 1954

(Reported by George E. Glover, President)

Most Frequently Encountered Malignancies in Children—Mary Ellen Haggard, Galveston.
Diagnosis and Treatment of Tumors of Cecum and Ascending Colon—Edgar J. Poth, Galveston.
Pathological Diagnosis of Pleural and Peritoneal Fluids—John H. Childers, Galveston.
Diagnosis and Treatment of Peripheral Circumscribed Lesions of Lung—A. W. Harrison, Galveston.

The Eighth District Medical Society met jointly with the American Cancer Society in Victoria on September 23. After the above outlined program was given by members of the faculty of the University of Texas School of Medicine, several cancer cases were presented by members of the society. Newly elected officers are George E. Glover, Victoria, president, and York Lancaster, Port Lavaca, secretary.

AUXILIARY SECTION

AN AWARD OF MERIT

The Woman's Auxiliary to the Texas Medical Association has another brag—it has received one of the fifty-five awards given in the United States for its work and contributions on behalf of the American Medical Education Foundation. Even though the Auxiliary has been recognized for its work in the past, members must remember that the need for additional funds is great.

Since the organization in 1951 of AMEF, 260 Texans have contributed $10,959.28 to the fund. In 1951, 31 contributed $991; in 1952, 27 contributed $1,065; and in 1953, 202 gave $8,903.28. Through 1953, the three medical schools in Texas had received a total of $185,342. Therefore, Texans have received much more than they have given. In 1952, only .32 per cent of the medical profession of the state contributed financially to the AMEF, and in 1953, 2.4 per cent of the profession donated funds.

Gifts to AMEF are combined with funds of the National Fund for Medical Education, and then the money is allotted to the various medical schools. The National Fund for Medical Education raises its money from big industry. The American Medical Association is the sole sponsor of the AMEF and co-sponsor of the National Fund.

The need for the AMEF is great. The medical schools need $10,000,000 more annually to meet operating expenses. The seventy-nine medical schools in the United States must provide doctors to take care of the needs of 158,000,000 people. These schools graduate more than 6,000 doctors each year, 1,000 more than a decade ago.

Cost of training a doctor has doubled in the past twenty years, and though tuition fees have been raised 165 per cent since 1940, tuition pays only one-fifth of the cost. Gifts, income from endowments, general university funds, and appropriations no longer meet current operating costs, let alone future demands, so funds must come from other sources. Unless new funds are made available, most medical schools are faced with three dangerous choices: (1) lowering their high teaching standards, (2) reducing the number of doctors they graduate, or (3) becoming subsidized by the government.

Mrs. J. L. Jinkins, Galveston, State Auxiliary and Southern Regional chairman of the American Medical Education Foundation, has suggested the following ways for the Auxiliary members to help obtain additional funds for the foundation:

1. Contributions from county auxiliaries.
2. Gifts from individual members.
3. Birthday gifts from members (10 cents to $1 per year of age).
4. Benefit parties (game parties, fashion shows, and teas).
5. Honorary gifts (in lieu of flowers or other gifts on birthdays or anniversaries or to pay tribute to another physician who has rendered some medical service to the Auxiliary member or a member of her family).
6. Memorial gifts (in lieu of flowers at funerals).

The Auxiliary is again called upon to help Texas carry its share of the load on medical education.

Officers of the Woman's Auxiliary to the Texas Medical Association: President, Mrs. Mark H. Latimer, Houston; President-Elect, Mrs. Joseph H. McCracken, Jr., Dallas; First Vice-President, Mrs. Mal Rumph, Fort Worth; Second Vice-President, Mrs. Harold Lindley, Pecos; Third Vice-President, Mrs. Howard R. Dudgeon, Jr., Waco; Fourth Vice-President, Mrs. Troy A. Shafer, Harlingen; Fifth Vice-President, Mrs. August J. Streit, Amarillo; Recording Secretary, Mrs. P. M. Kuykendall, Ranger; Corresponding Secretary, Mrs. William M. Palm, Houston; Treasurer, Mrs. J. C. Terrell, Stephenville; Publicity Secretary, Mrs. A. H. Neighbors, Jr., Austin; Parliamentarian, Mrs. John E. Hill, Marshall.

COUNTY AUXILIARIES

Galveston County Auxiliary honored the wives of interns and resident physicians in Galveston hospitals on August 11 with a coke party at the home of Mrs. Edgar F. Jones, Galveston. Mrs. Paul Brindley, Galveston, spoke on projects of the auxiliary.

Mrs. Haskell Hatfield, El Paso, president of the *El Paso County Auxiliary,* was requested by the Woman's Department of the El Paso Chamber of Commerce to write a play for presentation in public schools and to civic groups as a part of its clean up campaign. The play, "Don't You Be a Litterbug," expresses the relationship of health, sanitation, safety, fire prevention, and civil defense to cleaning up.

Mrs. George C. Farish, Houston, a member of the *Harris County Auxiliary,* is Republican candidate for the State Legislature, Place 3.

DEATHS

S. I. MILLER

Dr. Samuel Irving Miller, Jr., Houston, Texas, died on July 11, 1954, in a local hospital.

Dr. Miller was born in Galveston on December 14, 1912, the son of Mr. and Mrs. Samuel Irving Miller, Sr. He was graduated from Rice Institute, Houston, and from the University of Texas School of Medicine, Galveston, in 1938. He interned at Michael Reese Hospital, Chicago, until 1940, when he became an assistant resident in medicine at Billings Hospital, University of Chicago Clinics. In 1941 he took a residency in medicine at J. H. Pratt Diagnostic Hospital, Boston. He then served in the United States Army from 1942 until 1946, beginning the practice of internal medicine in Houston in 1947.

A member of the Texas and American Medical Associations through Harris County Medical Society continuously since 1947, Dr. Miller was certified by the American Board of Internal Medicine. He was a fellow of the American College of Physicians. He was a member of Alpha Omega Alpha honorary medical fraternity and was a member of the Jewish synagogue.

Survivors include his wife, Mrs. Betty (Russ) Miller, and two sons, Samuel Irving Miller, III and Ralph Henry Miller. Also surviving are his mother and a brother, Louis A. Miller.

W. H. BARNETT

Dr. William Harve Barnett, Abilene, Texas, died in a local hospital of pneumonia on July 18, 1954.

Dr. Barnett was born in Guntown, Miss., in 1866 and as an infant moved with his family to Kaufman County. After studying medicine in Louisville, Ky., Dr. Barnett was graduated in 1893 from Memphis Hospital Medical College, Memphis, Tenn., which later merged with the University of Tennessee College of Medicine. He practiced in Glen Cove for eight years and Runnells County for four years before moving to Abilene.

A charter member of the Taylor-Jones Counties Medical Society, Dr. Barnett had been a member of the Texas and American Medical Associations almost continuously since 1904. In 1947 he was elected an honorary member of the state organization. Dr. Barnett recently received a plaque from the University of Tennessee honoring him for having served his community for fifty years. He was a member of the Christian Church.

The former Miss Edna McDavid and Dr. Barnett were married on May 6, 1891, in Abilene. Mrs. Barnett died February 17 of this year. Dr. Barnett is survived by two grandsons, Robert E. Barnett, Austin, and Dr. W. L. Barnett, Cleveland; a brother, Richard Barnett, Eden; and five great-grandchildren.

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

J. W. SHARP

Dr. Jack Weston Sharp, Dallas, Texas, died on July 27, 1954, in that city of gunshot wounds.

Born on January 8, 1916, in Newkirk, Okla., Dr. Sharp attended Newkirk schools and was graduated from the North Texas Agricultural and Mechanical College, Arlington, in 1935. After being graduated from Baylor University College of Medicine, then in Dallas, in 1939, he interned at St. Paul's Hospital, Dallas, in 1940. He was director of the Dallas Venereal Diseases Clinic from 1940 to 1944, except for a two-month residency in venereal diseases at Vanderbilt University in 1941. He was field consultant to the Venereal Diseases Division of the Texas State Health Department until 1946 and was medical director of the Riverside Hospital in Waco from 1946 until 1947, when he entered private practice in Dallas.

DR. JACK W. SHARP

Dr. Sharp was a member of the Texas and American Medical Associations through Dallas County Medical Society in 1953.

He is survived by his wife; a son, Douglas Andrew Sharp, Dallas; and his grandmother, Mrs. Aldis Sharp, Newkirk.

W. A. MAUPIN

Dr. William Austin Maupin, Rowlett, Texas, died in a Santa Monica, Calif., hospital of coronary thrombosis and myocardial infarction on August 10, 1954, while visiting his daughters in Los Angeles.

Dr. Maupin was born October 20, 1869, in Kingston, Texas, the son of John A. and Martha (Hudspeth) Maupin. He was graduated from Calhoun College, Hunt County, Texas, and the Medical Department of the University of Tennessee, Nashville, in 1892, and did postgraduate work at Vanderbilt University in 1900. He practiced in Bailey for three months and had practiced in Rowlett since 1892.

A member of the American and Texas Medical Associations through Dallas County Medical Society almost continuously since 1922, he was elected an honorary member of the state organization in 1946. Dr. Maupin was a member of the Masonic Lodge and of the Knights of Pythias, was president of the Citizens Bank of Rowlett, and had

DR. W. A. MAUPIN

served numerous terms on the school board. He was local surgeon for the Missouri-Kansas-Texas Railway and a member of the Christian Church.

Surviving are Dr. Maupin's wife; two daughters, Mrs. Philip J. M. Doyle and Mrs. Corydon J. Glazier, Los Angeles; two sisters, Mrs. Geneva Largent, McKinney, and Mrs. Ann Yates, Los Angeles; two brothers, S. B. Maupin, Los Angeles, and J. R. Maupin, Dallas; and two granddaughters, Patricia Doyle and Peggy Doyle, Los Angeles.

W. E. JONES

Dr. William Edgar Jones, Texarkana, Texas, died there on July 3, 1954.

The son of Mr. and Mrs. S. C. Jones, Sr., of Dallas, Dr. Jones was born September 26, 1914, in Dallas. He attended Southern Methodist University, Dallas, and was graduated from the University of Texas School of Medicine, Galveston, in 1938. He interned and took a residency in internal medicine at Henry Ford Hospital, Detroit. From 1941 to 1946, Dr. Jones was on active duty with the United States Army Medical Corps, having served in the China-Burma-India theater. He was discharged as a major and was a lieutenant colonel in the Air Corps Reserve at the time of his death. After beginning his practice in Dallas in 1946, Dr. Jones moved in 1947 to Texarkana, where he practiced his specialty of internal medicine.

A member of the Texas and American Medical Associations continuously since 1946, Dr. Jones was first a member through Dallas County and then through Bowie County Medical Society. Dr. Jones was certified by the American Board of Internal Medicine; was a member of the Southern Medical Association, the Texas Heart Association, and the American Heart Association; was a fellow of the National Gastroenterological Association and the International Academy of Medicine; and was an associate fellow of the American College of Physicians. He was on the staff of St. Michael and Texarkana Hospitals.

Dr. Jones was a member of Alpha Omega Alpha honorary medical fraternity, Phi Chi medical fraternity, and Sigma Alpha Epsilon fraternity. He was a member of the Board of Stewards of the First Methodist Church in Texarkana. Having attended the School of Tropical Medicine in Calcutta, India, Dr. Jones lectured on that subject as an associate professor of medicine at the University of Arkansas School of Medicine, Little Rock, for the last few years.

He and the former Miss Gudrun M. Johnson were married on May 2, 1940, at Green Field Village, Dearborn, Mich. Survivors include his wife; two daughters, Sheila Jones and Victoria Jones; and two sons, William Edgar Jones, Jr. and Samuel Jones, Texarkana. Also surviving are his mother, Dallas; three brothers, James W. Jones, Spur; and S. C. Jones, Jr. and George F. Jones, Dallas; and a sister, Mrs. J. A. Cooper, Hillsboro.

R. DAWES

Dr. Raymond Dawes, Houston, Texas, died in a local hospital on August 3, 1954, of a cerebral hemorrhage.

Born in Ripon, Wis., on March 20, 1870, Dr. Dawes was the son of Hector and Jane (Ruggles) Dawes. He was a graduate of Ripon College, and of Dearborn Medical College, Chicago, in 1907. Dr. Dawes practiced in Chicago until 1913, when he moved to Houston.

Through Harris County Medical Society Dr. Dawes had been a member of the Texas and American Medical Associations continuously since moving to Texas, and he was elected an honorary member in 1950.

Dr. Dawes was a captain in the Army Medical Corps during World War I. He was a Scottish Rite Mason, a Shriner, and a member of the Presbyterian Church. Dr. Dawes was a descendant of William Dawes, who rode with Paul Revere on the night of April 18, 1775, taking the route from Boston to Concord. He was a second cousin to the late Charles G. Dawes, who was vice-president of the United States from 1925 until 1929.

Dr. Dawes and the former Miss Margaret Lahan were married on February 12, 1901, in Chicago. She died on October 6, 1939. He is survived by a son, Edward Lahan Dawes, Chicago; two granddaughters, Misses Patricia Ann Dawes and Marylahan Dawes; a grandson, Raymond Hector Dawes; and a nephew, Neil B. Dawes, all of Chicago.

G. BARTLETT, JR.

Dr. Glenn Bartlett, Jr., of Falfurrias, Texas, died in a local hospital on June 25, 1954, of coronary occlusion.

The son of Dr. Glenn Bartlett, Sr., and Mary (Haynes) Bartlett, Dr. Bartlett was born May 9, 1904, in Shafter. He attended Southwestern University, Georgetown, and the University of Texas, Austin, prior to entering the University of Texas School of Medicine, Galveston. After being graduated in 1931, Dr. Bartlett interned at Jefferson Davis Hospital, Houston, and did postgraduate work at Central Park Clinic, Buffalo, N. Y. He practiced in Buffalo and Sherman, N. Y., until 1938 when he moved to Texas. He practiced in Harlingen, San Diego, and Laredo before moving to Falfurrias. He specialized in surgery.

Dr. Bartlett had been a member of the Texas and American Medical Associations almost continuously since 1938, when he moved to Texas, being a member primarily through Brooks-Duval-Jim Wells Counties Medical Society. In New

York he had belonged to Erie County Medical Society. In 1940 he and his father began the Bartlett Hospital in Falfurrias, and Dr. Bartlett continued its operation alone after the death of his father in 1945. He was a member of the Catholic Church.

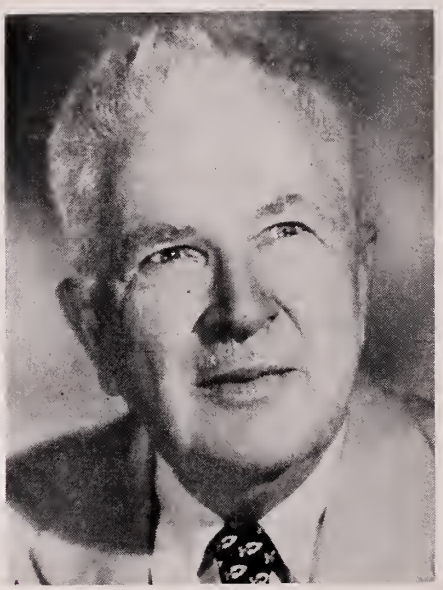
Dr. Bartlett and the former Miss Barbara Margaret Reimann, Buffalo, N. Y., were married January 6, 1938, in Tyler. He is survived by his wife; a son, Glenn Bartlett, III, Falfurrias; and two sisters, Mrs. G. Fry, San Antonio, and Mrs. Lee Daniels, Aransas Pass.

H. G. HEANEY

Dr. Harry Gilbert Heaney died on July 3, 1954, at his home in Corpus Christi, Texas, from hypostatic bronchial pneumonia and pulmonary edema.

The son of Dr. and Mrs. Alfred George Heaney, Dr. Heaney was born on April 11, 1878, in Thomaston, Conn. In 1882 his family moved to Corpus Christi. He was graduated from Texas Military Institute, San Antonio, and as valedictorian from the University of the South Medical Department, Sewanee, Tenn., in 1900. After an internship as clinical assistant at the Hospital for Diseases of the Chest, London, Dr. Heaney did postgraduate work in London, Edinburgh, and Paris from 1902 until 1905, when he began practicing in Corpus Christi. He retired in 1947 after a coronary occlusion.

A charter member of the Nueces County Medical Society and a member of the Texas and American Medical Associations almost continuously since 1905, Dr. Heaney was elected an honorary member of the state organization in 1948. He was a fellow of the American College of Surgeons and an early member of the Texas Surgical Society. He also belonged to the Fifth and Sixth Districts Medical Society. A member of Phi Gamma Delta fraternity, Dr. Heaney had served as city commissioner; president of the Rotary Club, of which he was a charter member; president



DR. HARRY G. HEANEY

of the Elks Lodge; senior warden of the Episcopal Church of the Good Shepherd; and a member of the Board of Regents of the University of the South. He was a thirty-second degree Mason and a Shriner.

Known for his interest in young people, Dr. Heaney entertained as many Navy men from the Naval Air Station and from ships visiting the port in Corpus Christi as his home would accommodate during World War II. Recently, Dr. Heaney arranged for Ringling Brothers, Barnum and Bailey Circus to entertain the children in Memorial Hospital while the circus was in town.

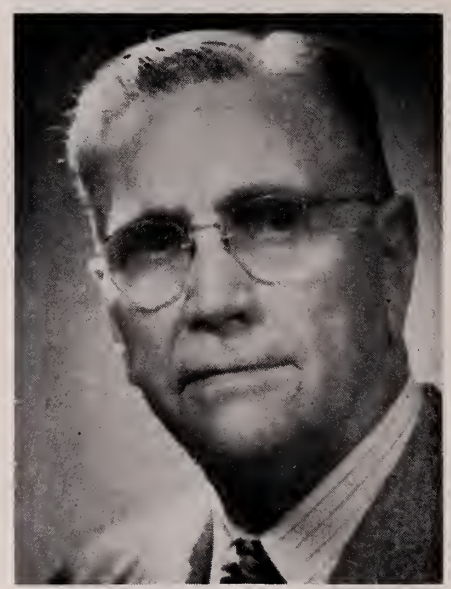
Dr. Heaney and the former Miss Mabel Winifred Pilter were married in Paris, France, in 1905. She survives, as do two sons, Dr. H. Gordon Heaney, Corpus Christi, and Dr. John P. Heaney, San Antonio; two daughters, Dr. Katheryn Heaney Heymann and Mrs. William F. White, Jr., Corpus Christi; two sisters, Mrs. Roy Miller and Mrs. Richard King, Corpus Christi; and twelve grandchildren.

F. E. SADLER

Dr. Finis Ewing Sadler, Abilene, Texas, died on June 1, 1954, in Abilene of cancer of the tongue.

The son of John W. and Belle (McGee) Sadler, Dr. Sadler was born on February 10, 1879, in Bonham. In 1904 he was graduated from the Memphis Hospital Medical College, Memphis, Tenn. Except for a short time, he practiced in Oklahoma until 1948, when he moved to Midland.

Dr. Sadler was on the staff of the Oklahoma State Department of Health for several years, working in the fields of maternal and child health and tuberculosis control. He was superintendent of the State Veterans Hospital in Sulphur, Okla., for fourteen years, except for a brief period when he served as director of the Corsicana-Navarro County



DR. F. E. SADLER

Health Unit. Dr. Sadler took over the Midland-Ector-Howard Counties Health Unit in 1947, and he became director of the Abilene-Taylor County Health Unit in 1952.

He had been a member of the Texas and American Medical Associations since 1948, first through Andrews-Ector-Midland Counties and then through Taylor-Jones Counties Medical Society since 1952. Dr. Sadler served as a first lieutenant in the Medical Corps Reserve during World War I. He was a member of the Presbyterian Church.

He is survived by his wife, the former Miss Mary Louise McMillan, whom he married February 10, 1945. She is now living in Midland. Also surviving are one son, Ewing C. Sadler, McAlester, Okla.; two daughters, Mrs. Hugh Hall and Mrs. Ed Rector, both of Oklahoma City; and three brothers, H. E. Sadler, Marlow, Okla.; J. R. Sadler, Port Arthur; and L. R. Sadler, Corpus Christi.

President's Page

EFFECTIVE ACTION THROUGH COMMITTEES

Early in my term as President, I expressed my intention to encourage an improvement in the functioning of the various councils and committees of our Association. I regret to report my success in this effort so far has not been altogether satisfactory. Therefore, I feel it is timely that I write you about this organizational problem; and I earnestly solicit your cooperation and assistance.

The committee mechanism offers an established and time-tested method in carrying out the program of an organization. In the long life of our Association, experience has proved that there are certain problems which arise and need attention year after year and certain areas of activity which require continuous observation and study. To have an effective organizational mechanism to cope with such conditions, our House of Delegates established certain councils and standing committees and has named them and outlined their functions in the Constitution and By-Laws. In addition, special committees are named by the President on an annual basis to deal with problems considered to be of a special nature or shorter duration. These committees may be perpetuated from year to year as necessity dictates if the incoming President sees fit to rename them. He has the responsibility to create new special committees if new needs arise.

The councils and committees receive material referred to them by the House of Delegates and the officers for evaluation and study. Such working units often are charged with the responsibility to take the initiative and leadership for the Association in a certain aspect of its program, making progress reports to the Executive Council or the House of Delegates periodically.

Selection of members for committee assignments is a difficult task. Many members who have special knowledge or aptitude for a particular responsibility may be unable to accept because of other commitments of their time. Too, consideration has to be given to proper geographical distribution of membership of official bodies. In spite of deliberate effort to make wise choices, and after much corresponding,

telephoning, and conferring, I have felt that perhaps I have not been able to take full advantage of the available talent in our Association. Nevertheless, I am confident that much good new timber has been added to our councils and committees this year.

In the hope of tapping new talent and interest among the membership for next year, I suggest that any physician who has time and means and willingness to contribute to the work of a council or a committee notify the central office, indicating the part of the Association program preferred. Although there are not enough vacancies to utilize all of those who might be interested in serving, such information as might be furnished the central office should prove very helpful to the President-Elect in selecting members for assignments next year.

Some of our committees have made deliberate and energetic efforts to carry out their responsibilities and, in some instances, have expressed disappointment in their failure to get responses from other members of the Association to inquiries. If a council or committee requests information or help, each physician should respect the request and reply promptly. Further, the members at large should feel an obligation to inquire of the councils and committees for information or assistance that may be desired and to try to improve the Association by making constructive suggestions. Using our established organizational setup in this manner will improve the effectiveness of individual programs.

I should like to ask each member of a council or committee to reexamine his assignment and see if as much is being done as can be done. More particularly, the chairman has the responsibility to take the initiative and guide the work of his group. I am sure that the staff at the central office stands ready and willing to assist, as do the other officers of our Association.

A sustained effort should be made to implement the functions of the various councils and committees. Let us use the entire organizational framework that exists and develop a more effective program.

T. J. L. Blasingame, M.D.

Volunteer Now—The Association Needs You

TPR diagnotes

REPORT OF COMMITTEE ON PUBLIC RELATIONS: Meeting in a shirt-sleeve, idea session in Austin on October 31, a working Committee on Public Relations came up with a thoroughly strong campaign to publicize adequately the excellent program planned for annual session in Fort Worth next April. This session's bigger budget provides one of the most outstanding programs ever, both in scientific and entertainment aspects. Refresher courses, highlighting the meeting, will be both informative and engrossing.

In an effort to provide all members with a factual digest of the Association, the Committee considered preparation of a Guide to Services handbook, which will be filled concisely with Association information. Distribution is tentatively scheduled for early next year. The book should be an important addition to every doctor's library.

Concerned with strengthening county societies to tighten the grass roots level of organized medicine, the Committee discussed county society attendance—believes all societies should elect both a president-elect and a secretary-elect; also feels that going a step further with long-term delegates will insure well informed officers, resulting in stronger societies with more interest and better attendance.

For the Presidents' and Secretaries' Meeting held in Austin every January to indoctrinate new society officers, committee members planned a strong, informative program of interest to all Association members. The 1955 meeting will include presidents-elect and secretaries-elect, as well as delegates, PR chairmen, and legislative chairmen.

FROM OVER THE STATE: A top-notch special medical section in the Austin American-Statesman October 17 heralded the four-day birthday celebration of the Travis County Medical Society. Observing 101 years of service in Travis County, the society's open house at the Texas Medical Association building gave laymen a chance to meet their doctor-hosts socially, see exhibits of widespread interest, and hear an outstanding public forum, so popular that would-be listeners lacked seating space. Public interest demanded the program be extended past the original closing hour.

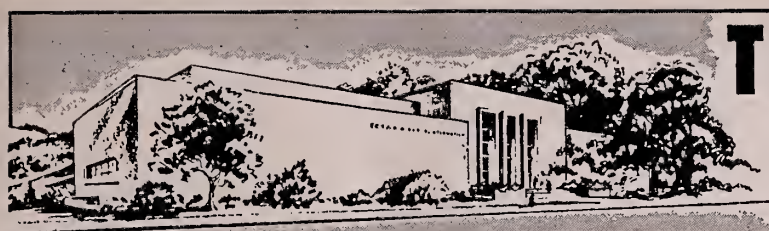
Bexar County Medical Society, recognizing the value of drop-in ads it has sponsored in local San Antonio papers, is continuing the project for another series. Ads feature 'round-the-clock medical service—advise readers to secure the services of a personal physician before problems arise.

"Serving the Suffering," lecture-clinic for physicians and ministers in Lubbock, showed cooperation of the two groups for mutual aid and betterment of patients. Program presented October 7 and 8 by director's committee on religious activity of the Methodist Hospital, Lubbock, was reported a great success.

ON THE NATIONAL FRONT: Completing the series of ten kits scheduled for release in 1954 by the AMA, six kits covering PR projects and how to organize them were added to the four published early this spring. Since the supply of this material is limited, copies will be available, on request to state societies, for use on loan to county societies planning PR projects. The first four kits in the series supplied information on emergency calls, mediation or grievance committees, health forums, and TV programing. New titles are "Indoctrination of Members," "Medical Care for All," "Public Service Projects," "Speakers' Bureaus," "Citizenship Projects," and "Press Relations." Societies interested should write Texas Medical Association central office.

TIP OF THE MONTH

This column was designed as an idea-exchange for county societies. The Committee on Public Relations will sincerely appreciate each county society making monthly reports on its activities. The program you are enjoying may be one some other society has been looking for. Please address reports to PR Diagnotes, Texas Medical Association, 1801 North Lamar Boulevard, Austin.



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ANNUAL OFFICERS' MEETING BROADENED

New officers will be elected by the majority of the county medical societies in Texas next month, and the Texas Medical Association is wasting no time before giving these local leaders an opportunity to air their problems and to learn about their state and national medical organizations. The fourth annual County Medical Society Presidents' and Secretaries' Meeting, to be held Saturday, January 22, at the headquarters building in Austin, has been broadened to include delegates and public relations and legislative committee chairmen. Invitations also are being extended to members of all councils and committees of the Texas Medical Association.

The program will consist of a general session with special sessions on legislation and on medical economics and public relations. Although the plans are not definite, tentative arrangements include a number of brief talks by physicians and laymen, bringing in the nonscientific phases of medical practice, from combating public criticism to what happens to the dues dollar. Of particular interest to delegates will be an account of the issues pending before the House of Delegates. County society secretaries may have many of their questions answered in a discussion on dues, records, and other business matters. A buffet luncheon also is on the agenda.

It is expected that at least two noted out-of-state speakers will take part in the day-long program, which will precede the Executive Council meeting on Sunday, January 23, and probably three guests will come to Texas for the activities. Others on the program will be officials of the Texas Medical Association, including Dr. F. J. L. Blasingame, Dr. Milford O. Rouse, Dr. Hobart O. Deaton, Dr. Robert W. Kimbro, Dr. R. G. Baker, Dr. May Owen, and Dr. William M. Crawford, together with C. Lincoln Williston of the central office staff.

In the field of legislation on the county society level, two panel discussions will be held simultaneously for smaller and larger societies, with Dr. J. W. Rainer and Dr. J. R. Donald-

son as moderators. Dr. C. S. E. Touzel, president of the Tarrant County Medical Society for 1955, will extend a welcome to the 1955 annual session in Fort Worth, mentioning some of the special events being planned.

A successful meeting depends on the cooperation of each county medical society, both large and small, in reporting new officers and committee chairmen immediately upon their election and/or appointment and in urging them to attend. The Presidents' and Secretaries' Meetings in the past have been considered by county and state officers alike as one of the most effective programs ever attempted.

The 1955 session has been planned to help more society leaders—the presidents, secretaries, delegates, public relations chairmen, and the legislative chairmen—meet the problems and answer the questions that are likely to arise during their year in office. If these men take advantage of the January 22 program, a stronger medical organization on all levels could result.

REFRESHER COURSES IN FORT WORTH

A brand new feature has been added to the 1955 Texas Medical Association annual session, which will be held in Fort Worth, April 24-27. Approximately twenty-four refresher courses on subjects important in everyday practice are being arranged with eight scheduled to run simultaneously each morning Monday through Wednesday from 8:15 until 9:45 o'clock. This time has been set aside especially for refresher courses so that each physician will be free to take part in three courses without missing other programs.

Registration for the courses, which will be limited to about fifty physicians each, will be completed prior to the meeting; details will be announced later. There will be no charge.

Given by a guest faculty of outstanding speakers from all over the United States, the courses will be divided into an hour of instruction followed by a thirty minute question and answer period. Informal credit hours, which must be reported beginning January 1 for maintenance of good standing in the Texas Academy of General Practice, will be granted by the Academy for attendance at the scientific sessions including the refresher courses.

Eminent representatives from all medical fields will come to Fort Worth in April to give the refresher courses, talk before general meetings, or participate in section or related specialty organization programs. Most will speak several times. The following is a list of speakers who have accepted invitations:

Dr. Frank N. Allan, Boston, Executive Director of Medical Department, Lahey Clinic.

Dr. John A. Anderson, San Francisco, Professor and Head of Department of Pediatrics, Stanford University School of Medicine.

Dr. William H. Bickel, Rochester, Minn., Associate Professor of Orthopedic Surgery, Mayo Foundation.

Dr. Francis J. Braceland, Hartford, Conn., Clinical Professor of Psychiatry, Yale University.

Dr. Walter A. Fansler, Minneapolis, Clinical Professor of Surgery and Head of Division of Proctology, University of Minnesota.

Dr. Russell S. Fisher, Baltimore, Chief Medical Examiner of the State of Maryland.

Dr. Norman E. Freeman, San Francisco, Associate Clinical Professor of Surgery, University of California.

Dr. Douglas M. Kelley, Berkeley, Professor of Criminology, University of California.

Dr. William J. Kerr, San Francisco, former Professor of Medicine and Chairman of Division of Medicine, University of California.

Dr. Clair M. Kos, Iowa City, Professor of Otolaryngology and Maxillofacial Surgery, State University of Iowa.

Dr. Hugh R. Leavell, Boston, Professor of Public Health Practice, Harvard University School of Public Health.

Dr. C. Ferd Lehmann, San Antonio, Practicing Dermatologist and Consultant, Brooke Army Hospital.

Dr. Nicholas C. Leone, Bethesda, Md., Staff Member of the National Institute of Dental Research, National Institute of Health.

Dr. Frank R. Lock, Winston-Salem, N. C., Professor of Obstetrics and Gynecology, Bowman Gray School of Medicine, Wake Forest College.

Dr. John S. Lundy, Rochester, Minn., Professor of Anesthesiology, Mayo Foundation.

Dr. Walter B. Martin, Norfolk, Va., President of the American Medical Association.

Dr. Alton Ochsner, New Orleans, Chairman of Department of Surgery, Tulane University of Louisiana School of Medicine.

Dr. Lester W. Paul, Madison, Professor of Radiology, University of Wisconsin.

Dr. Robert L. Sanders, Memphis, Tenn., Senior Surgeon, Baptist Memorial Hospital.

Dr. Lucian A. Smith, Rochester, Minn., Member of Division of Internal Medicine, Mayo Clinic.

Dr. Phillips Thygeson, San Jose, Clinical Professor of Ophthalmology, University of California.

In addition to the refresher courses to be conducted by the guests, a course on "Athletic Injuries" will be given by Dr. Edward T. Smith, Houston, team physician for the Rice Institute Owls; Jess Neely, athletic director and head football coach at Rice; and Eddie Wojecki, trainer for the Owls.

Every physician who is absent from the 1955 annual session will miss a scientific program which has been redesigned this year with him in mind. Whether a doctor is a general practitioner or a specialist, there will be refresher course and general meeting subjects, as well as topics of more restricted appeal, to interest him. Furthermore, the special guests have been invited to be in Fort Worth during the entire session so that more Texas doctors will have an opportunity to meet and talk with them about individual problems.

Now is the time to mark the calendar so that the meeting in Fort Worth will not be missed.

NEW OFFICIAL NAMED

A new helmsman has taken the wheel at the central office of the Texas Medical Association, and members of the Association can do much to assure him steady winds and a willing crew to keep the organization on its course. C. Lincoln Williston, who came from Illinois last April as assistant executive secretary, was elevated to the executive secretaryship November 1 following the resignation of N. C. Forrester. Mr. Forrester left the Association after serving on the staff since June, 1950.

Because of the county medical society visitation program which Mr. Williston has activated in recent months, many Texas doctors and their wives already know him. It is the hope of the Board of Trustees, which named him to his new post, that every member of the Association soon will know Mr. Williston and will cooperate with him in achieving the organization's goals.

CURRENT EDITORIAL COMMENT

HELPING PATIENTS TO BUY ACCIDENT AND HEALTH INSURANCE

Doctors often are called upon to advise on problems which are not strictly medical, including this or that health insurance plan. Doctors are not inclined to praise or condemn any specific insurance company or plan. Yet, in some situations a plea for advice may be strong enough to offset a doctor's natural hesitancy. What then can a doctor say to his friends or patients in terms that will be most helpful? Here are some pointers:

Study present insurance coverage. If the person has insurance where he works or through another organization, he should find out how much and for what. Group insurance is usually the broadest and cheapest protection available. However, it is often not enough or the patient may not be a member of such an insurance-providing group.

Figure out what is needed. A family head needs insurance as replacement for at least half of his take-home income to meet current living expenses while he is laid up. A doctor can be helpful by explaining the general level of local hospital room rates, the charge for professional calls, and some of the more common surgical procedures. He should caution the person to budget about 3 per cent of his annual net income for other health costs which insurance does not or cannot cover.

Look at the types of policies available. Protection can be bought for either accident or sickness separately, but it is a good idea to get both either in a combination policy or in two separate policies.

This department of the JOURNAL *presents editorial comments on current items pertaining to the science, art, and practice of medicine, contributed by members of the Texas Medical Association and others closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the Texas Medical Association to submit such discussions for this department. The discussions preferably should be between 300 and 500 words in length.*

Loss of income policies pay weekly or monthly benefits when a person cannot work at his job, or any job, or both—whichever benefits are desired and for which the individual is willing to pay. The loss of income policy also pays lump sum death or loss of limb benefits. Noncancellable policies cost substantially more than those that can be cancelled by the insurance company. However, a 1952 survey shows that nationally only .4 per cent of the cancellable policies then in force were cancelled by companies.

Hospital insurance pays a certain daily amount for room and board and another amount for extras. The extras are important, for they can often account for a major portion of the hospital bill. Pregnancy is often covered under hospitalization policies, but usually there is a nine month waiting period before eligibility for benefits. A deductible feature in some hospital policies—as in automobile collision insurance—will save money on premiums.

Surgical insurance pays a maximum amount for operations listed in a "schedule." Provision is usually made for operations not listed to be paid according to their comparative difficulty up to a maximum of the schedule.

Medical insurance pays for doctor calls at home or in the hospital, usually when no surgery is involved or when a patient comes to the doctor's office.

Major medical expense insurance helps pay the catastrophic accident or sickness costs. Top limits usually run from $2,500 to $10,000. Often there is a deductible clause on the first $500, but expenses within that amount may be met substantially by the regular hospital-medical-surgical coverages. On the remainder of the bill, most policies pay 75 per cent. The patient pays the rest.

Decide from whom to buy. An insurance company representative who is well regarded in the community should be consulted. If a person wishes to do so, he may get the views of policyholders who have recently received insurance benefits.

Know the policy. An insurance buyer should understand completely what a given policy provides before deciding to buy it. The questions he should ask about a policy will be pointed out in the fourth and last article in this series.

HEALTH INSURANCE COUNCIL,
Chicago, Illinois.

208 South LaSalle Street.

This is the third in a series of articles prepared at the request of the Hospital-Insurance-Physicians Joint Advisory Committee of Texas. The first two, explaining income insurance for doctors and some ABC's of health insurance, appear in the September and October issues of the JOURNAL, *respectively.*

OPEN-CHANNEL TV USED FOR CLINIC

A successful experiment in the use of open-channel television for postgraduate medical education conducted by the Division of Graduate and Postgraduate Medical Education of the University of Utah has been reported by Dr. Robert S. Warner and Dr. John Z. Bowers in the October issue of the *Journal of Medical Education.*

Choosing 7 to 8 a. m. as an hour convenient for most doctors and one free from commercial television interference, the university telecast four clinics which reached an audience area including 75 per cent of the practicing physicians in Utah.

The clinics were televised weekly for four weeks and covered roentgen-ray diagnosis of calcifications in the abdomen, gastrointestinal hemorrhage in the elderly patient, the approach to congenital heart disease, and a diagnostic clinic. Physicians in the reception area were given the number of an unlisted telephone installed at the site of the telecast and were urged to place questions by collect calls.

The authors report that a survey indicated 48.9 per cent of the potential doctor audience viewed the telecasts, with 74 per cent of the viewers stating they learned new facts. Sixty-one per cent felt that their "previous knowledge had been revitalized," and 53 per cent indicated renewed interest in a specific field.

A questionnaire revealed that 46.7 per cent of all physicians interviewed thought that televised clinics were the best means of gaining new information. Drs. Warner and Bowers emphasized that rural practitioners, in particular, could benefit from this type of presentation.

ACCIDENTAL DEATHS

Heart disease and cancer are the only diseases causing more deaths than accidents among American men in the ages of 15 through 64 years, according to statisticians of the Metropolitan Life Insurance Company.

The three leading causes of accidental death—motor vehicles, falls, and drownings in that order—were responsible for about seven out of every ten accidental deaths in this insured group, and a large part of the remaining mortality was due to burns, firearms, and poisoning.

The reduction in mortality among men between 15 and 64 has amounted to about one third over the past twenty years.

ORIGINAL ARTICLES

CLINICAL EVALUATION OF RADIOACTIVE IODINE(I^{131}) AS A DIAGNOSTIC AND THERAPEUTIC AGENT

RALPH S. CLAYTON, SR., M. D., Dallas, Texas

RADIOACTIVE iodine (I^{131}), the eight day half-life radioactive isotope of iodine, has been in large-scale use in research and in clinical medicine only since 1946. Prior to that time, small-scale studies with this and other short-lived isotopes had been reported.[9, 10]

This paper is concerned with the current status of I^{131} in clinical medicine only.

It is important to recognize that procedures employing this isotope are still in the process of development and differ in many details among various laboratories; therefore only broad concepts can be described. Generally, I shall outline the principles involved in and the indications and contraindications for the use of I^{131} at present. Furthermore, since by far the widest use of this isotope is in the diagnosis and treatment of thyroid disease, this paper is concerned mostly with its use in this field.

PROPERTIES OF I^{131}

These properties of I^{131} are responsible for its usefulness in clinical medicine: (1) its metabolism is identical to that of stable iodine and therefore is well known; (2) the quantities of I^{131} which provide sufficient radioactivity for diagnosis and therapy are nontoxic to the patient; (3) the physical half-life of eight days is relatively short, and on the basis of no excretion of the isotope, 87.5 per cent of its radiation is delivered in twenty-four days; (4) the half-life is long enough to permit deliberate preparation, assay, shipment, storage, and administration without excessive losses; (5) radiation from I^{131} is biologically highly effective, yet it is easily shielded for safe handling; (6) the gamma ray emission permits in vivo measurements by instruments outside the patient; (7) the cost of the I^{131} and equipment for its measurement are reasonable; and (8) the eight day half-life makes laboratory contamination much less of a problem than with substances of longer half-lives such as radioactive cobalt (Co^{60}).

DIAGNOSIS OF THYROID DISEASE

Tracer studies should be considered only as supplementary to older, more established tests of thyroid function. They should not replace any of these tests nor any part of an adequate clinical study. Thorough clinical study and follow-up are just as essential to the successful management of thyroid conditions with I^{131} as they were before its discovery. I^{131} studies are not indicated in the vast majority of cases of thyrotoxicosis where there is no doubt of the diagnosis. Their greatest value is in diagnostic problems, especially in suspected hyperthyroidism or hypothyroidism, suspected carcinoma of the thyroid, and vague clinical syndromes. Uptake studies always should be done before therapy with I^{131} for any reason.

When other evidence of thyroid function is equivocal, I^{131} data are usually definitive; rarely are both equivocal in the same patient. Tracer studies on patients with nonspecific signs and symptoms have revealed positive evidence of hyperthyroidism and hypothyroidism.[15] The full potentialities of I^{131} in this regard have not been determined fully.

I^{131} diagnostic tracer techniques involve the determination of one or more of several aspects of thyroid metabolism:

1. I^{131} uptake by the thyroid—total uptake, with or without the rate of accumulation by the gland, at twenty-four to thirty-six hours, as percentage of a tracer dose.

2. I^{131} renal excretion—total excretion, with or without the rate of excretion, at forty-eight to seventy-two hours, as percentage of a tracer dose.

3. Distribution of I^{131} within the thyroid and in other organs and tissues, with or without the rates of uptake and loss from each area.

4. Rate of plasma clearance of I^{131} related to the thyroid accumulation rate.

From the Department of Radiology of Parkland Memorial Hospital and of Southwestern Medical School of the University of Texas.

Read before Section A (Medical), Texas Medical Association, Annual Session, San Antonio, May 4, 1954.

5. Plasma I^{131} levels as an indication of the rate of conversion of iodine to thyroxine.

Figure 1 is a schematic representation of thyroid uptake curves in hyperthyroid, euthyroid, and hypothyroid states and in functioning thyroid carcinoma. The thyroid function curves overlap in a small percentage of cases. Total thyroid uptake values at twenty-four hours are about 75 per cent plus or minus 15 per cent in hyperthyroidism, 25 per cent plus or minus 15 per cent in euthyroidism, and 5 per cent plus or minus 5 per cent in hypothyroidism. The hyperfunctioning gland takes up more iodine more rapidly and loses it faster than the normal. Hypofunctioning

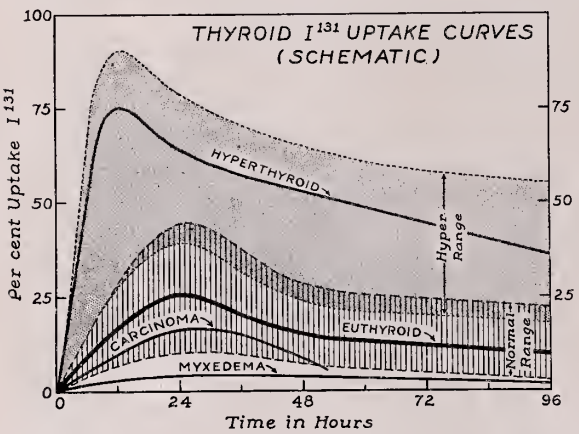

FIG. 1. Graph shows a schematic representation of thyroid I^{131} uptake curves in hyperthyroid, euthyroid, and myxedema states and in functioning thyroid carcinoma.

glands take up less iodine more slowly and lose it slower than normal. Thyroid carcinoma of functioning type always takes up less than normal thyroid tissue and loses it at the most rapid rate of all.

Figure 2 is a schematic representation of renal excretion curves in hyperthyroid, euthyroid, and hypothyroid states and in functioning thyroid carcinoma. Except for a 10 to 15 per cent insensible loss through perspiration and the intestinal tract and in tissue reservoirs, all iodine not taken up by the thyroid is promptly excreted by the kidneys. Measurement of excretion is an accurate indirect method of determining thyroid intake.

Discussion of the relative accuracy and difficulty of these tests is not within the scope of this paper. The tests commonly used today in declining order of frequency are total thyroid uptake, total urinary excretion and rate of excretion, thyroid uptake rate, and others.

Mapping the distribution of the radioiodine and observing the rates of accumulation and loss in each area may be highly informative. Reynolds, Corrigan, and Hayden[14, 15] have reported an amazing success with the skin contact scanning technique in detecting unsuspected thyroid carcinoma and in the differential diagnosis of cervical and mediastinal masses. Toxic and nontoxic nodules, extensions of thyroid tissue into the retrotracheal region and anterior and posterior mediastinum, and residual masses of thyroid tissue after thyroidectomy have been shown beautifully by this method. Furthermore, accurate estimates of the volume of functioning thyroid tissue are possible by the distance scintillation counter, linear scanning technique of Goodwin and others.[2, 8] However, the equipment for this procedure is expensive at present.

The technique now used at Parkland Memorial Hospital, Dallas, is to measure total thyroid uptake at twenty-four hours, with determination of the effective half-life when I^{131} therapy is contemplated. Corrections are made for effective depth of the thyroid, background radiation, and Geiger tube resolving time counting losses.[16] We have begun to employ the skin-contact mapping technique and thyroid uptake rate determination but have had too little experience at this time to warrant comment.

The uptake of I^{131} by the thyroid may be seriously altered by many factors. Iodine in therapeutic doses

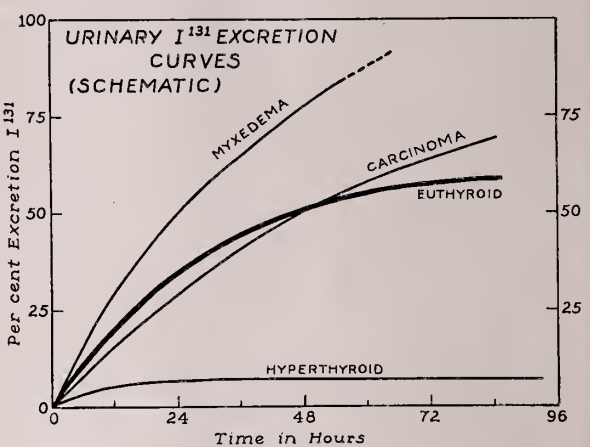

FIG. 2. A schematic representation of renal I^{131} excretion curves in hyperthyroid, euthyroid, and myxedema states and in functioning thyroid carcinoma is given in the graph.

saturates the thyroid so that uptake is deceptively low. Thiouracil and its derivatives block the conversion of diiodotyrosine to thyroglobulin, thus reducing uptake. Desiccated thyroid, by inhibiting the production of thyrotropic hormone from the pituitary gland, results in the most severe depression of I^{131} uptake of all these factors. Some of the influences which tend to decrease uptake and the approximate periods during which their effects on uptake may persist are listed in table 1.

Any unexpectedly low uptake should suggest the possibility of thyroid block. Antithyroid drugs or

iodine should be discontinued at least one to two weeks, longer if possible, before diagnostic or therapeutic doses of I^{131} are given. Desiccated thyroid should be stopped three months before tracer studies if at all possible. Careful history should be taken to exclude other influencing agents.

Thyroid uptake tends to be deceptively high in the presence of impaired renal function, cardiac edema, or thyroid hypertrophy following prolonged antithyroid therapy. In cardiac edema, occult or detectable, and in renal diseases, the increased extracellular fluid acts as a reservoir which can hold considerable iodide.

TABLE 1.—*Influences Which Tend to Decrease Thyroid Uptake and Approximate Duration of Each.*

	Duration
Stable iodine (therapeutic, dietary, vitamin preparations, and the like)	1 to 4 weeks
Radiographic contrast media	
Diodrast	2 to 7 days
Gallbladder dyes	1 to 3 months
Lipiodol and Pantopaque	months to years
Antithyroid drugs	1 to 2 weeks
Desiccated thyroid	2 to 4 months
Thyroiditis	weeks to months or no effect
Previous irradiation with I^{131}	months to years or no effect

This results in a longer exposure of the thyroid to higher values of circulating iodine, thereby increasing the total amount taken up.

TREATMENT OF THYROTOXICOSIS

Radioisotope therapy is attended by mild morbidity. Except for one or two isolated reports of death from a thyroid crisis a few days after a therapeutic dose, there is no mortality. The one significant complication is permanent hypofunction of the thyroid requiring replacement therapy. From 6 to 12 per cent of patients show evidence of hypothyroidism one to three years after treatment. The proportion of cases showing permanent hypofunction probably will be less than this figure. This incidence possibly may be reduced by divided dose treatment regimens now under evaluation in many centers.

My experience with cases seen in three radioisotope laboratories in and near Dallas has paralleled that contained in the current literature. Though I was unable to make a detailed study of results of all cases treated in the time available, the response to treatment has been satisfactory, with few cases requiring any replacement therapy for hypothyroidism.

Practically all patients with hyperthyroidism can be rendered clinically euthyroid if careful follow-up is done and supplemental doses of I^{131} are given as indicated.

The objective in treating thyrotoxicosis is to render the patient euthyroid. It appeared logical at first to calculate therapeutic dosage on the basis of gland size, percentage uptake, effective half-life, severity and duration of symptoms, and the age of the patient.[11] Experience to date, however, reveals poor correlation between the response to treatment and calculated dosage.[12, 17] There is a growing tendency to give a standard initial dose of 3 or 4 millicuries and to give small supplementary doses as required. Data concerning any improvement in results by this method of management are not yet available.

Until they are proved to be unnecessary, I shall continue to take certain factors into account in making decisions on dosage to assist in evaluating results and as a matter of principle in teaching. These factors are (1) percentage uptake of I^{131} by the thyroid at twenty-four hours; (2) effective half-life of I^{131} in the thyroid; (3) estimated weight of the thyroid gland; (4) duration and severity of symptoms; (5) age of the patient; and (6) response to previous I^{131} treatment.

Treatment with either Lugol's solution or antithyroid drugs may be initiated three to seven days after the therapeutic dose, if indicated, to control symptoms until effects of the radiation are manifest two to four weeks later. This is particularly important in patients showing evidence of rapidly increasing severity of symptoms and if there is any possibility of thyroid crisis.

Diffuse Toxic or Exophthalmic Goiter.—I^{131} is rapidly replacing surgery in the treatment of diffuse toxic or exophthalmic goiter where the isotope is available. Most investigators at present prefer to avoid treatment of patients under 25 years of age because the question of carcinogenesis[4] or genetic[13] effects of I^{131} irradiation has not been resolved, but young patients are treated when surgery is contraindicated or is refused. Unless evidence of carcinogenesis or adverse genetic effects is demonstrated soon, I^{131} is likely to replace surgery as the treatment of choice for toxic diffuse goiter at all ages.

Nodular Toxic Goiter.—Surgery is the treatment of choice for nodular toxic goiter. The short range (2.2 mm.) of the beta particles makes them relatively ineffective in reducing the size of nonfunctioning nodules. Larger doses are required, and the risk of hypothyroidism is perhaps greater than in diffuse goiter. However, if surgery is contraindicated because of coexisting disease, conservative I^{131} treatment certainly may be considered.

Recurrent Hyperthyroidism.—I^{131} is the treatment of choice for recurrent hyperthyroidism after either thyroidectomy or failure of antithyroid drug therapy. Since the volume of functioning tissue after surgery is usually small and palpation is impossible, calculation of dosage on the basis of tissue volume cannot be done. Dosage, therefore, is somewhat empirical.

Slightly larger doses of I^{131} are required than in the initial treatment of diffuse toxic goiter.

Thyrotoxicosis During Pregnancy.—Iodine therapy for thyrotoxicosis should not be considered during pregnancy. In the first trimester there is a small possibility of the radiation producing malformation of the fetus. The fetal thyroid gland is functioning during the second and third trimester and may be damaged. Even tracer studies should not be done if avoidable.

Solitary Thyroid Nodule.—Because of the high probability of malignancy,[5, 6] the solitary nodule in the thyroid gland should be treated by surgery only. Since up to 20 per cent of these nodules prove to be malignant, they should be removed as soon as detected. Except as a last resort, and only if surgery is absolutely contraindicated, is there any reason to consider I^{131}, and then only if the nodule takes up significant amounts of the iodine.

Simple (Colloid) Goiter.—Simple (colloid) goiter should not be treated with I^{131}.

Nodular Nontoxic Goiter.—Multinodular goiter should receive I^{131} only if surgery is positively contraindicated and then only in carefully selected cases.

Intrathoracic Goiters.—Diffuse toxic goiters with demonstrated mediastinal extensions but not showing large masses near the trachea may be treated with I^{131}. Large masses may swell from the irradiation and could produce respiratory obstruction. Intrathoracic multinodular goiters should be removed surgically.

TABLE 2.—*Indications and Contraindications for Tracer Studies and Therapy with I^{131}.*

Indications for tracer studies with I^{131}—	Indications for therapy with I^{131}—
Determination of thyroid function in diagnostic problems.	Diffuse toxic or exophthalmic goiter.
Suspected residual or aberrant thyroid tissue.	Thyrotoxicosis after thyroidectomy or antithyroid drugs.
Suspected thyroid carcinoma.	Toxic nodular goiter when surgery is contraindicated.
Suspected metastases of thyroid carcinoma.	Thyrotoxicosis at any age when the patient absolutely refuses surgery or antithyroid drugs.
Undiagnosed intrathyroid, cervical, and mediastinal masses.	Intractable congestive heart failure or severe angina pectoris.
Suspected brain tumors or liver masses.	
Contraindications to tracer studies—	Contraindications to I^{131} therapy—
Pregnancy, especially second and third trimester.	Relative:
Current therapy with iodine or antithyroid drugs.	Toxic nodular goiter at any age with high uptake (more than 15 per cent).
Vomiting or diarrhea.	Young patient (under 25 years).
	Exophthalmic goiter with large gland.
	Absolute:
	Pregnancy.
	Nontoxic nodular goiter.
	Nontoxic diffuse (colloid) goiter.
	Solitary nodule of thyroid gland.
	Toxic nodular goiter at any age with low uptake (under 15 per cent).
	Intrathoracic multinodular goiter.
	Goiters producing mechanical obstruction.
	Hard glands likely to be malignant.

MALIGNANCY OF THYROID

I^{131} uptake and excretion curves have been used successfully in the diagnosis of thyroid cancer. Thyroid carcinoma tends to take up less iodine and lose it faster than normal thyroid tissue. The urinary excretion and liver uptake and retention curves are altered.[14, 15] I have not had the opportunity to study a case by this uptake and retention curve technique. Patients suspected of having thyroid carcinoma should receive a large tracer dose of I^{131} the day before operation to permit radioautographic studies and measurements of the uptake by the malignant tissue. The patient also should be scanned for unsuspected metastases.

Surgery is the only method of treatment of thyroid carcinoma which has any significant chance of cure. Radiation is indicated in persistent disease or for the detection and treatment of metastases in certain types of tumor. Effective treatment of thyroid malignancy with radioactive iodine is possible only when significant amounts of the I^{131} are taken up and retained by the malignant tissue. Only the well differentiated adenocarcinomas, particularly those which form colloid, may be expected to do so. The cancerous tissue must take up from 50 to 100 times as much activity per gram as the rest of the body if any damage to the cancer is to result.

Early optimism that I^{131} might cure carcinoma of the thyroid gland has not been justified by experience to date. Few real cures have been obtained, but a good proportion of patients whose tumors take up iodine do receive significant palliative benefit.

Less than 10 per cent of thyroid tumors will take up enough I^{131} to justify treatment. A large dose of from 25 to 50 millicuries of activity should be given initially, and repeated if necessary, to destroy all normal thyroid tissue. In some cases, this may result in an increased uptake by the carcinoma. Thyrotropic hormone has been shown to increase tumor uptake in some cases. The behavior of metastases is entirely unpredictable, some showing no uptake with one dose but taking up considerable iodine a few months later.

Treatment of carcinoma requires large doses of

I^{131}, but there is a limit to total dosage. Severe depression of hematopoiesis has resulted in a few cases. Myxedema is prevented by replacement therapy.

However, in view of the poor prognosis of metastatic thyroid carcinoma by any other method of treatment, I^{131} should be tried if the histology and uptake studies suggest any possibility of help by this method. At present a therapeutic trial is the only valid way to determine whether the radioactive isotope will affect the tumor.

INTRACTABLE CARDIAC DISEASE

Patients having intractable congestive cardiac failure or severe angina pectoris may receive significant benefit from reduction of thyroid function with I^{131}, thus reducing the work required of the heart. From one-half to two-thirds of these patients may be expected to show improvement for from nine months to three years; the remainder will not be improved.[3] From two to three times the therapeutic dose for hyperthyroidism is required since the normally functioning gland takes up less iodine and is less radiosensitive than the hyperfunctioning gland.

The purpose of treatment is to reduce thyroid function to low levels without the shock of an operation, and then to maintain the patient just above myxedema level with desiccated thyroid. No complications of any significance have been reported, and the cost of the treatment is low. In selected cases, I^{131} therapy appears to be indicated on the basis of experience to date.

OTHER CONDITIONS

Diiodofluorescein and iodinated human serum albumin, made with I^{131}, have been used successfully in the diagnosis of brain tumors and certain other conditions which alter the blood brain barrier so as to increase the deposition of the radioactive material in the extravascular spaces. The resulting irregular distribution is detected by measuring the gamma-ray emission from symmetrical areas of the brain. Ashkenazy[1] has reported an accuracy of 95 per cent in the diagnosis of brain tumors. Other reports describe varying degrees of success with this technique.[7]

Total blood volume may be measured accurately with radioiodinated human serum albumin by employing the principle of simple dilution. Circulation times can be determined by this method. Detection of intrahepatic masses by studying the distribution of the isotope in the liver has been reported.[18]

SUMMARY

The current status of radioactive iodine (I^{131}) in clinical medicine has been reviewed. Tracer studies utilizing this isotope provide valuable additions to older diagnostic regimens. Treatment with this isotope is indicated in selected cases of thyroid and cardiac disease.

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BALLISTOCARDIOGRAPH PERFECTED

After more than two decades of medical research, the first successful bloodless method of accurately measuring the strength of a human heart beat has been achieved. Perfection of the ballistocardiograph apparatus was announced recently by the Air Research and Development Command in Baltimore.

The new device at present is employed by the Air Research and Development Command to evaluate the effect of partial pressure suits on the output of blood from the heart. However, it has been used clinically with promising results.

The apparatus consists of a light-weight bed suspended in so sensitive a manner that it moves with each minute rebound of the body caused by the ejection of blood from the heart. Coupled with a highly-sensitive accelerometer, the ballistocardiograph apparatus records on a graph the force and time course of the heart beat.

BENIGN BREAST TUMORS

FRANK A. SELECMAN, M.D., and ROBERT A. McCALL, M.D., Dallas, Texas

EXPERIENCE in private practice with more than 400 cases of breast lesions has stimulated our interest in this subject. Approximately 72 per cent of the patients with breast lesions have been found to have benign breast tumors of some sort. This paper was written to correlate our information so that we might gain a better understanding of these conditions. No attempt is made to mention every variety of benign breast tumors but rather to consider those that are most frequently observed.

A high percentage of benign breast tumors fall into a group in which much confusing terminology has been used. For example, there are the terms cystipherous desquamative epithelial hyperplasia, Brodie's disease, Reclus' disease, Bloodgood's blue dome cyst, mazoplasia, adenofibromatosis, Schimmelbusch's disease, nodular hyperplasia, fibrocystic disease, mastodynia, and chronic cystic mastitis, to name a few.

The impact of Geschickter's book[8] on the classification of breast tumors has been noted in recent years, and our discussion is confined chiefly to the following classifications: (1) mammary dysplasia, under which we note mastodynia, adenosis, and cystic disease; (2) fibroadenomas; (3) papillomas; and (4) hypertrophies, namely, prepuberal, virginal, and gynecomastia. In addition, the relation of benign breast tumors to carcinoma is discussed.

MAMMARY DYSPLASIA

Clinical observations and experimental studies have indicated the factors of hormonal imbalance in relation to the development of benign breast tumors. It has been stated that these tumors are "an expression of endocrine dysfunction." It is recognized that mammary development is secondary to the stimulation by estrogen, causing the development of lobular buds. It is known also that the stimulation by progestin causes differentiation of the epithelial cells in ducts in the breast tissue and that stimulation by the anterior pituitary gland activates the secretory mechanism. Experimentally, it has been shown in monkeys and rodents that testosterone has an action like that of progestin, and one would infer that this same function might be true in human beings. There are certain tumors of the adrenal cortex and there have been lesions in the third ventricle which also were shown to stimulate mammary growth and activity. Studies by Ewing indicated hereditary tendencies toward unusual mammary development.

Read before Section B (Surgical), Texas Medical Association, Annual Session, San Antonio, May 5, 1954.

Cyclic changes in the breast have been noted over a long period of time and are considered physiologic and normal. Hormones may be used experimentally in rabbits and rodents to cause the development of almost every known breast tumor or neoplasm. Clinical studies, particularly using assays on urinary excretions, have indicated that patients with benign breast lesions have a relative hyperestrinism. To explain why only a certain portion of one breast or certain parts of both breasts are involved, Nathanson[13] has stated, "Localized areas of the specific tissue are unusually sensitive to a stimulus."

Mastodynia

Following Geschickter's classification, let us first consider mastodynia, which occurs most commonly in persons between 20 and 40 years of age. It constitutes the largest group of benign breast lesions. The diagnosis is made on the basis of the presence of pain, tenderness, and a thickened area which is usually located in the upper outer quadrant of one or both breasts. When a biopsy is performed, the pathologic picture is that of imperfect lobules with an increased connective tissue component. The treatment is usually nonsurgical in that as a rule the condition is self-limited (if it persists, it indicates the development of adenosis) and will terminate with a pregnancy or the menopause. These patients need reassurance. Some physicians prefer to treat them with mild, stimulating doses of endocrines, including both estrogen and testosterone, and luteal factors as well. Mild, stimulating doses of estrogen are believed by some physicians to stimulate activity of corpus luteum. Testosterone is thought by some doctors to counteract the effects of excess estrogen and progestin. There is no standardized hormone treatment.

It has been interesting to us over a period of years to know about the work of three brothers named Biskind, one a gynecologist, one an internist, and one a pathologist. In their studies, they noted the frequent association of cystic disease of the ovary, hyperestrinism, and benign breast lesions. They developed the thought that hyperestrinism was associated with poor liver function so that the liver did not conjugate the excess estrogens in the blood stream. Good results were reported in these cases following the administration of vitamin B complex to improve liver function.[3] This simple form of treatment we frequently have utilized along with heat and support. Clinically, it has been satisfactory since most patients

generally feel better following its administration anyway.

Adenosis

Adenosis occurs most commonly in persons between the ages of 35 and 45 years. Whereas mastodynia is usually self-limited, adenosis is more persistent. The diagnosis is made by the finding of definite nodularity; about one-third of the patients present themselves because of pain and two-thirds because of being conscious of the presence of a nodule. Adenosis may mimic carcinoma, and most cases require biopsy. Following the excision of a wedge of breast tissue containing this nodular area, the pathologic picture is that of a limited or a diffuse lesion in which there is a marked fibrous component, frequently small cysts, adenomas, papillomas, and epithelial hyperplasia. This condition is frequently difficult clinically to differentiate from carcinoma, and the microscopic picture also may be difficult to interpret, particularly on frozen section. It is well to be considerate of the pathologist when he requests that the diagnosis be deferred for permanent section.

Treatment for adenosis usually begins with the establishment of the diagnosis by biopsy. Occasional cases that do not cause concern from the clinical picture may be treated with progestin or B complex while being carefully observed at frequent intervals. It has been stated that adenosis will clear up if the patient becomes pregnant; this fact we have not personally witnessed nor have we been able to verify from several obstetricians.

Cystic Disease

Cystic disease of the breast occurs chiefly in the fourth decade of life. This condition is diagnosed by finding one or more cysts, more than 1 cm. in diameter, particularly during or near the menopause. Forty per cent of these patients have mild pain. The lesions, as a rule, will transilluminate and also may be diagnosed by aspiration; however, obtaining these signs is a problem if the cyst lies deeply in the breast or is thick walled. Treatment in the past was excision alone. These lesions do not respond to endocrines; however, 7 per cent are said to regress spontaneously. Geschickter[7] stated that 85 per cent do not recur following excision and that 35 per cent do not recur following aspiration. Many agree with Nathanson,[13] who stated that a physician may aspirate a solitary cyst with considerable safety.

If aspirations are done for diagnosis and treatment, certain precautions should be advised. Each case should be individualized with the following points in mind: (1) Patients who develop cysts after the menopause should have them excised as there is much greater hazard of neoplastic change and less likelihood of relative hyperestrinism. (2) If on aspiration the contents are found to be bloody or microscopic examination of suspicious looking contents shows marked epithelial elements, the cyst should be excised. (3) In many cases excision of the first simple cyst may be advisable, and then recurrent cysts may be aspirated with a feeling of safety. (4) If a nodularity is noted in the region of the aspirated cyst at the time of aspiration or when the patient is checked in three or four weeks, excision of this area should be performed. (5) Those patients who have recurrence of a cyst following a second aspiration should have the cyst excised. (6) A patient who cannot return conveniently for careful follow-up studies at frequent intervals should have a biopsy performed.

Many patients come to us with multiple cysts in both breasts and few are willing to have bilateral, simple mastectomies unless their lesions are exquisitely painful and sensitive. It is our opinion that simple mastectomy is performed too often for these benign lesions and should be avoided. In our experience, 25 per cent of the patients with cystic disease required only one aspiration. After seeing nearly 400 benign breast tumors in the office, we have witnessed the development of carcinoma in only 1 patient who had been followed over a period of thirty-two months with multiple cysts in both breasts.

FIBROADENOMAS

Not much time need be spent on discussing fibroadenomas. These occur most commonly in younger women. They are characteristically firm and do not transilluminate or aspirate. Recurrences are common, with as many as five or six recurrences in a single patient. Several Dallas physicians have noticed the frequency of necrosis in preexisting fibroadenomas with the beginning of lactation or in any part of pregnancy.

PAPILLOMAS

Papillomas are, of course, intraductal lesions, and the first symptom is commonly bleeding from the nipple. The discharge from the nipple may also be serous. It is recognized that nipple discharges may accompany inflammatory conditions within the ducts. Many have stated that it is safe to watch such cases until a palpable tumor presents itself, but the study of smears made of breast secretions has somewhat altered this conception. It also has been stated that more than 50 per cent of intraductal papillomas can be cured by a simple operative procedure which involves excision under general or local anesthesia and frozen section. When one can press on a single spot and see that a discharge of a drop of blood comes from a single duct, it has been possible to insert the

eye end of a milliner's needle into the duct and cut down on this to disclose the underlying papilloma, which may be small in size. This technique was used by one of us (F. A. S.) and found satisfactory before it was published by Babcock.[2] The value of smears can be shown best by the findings in 2 cases.

CASE 1.—Mrs. J., a 33 year old woman, had noted a bleeding from the left nipple for two days. She had seen her obstetrician and surgeon. Pressure on the lower inner quadrant of the breast caused a few drops of blood to appear from a single duct at the nipple. The laboratory report on a smear gave the following microscopic description: Sections of this tissue show many clumps of cells which are of large size and have the appearance and arrangement of malignant cells. The diagnosis was carcinoma of the breast. At operation, the milliner's needle was inserted into the duct from which a bloody appearing fluid could be expressed. This duct and all of its ramifications were followed to the periphery of the breast and a wedge excised. Upon excision of this wedge of breast tissue, multiple intraductal papillomas were noted near the periphery of the breast. Frozen section was reported as not malignant, but a permanent section was thought to be necessary; this was reported two days later as papillary adenocarcinoma. Following radical mastectomy there was no evidence of metastasis to axillary nodes.

CASE 2.—Mrs. S. T. D., a 62 year old woman, had a history of discharge and discomfort of the right breast for two months, with recent bleeding. Past history revealed that the patient had had a benign tumor removed from her right breast ten years previously. She had a scar above the areola of the right breast and a thickened narrow area exactly lateral to the areola of the right breast; several drops of blood were expressed from a single duct by pressure on this area. Microscopic examination of this smear showed clumps of cells having an appearance and arrangement suggestive of malignant cells. The pathologist gave the diagnosis: appearance very suggestive of malignancy. The patient had an operation similar to that of the patient in case 1. However, frozen section revealed adenocarcinoma and, following radical resection, the pathologic diagnosis was mucinous adenocarcinoma with six negative lymph nodes.

These cases do not belong in a paper on benign breast tumors but are included to show the value of smears and the fallacy of watching and waiting for a palpable tumor mass.

HYPERTROPHIES

Hypertrophy may be included in a discussion of benign breast tumors. There may be prepuberal hypertrophy in either male or female breasts. Teen-age boys frequently will have a doughnut-like hypertrophy which often is rather sensitive and occasionally embarrassing in size. As a rule these are self-limited and respond to hot applications and observation for a short period of time. Several girls 10, 11, and 12 years of age have been seen to have unilateral hypertrophy usually with a ring of breast tissue with a central depression, and conservatism is warranted in these cases also. Virginal hypertrophies are occasionally massive. Our experience has been limited to 1 case in which plastic surgery was necessary for both physical and psychologic reasons.

Hypertrophy of the male breast is well known as gynecomastia; many of these lesions deserve observation and will regress spontaneously. If there is a question of irregular induration or persistent pain, a simple mastectomy is warranted and can be performed, as a rule, through an incision halfway around the circumference of the areola.

RELATION TO CARCINOMA

The relationship of benign tumors to carcinoma of the breast has been widely considered. Many physicians have seen more than one patient with a breast tumor which had been present for ten to twenty years before a sudden increase in size, accompanied usually by some pain, was noted and the patient was found to have a malignant condition. Most of these malignancies, we believe, have formed in persisting cysts into which papillary projections have grown and malignant changes developed over a period of many years, mostly in the postmenopausal patient. All doctors agree that mastodynia is not related to the development of carcinoma. Geschickter[7] has stated that adenosis was related to the development of carcinoma in approximately 4 per cent of his patients. Again, Geschickter stated that 5 of 445 patients with cystic disease followed for a period of ten years developed carcinoma. In his study at Boston, Warren[17] found that patients with cystic disease had four and a half times the likelihood of developing carcinoma as the average in the state of Massachusetts. Clagett,[4] at Mayo Clinic, reported five times the likelihood in similar cases in the state of Minnesota. Lewison[10] stated that evaluation was a sort of game to consider the transition from normal breast through the intermediate stage to carcinoma and believed the practical approach to be careful clinical follow-up. His studies indicated that 2.6 to 3.6 times the likelihood of developing carcinoma was found in patients with previous benign breast tumors.

The term "premalignant" is one that should be used carefully, and it is believed that simple mastectomy for this so-called condition is performed too often. It is known that 7.5 to 10 per cent of patients with a carcinoma in one breast will develop carcinoma in the opposite breast, and a simple mastectomy of the opposite breast is frequently indicated and should be performed if the breast is massive or questionable nodules are present.

Aberrant breast tissue is almost altogether limited to the axilla; malignant tumors which develop within it are usually highly malignant, and it is a good general practice to advise excision of axillary breast tissue. Massive virginal hypertrophy may be followed by malignant changes, and plastic surgery may be

indicated in these patients. An occasional painful nodular breast which defies other diagnostic procedures may warrant unilateral or bilateral simple mastectomy.

Following the previously mentioned considerations, further evaluation is indicated. It is interesting to note that, after years of intense estrogen administration, the rhesus monkey failed to produce tumors. Another interesting point is that massive and prolonged estrogen therapy in patients with advanced or metastatic breast carcinoma has not been found to develop benign tumors or secondary carcinoma when it is applied in the postmenopausal state. It has been noted that gynecomastia follows estrogen administration for carcinoma of the prostate. Stout[16] reported the finding of chronic cystic mastitis in 74.4 per cent of 1,038 surgically treated breasts and reported the finding of chronic cystic mastitis in 78.5 per cent of 410 patients with carcinoma of the breast. Frantz and her co-workers,[6] in routine autopsies, found chronic mastitis in 53 per cent of the breasts in patients who had not previously had breast problems. Therefore, it is evident that we do not have complete knowledge in regard to the effect of hormones or the relationship of benign breast tumors to carcinoma.

SUMMARY AND CONCLUSIONS

A simple classification of benign breast tumors has been presented. Etiology, diagnosis, and treatment have been discussed, and the relationship of benign tumors to malignancies has been evaluated.

In conclusion, the following recommendations are suggested for practical use:

1. Patients with breast lesions should have regular follow-up checks and also should be instructed in the technique of self examination.

2. Aspiration of cysts of the breast for diagnosis and treatment may be done safely with certain limitations mentioned previously.

3. Microscopic study of smears made from discharges from the nipple is a valuable aid in diagnosis.

4. Aberrant, or accessory, breast tissue should always be excised because of the high incidence of malignant changes.

5. Patients past the menopause with cysts or lumps in their breasts should have biopsies performed.

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Medical Arts Building.

Physicians Earn Less Than $4 Per Hour

A survey made by the Bureau of Medical Economic Research of the American Medical Association of data supplied by 30,000 physicians for a study of 1949 incomes made jointly by the bureau and the United States Department of Commerce indicates that physicians averaged more than 56 hours of work a week, general practitioners more than 60 hours, and some specialists 50 to 56 hours. Distribution of net annual earnings over the number of hours worked, with the number of hours computed according to prevailing practices of large employers in the United States regarding overtime pay, would give an average "hourly wage" for physicians of $3.13 in 1949 and, on the basis of small sample studies of the U. S. Department of Commerce, $3.26 in 1950 and $3.54 in 1951.

Similar computations based partly on a survey by the Bureau of Economic Research and Statistics of the American Dental Association show the average work week of dentists to be 45 hours with the average "hourly wage" for dentists $3.01 in 1949, $3.12 in 1950, and $3.31 in 1951.

These figures are announced in an editorial in the October 2 issue of *The Journal of the American Medical Association.*

Nursing Activities Manual

A publication to aid hospitals in making better use of personnel, entitled "How to Study Nursing Activities in a Patient Unit," has been put out by the United States Public Health Service. A manual offering a method by which hospitals of all sizes may determine how nursing personnel time is distributed between duties requiring nursing skills and those which could be performed by other hospital personnel, the purpose of its publication is to teach administrators how to give nurses more time to be with patients and effectively use their nursing skills.

McWHIRTER TECHNIQUE FOR TREATMENT OF BREAST CANCER

An Appraisal

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THE treatment of breast cancer falls to the surgeon and the radiotherapist, but the problem of breast cancer is shared by every physician. Every physician is a counselor who must answer for his patients and for himself the contradictory views that arise as to diagnosis, prognosis, method of treatment, and effectiveness of treatment.

The role of radiotherapy in the treatment of breast cancer is one point of sharp disagreement. Taylor[8] stated that he was unable to establish that prophylactic irradiation improved the results of operation or decreased or deferred the appearance of operative field recurrences. In reporting on the results at the Massachusetts General Hospital, he stated that when there was no axillary involvement, about 75 per cent of the patients were cured at five years, but when there was axillary involvement, the cures were about 33 per cent. McWhirter,[5, 6] observing the same disease, challenged the usefulness of radical mastectomy. He argued that if disease was localized to the breast, radical mastectomy was unnecessary. If axillary metastases were present, then the axillary dissection of radical mastectomy was not conspicuously successful because the cure rate dropped from approximately 70 per cent to 30 per cent despite the dissection of axillary lymph nodes. He reasoned that simple mastectomy and radiation of the lymphatic drainage areas would do as well.

In 1941 in southeast Scotland a program was undertaken in which a treatment policy for breast cancer would be simple mastectomy plus a rigidly prescribed and executed course of postoperative radiotherapy.[5] The five and ten year results of this program are now available and compare favorably with the results of radical mastectomy (table 1).

TABLE 1.—*Five and Ten Year Results of Treatment of Breast Cancer by Radical Mastectomy and by Simple Mastectomy and Radiation.*

	Absolute Survival Rate			
	5 Years		10 Years	
Treatment	No. Patients	%	No. Patients	%
Radical mastectomy (Haagensen[1])	668	47.2	None available	
Simple mastectomy and radiation (McWhirter[6]) .	1,882	42.0	480	25.0

The absolute survival rate is preferred for comparing the effects of treatment in different institutions. It is based upon all the primary cases of breast cancer that are seen, early or late, operable or too advanced for any form of treatment. All survivors are counted whether they are treated or not. Although each institution is apt to have a dominant treatment policy, it is obvious that not all patients will be eligible for a single form of treatment. The absolute survival rate, therefore, compares the course of the disease in different centers as it is influenced by the treatment policy of the institution. If one were to deal only with patients selected for a given form of treatment, the criteria for selection could not be uniform from one center to another and the effect of treatment could not be compared directly.

In studying the survival figures as a measure of the effectiveness of treatment, it should be remembered that no author intentionally implies that all survivors are living solely as the result of treatment or that all living patients would be dead had they not been treated. The natural duration of breast cancer is subject to extreme variation. We are all aware of reported instances of patients living for twenty years or more without treatment, and many physicians have personal knowledge of treated but uncured patients who lived ten years or more. It must be concluded, therefore, that some patients in any group of survivors would have survived even without treatment.

Any unselected series of consecutive patients could be divided into three groups. Group A would be those with disease confined to the breast. For these patients, cure should be possible either by simple or radical mastectomy. Group B would be those patients with metastatic disease limited to the accessible axillary lymph nodes. Group C would be those patients with more distant spread of disease in whom cure by any method of treatment would not be a reasonable goal.

If there is any difference in the adequacy of surgical dissection and radiation in the treatment of axillary metastases, it is the survival of patients in group B that could be influenced by the choice of treatment.

Since survival rates under the two treatment policies do not show a significant difference, one might conclude that either the methods are equally effective

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or group B is so small that any difference in effectiveness is not evident in over-all survival.

Recent work by Handley,[2, 3] by Wangensteen,[9] and by McDonald, Haagensen, and Stout[4] has shown a previously unsuspected incidence of metastases in the supraclavicular and internal mammary regions. Many patients, formerly believed to have localized disease, must be placed in the inoperable group due to distant spread. Handley's results,[3] shown in table 2, were based on an investigation of operable patients. Approximately one-half the patients with axillary metastases also had metastases in internal mammary lymph nodes.

TABLE 2.—*Incidence of Metastases to Internal Mammary Lymph Nodes as Reported by Handley.*[3]

	Incidence (%)
No axillary metastases found	9
Axillary metastases found	48
All operable cases	34
Primary in inner half of breast	74
Primary in outer half of breast	27

On the basis of clinical findings, group B is represented by those patients in whom axillary lymph nodes are palpable. For this group, McDonald, Haagensen, and Stout[4] recommended in a 1953 report the "triple biopsy" prior to radical mastectomy. In their procedure the diagnosis is confirmed from the primary lesion, and if metastases are found in either the supraclavicular or internal mammary region, the patient is not eligible for radical mastectomy. Of the first 13 patients so investigated, 8 had metastases in both sites. This suggests that group B (those patients with metastases limited to the axilla) may be small. The group will be even smaller than indicated because the recognized metastases must, of course, be large enough for the pathologist to find. The incidence of metastases increases with painstaking dissection and with serial sections of lymph nodes,[7] but there must always remain the earliest metastasis which is too small to find. We come to the conclusion, then, that whenever axillary lymph nodes are positive for metastatic cancer, there is a high likelihood of more distant spread of disease.

BASIS OF COMPARISON

In weighing the merits of radical mastectomy versus simple mastectomy with radiation, these features must be considered:

1. Both are forms of treatment limited to the chest wall and the regional lymphatics.

2. Outcome, in terms of survival, depends on the extent of the disease at the time of treatment rather than upon treatment itself.

3. Treatment methods should be evaluated and compared on a basis of control of the disease in the treated area.

Treatment methods are compounded of knowledge of the natural course of the disease, development of technical skills, and analysis of the effects of treatment.

There are always two approaches to treatment of disease. One is to act upon the conclusions from past experience and attempt to equal accepted standards; the other is to test the validity of these conclusions by modifying techniques in an attempt to improve on accepted standards.

Radical mastectomy is an example of the first approach to treatment of carcinoma of the breast and remains the accepted form of treatment for operable breast cancer. However, the work of Handley,[2, 3] Wangensteen,[9] and McDonald, Haagensen, and Stout[4] represents new knowledge of the natural course of the disease and McWhirter's work is the development of an alternate technique of treatment which is apparently equally effective. The application of the McWhirter technique for the treatment of breast cancer is an example of the second approach to treatment.

McWhirter's evidence may be tested justifiably in the following circumstances:

1. When patients are poor operative risks because of age or competing disease.

2. When breast cancer is inoperable by the strictest application of the criteria of operability. Haagensen's criteria of operability[4] have been revised recently to exclude those patients who are discovered by the triple biopsy to have occult metastases in the supraclavicular region or internal mammary chain. There will be an appreciable number of patients in this category who were formerly eligible for radical mastectomy and may now properly be offered treatment by the McWhirter technique.

3. When the control of the primary lesion is important to the management of a patient, even in the presence of limited distant metastases.

If the McWhirter technique is applied in the circumstances outlined, experience will be gained in the technical aspects of the method. An appraisal of the usefulness of this approach cannot be made on a basis of survival rate because the favorable cases have been selected for radical mastectomy. Even in the unfavorable circumstances which have been recommended for testing the technique of simple mastectomy and radiation, there is a practical basis for testing its merit. This would include control of the disease on the chest wall and in the axillary and supraclavicular drainage areas; mortality and morbidity; anatomic defect; late sequelae, for example, lymphedema or radiation injury; and functional impairment.

These are the direct and observable effects of any treatment for breast cancer. They are equally applicable for the evaluation of the McWhirter technique

of simple mastectomy and radiation, the conventional radical mastectomy, or the so-called super-radical mastectomy now being carried out in some centers. These aspects have not been critically analyzed for any series of breast cancer treated by any method.

Available information indicates that because of the nature of the disease, no marked difference may be expected in the survival rates associated with any form of treatment. The direct and observable effects of treatment that have been outlined represent data yet to be collected before the relative merit for different methods of treating breast cancer can be determined.

SUMMARY

Survival statistics for patients treated by simple mastectomy and radiotherapy compare favorably with those treated by conventional radical mastectomy. The basis for establishing the relative place of these two methods of treating breast cancer requires a critical analysis of the direct and observable effects and complications of the two methods. This information is not yet available.

At present, radical mastectomy is the accepted form of treatment for favorable cases of breast cancer. Its proper application requires strict observance of criteria of operability which were designed to offer reasonable assurance that disease is still localized to breast and surgically accessible lymph nodes. When radical mastectomy was the only form of treatment, compassion sometimes influenced judgment and patients unsuitable for radical surgery were subjected to futile operation. Simple mastectomy and radiation are now sufficiently well established to merit serious consideration. The method might justifiably be tested in a group of patients who are shown to be ineligible for radical mastectomy. Experience with the local effects of the method will provide a basis for determining the ultimate role of the McWhirter approach to the treatment of breast cancer.

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MORTALITY AT SCHOOL AGES DECLINES

Extraordinary gains have been made over the past twenty years in reducing mortality at the school ages, statisticians of the Metropolitan Life Insurance Company report. In the experience of the insurance company's industrial policyholders at ages 5 to 14 years, the death rate for boys dropped nearly two-thirds, from 158 to 57 per 100,000 between 1933 and 1953, and the rate for girls has declined even more sharply, from 126 to 37 per 100,000.

In each sex decreases of 85 per cent or more were recorded over the twenty year period in the death rates for a number of diseases, including the principal communicable diseases of childhood, appendicitis, pneumonia and influenza, and tuberculosis.

Despite this progress, there are still about 15,000 deaths among children at school ages in the general population of the United States, and a considerable part of the loss of life is amenable to control, according to the statisticians.

Accidents are the greatest single menace to child life, accounting for more than two-fifths of the total mortality among boys, and for more than one quarter of the mortality among girls. Second in rank as a cause of death are the cancers, which twenty years ago were a minor cause of death at the school ages. The leukemias account for nearly a half of all the deaths attributed to malignancy among school-age children.

Although spectacular progress has been made in the control of the infectious diseases, they are still responsible for an appreciable loss of life among children. Pneumonia and influenza, and acute poliomyelitis continue to be among the leading killers at ages 5 to 14, but the death toll from these diseases varies from year to year with their prevalence and virulence.

NEW PORTABLE RESUSCITATOR

A resuscitator that can be used anywhere from a dentist's office to a battlefield has been developed while researchers at Western Reserve University and the University Hospitals of Cleveland were working on a small oxygen inhalator for use in hangover treatment of acute alcoholism, Dr. Robert A. Hingson, Cleveland, said in the October 9 *Journal of the American Medical Association.*

The device, without tanks attached, weighs about 17 ounces and can be held in the palm of one hand; it has a rubber face mask, a rebreathing bag, and two aluminum arms to contain gas or oxygen cylinders.

Dr. Hingson said that the pocket-size resuscitator could be used by patients with heart trouble, by passengers of planes at high altitudes, and by police and firemen in drowning accidents, mine explosions, fires, and other suffocation emergencies. He said that the device could be dropped undamaged from a plane without a parachute to forward positions on the battlefield and in disaster areas.

The smallest such unit now in use weighs 40 pounds; the new device weighs only 2 pounds, including gas or oxygen cylinders, and could be used even as a gas mask for twenty minutes to an hour during evacuation from dangerous areas of smoke, poison gas, or incendiary explosives, he stated.

RADIATION THERAPY IN MANAGEMENT OF THE LYMPHOMAS

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A DISCUSSION of the lymphomas (exclusive of leukemias) is necessarily a broad subject. To be more meaningful to the practitioner it would seem that problems relating to diagnosis are of equal importance with those of treatment. Rather than describing technicalities in the management of lymphomas by irradiation, this presentation emphasizes a discussion of problems referable to diagnosis and to treatment as they relate to certain of the pathologic and clinical forms of the disease.

In a group with as widespread manifestations as exist with the lymphomas, one finds varying opinions and practices regarding methods of irradiation or the use of chemotherapy. The views expressed herein are those which result from fifteen years' experience in the management of the lymphomas in the Tumor Institute of the Swedish Hospital. They are experiences which we as a group have accumulated and from which we have evolved our present methods of management.

Finally, to bring so large a subject into sharper focus, it may be more instructive to discuss a limited number of problems than to attempt a general survey lacking in direct clinical application.

Pathologically, we are speaking of the lymphomas as a group comprised of Hodgkin's disease, lymphosarcoma, and giant follicle lymphoma. For purposes of discussion here it is not important to differentiate further between the separate pathologic varieties of Hodgkin's disease or lymphosarcoma, as there seems to be little correlation between the pathologic subdivisions in either and their radioresponsiveness or prognosis. It is important, however, to differentiate by microscopic confirmation whenever possible whether one is dealing with Hodgkin's disease, lymphosarcoma, or giant follicle lymphoma because the treatment, radiosensitivity, and more particularly, the natural history have important dissimilarities. The diseases are similar, however, in that they mask or simulate so many other pathologic states and may be so bizarre in signs and symptomatology that in many instances the problems of diagnosis are in themselves extremely puzzling. Whereas one or more decades ago syphilis found its way into the list of those diseases to be excluded in not too obvious diagnostic problems, its place may now be taken by the lymphomas. In our experience they affect all ages and may be manifest to varying degrees in all important organ systems to produce at times an Oslerian problem in differential diagnosis. Fortunately the pathologist often can resolve the problem if only the physician thinks of the lymphomas as possibly the underlying disease state and can furnish him the material for pathologic study.

From the Tumor Institute of the Swedish Hospital.
Read before Section A (Medical), Texas Medical Association, Annual Session, San Antonio, May 5, 1954.

HODGKIN'S DISEASE

Patients with Hodgkin's disease in whom the initial manifestation is lymphadenopathy limited to a single regional group of lymph nodes seem to be in the minority. When such a finding results and careful clinical and roentgenologic examination gives no evidence of other demonstrable involvement, the patient receives roentgen therapy directed to the regional lymphadenopathy.

It is our aim to give sufficient irradiation to produce permanent arrest of the local process. In our experience one cannot be certain of this short of a dose of 3,500 r minimum delivered to the tumor-bearing area in three to four weeks. There are also those in whom larger doses are required for local arrest of growth. The majority of such patients eventually will have progression of the disease in other superficial or deep lymphatics, or later will succumb by invasion of the important organ systems. Yet the time factor for this progression of events cannot be predicted at the outset with any certainty. We have seen rapidly lethal Hodgkin's disease, and also have seen patients who have been in a relatively good and efficient state of health over several years before impairment becomes serious. There are those few and unpredictable patients in any large group who survive (perhaps with their Hodgkin's disease) for long periods and seemingly have no symptomatic reappearance. In our material there are 3 patients, all with cervical and mediastinal disease, who have survived for ten or more years.

It is for reasons of unpredictability that we heavily irradiate the more localized Hodgkin's disease, and particularly that appearing as cervical, axillary, or mediastinal lymphadenopathy. When the disease as first seen involves the abdomen, bone, retroperitoneal, or pelvic lymphatics, the prognosis is less favorable for long survival. If, however, the general condition of the patient is reasonably good and without evidence of severe bone marrow replacement, then if

one hopes to obtain any kind of worth-while palliation, irradiation still must be carried to a dose within the diseased tissues which is sufficiently great to produce freedom from major complaints from the irradiated region. Otherwise maximum benefits of irradiation are not obtained. Resorting to reirradiation at a later time is usually not helpful, although we have done so successfully to accomplish local arrest in a few cases when initial irradiation had been inadequate, either in dose or in volume of tissue irradiated.

With certain exceptions to be mentioned later, we have continued the use of external roentgen-ray therapy as the primary therapeutic agent when the disease clinically advances to involve other lymphatic areas and is producing symptoms which are important to the patient's welfare. We do not always attempt to irradiate all scattered lymphadenopathies if certain of these are asymptomatic. Realizing that the patient will require more irradiation as time goes on, we prefer to spare him the injury to hemopoietic tissues and use roentgen therapy when one or another focus becomes symptomatic. We do so with the realization that in other than Hodgkin's disease which is seen in a stage involving a single or at the most contiguous lymphatic areas, the process eventually and inevitably will become more generalized. So-called "prophylactic irradiation" to regions as yet uninvolved or to asymptomatic or to nonprogressing adenopathies wastes both the patient's recuperative reserves and the roentgen therapy which may be needed later for more important infiltration. We see no detriment to the patient in regularly observing quiescent lymph nodes and treating them when enlargement becomes important. Following this course we have used roentgen therapy to cause sufficient local regression of fossae as they have become clinically important to

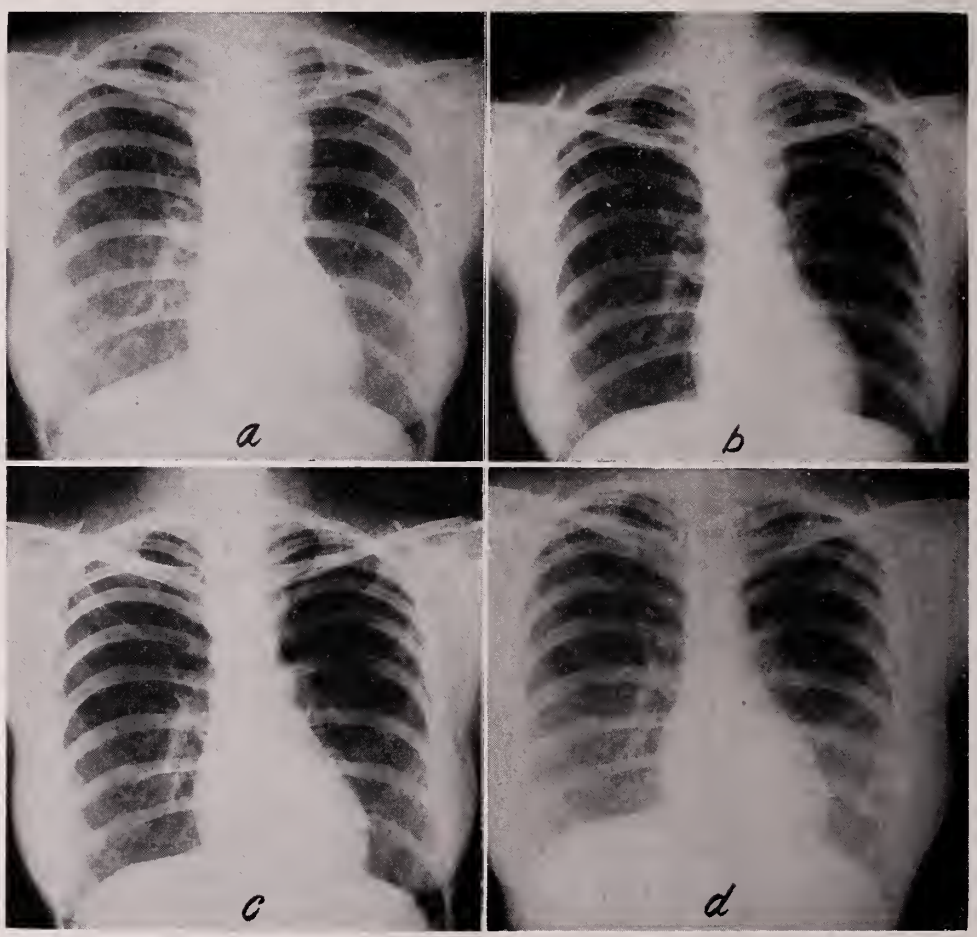

FIG. 1a. Mediastinal lymph node enlargement associated with bilateral supraclavicular lymphadenopathy was discovered on preemployment examination of a 33 year old woman. The original lesion as of March 7, 1945, is pictured. Biopsy revealed Hodgkin's disease. Roentgen therapy, 2,500 r to the mediastinum, was given in twenty-seven days.

b. A roentgenogram made August 8, 1945, showed the hilar mass to be regressing.

c. One year after irradiation, February 2, 1946, gradual regression was apparent. No irradiation to the neck was administered until 1950, when 3,500 r to the left cervical region in fifteen days was given because of an enlarging cervical lymph node.

d. A roentgenogram made March 24, 1951, indicated that the patient was well. She remained so to 1954.

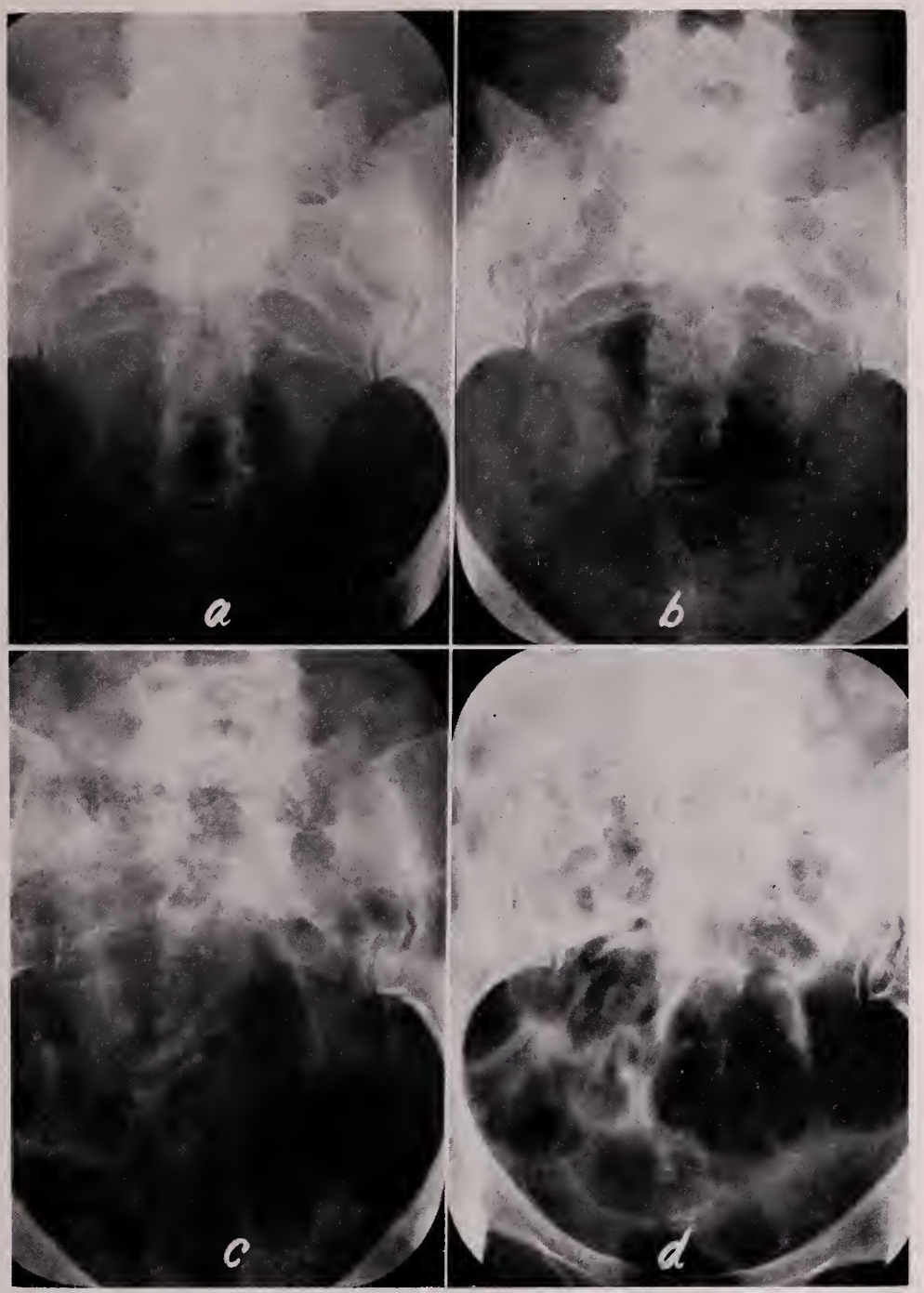

FIG. 2a. A woman aged 42 was seen originally in 1944 with massive bilateral cervical and axillary lymph nodes. The condition was diagnosed as Hodgkin's disease. Radiation therapy was given to the cervical disease in 1944 and to a mass in the left part of the pelvis in January, 1945. The pelvis was asymptomatic in 1944 when this roentgenogram was made.

b. Swelling and pain in the right sacroiliac region was evident when a roentgenogram was made June 29, 1948, and destruction of bone in the right upper sacrum had begun.

c. Spinal fusion was done by a surgeon unaware of the presence of Hodgkin's disease, and he found bone destruction, as evidenced in the roentgenogram made September 15, 1948.

d. This roentgenogram was made December 8, 1948, following spinal fusion and roentgen irradiation to the right sacral focus with bone regeneration. The patient died in 1949 of uremia of Hodgkin's disease.

carry a number of patients for a period of years before irradiation is no longer useful.

In the irradiation of every patient with Hodgkin's disease due attention is given to maintaining the general condition of the patient. Nutrition, weight, status of the blood, fever, sweating, and pain are all to be queried, observed, and treated as they bear directly on the ability to sustain adequate irradiation locally as well as being signs of possible further spread of disease which one is not at the time treating.

The only agents other than roentgen rays which currently have any place in the treatment of Hodgkin's disease are systemic irradiation by radioactive substances, primarily radioactive phosphorus, and the use of chemotherapy in the form of the nitrogen mustards. We have had little experience with radioactive phosphorus, but in those more advanced states wherein it has been used, its effects have not been as satisfactory as the nitrogen mustards. Radioactive colloidal gold or chromic phosphate can be useful, how-

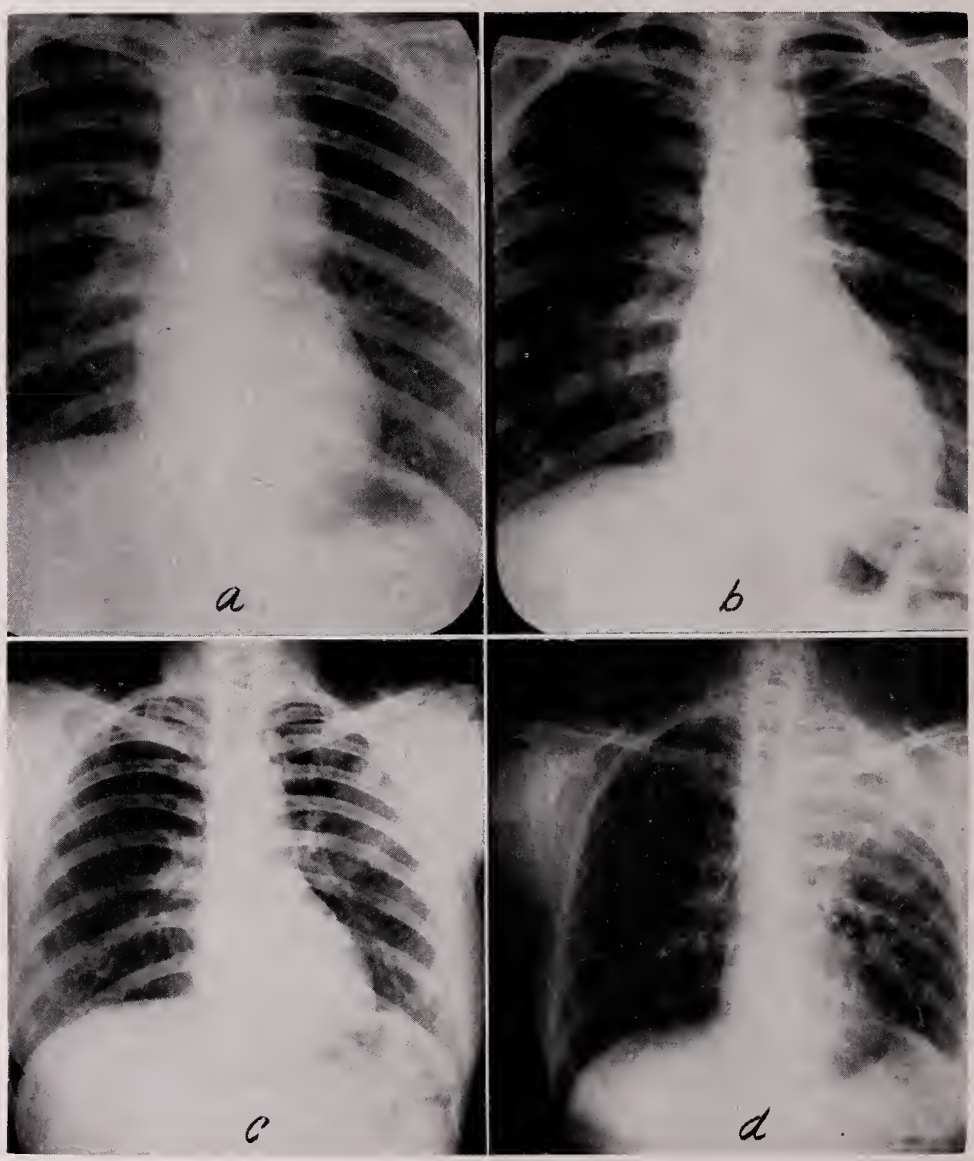

FIG. 3a. A woman aged 22 was seen in February, 1949 (roentgenogram made February 9), with bilateral cervical and mediastinal lymph node enlargement. Hodgkin's disease was diagnosed. Roentgen therapy was administered, 2,800 r to the midmediastinum in thirty-seven days.

b. A roentgenogram of the chest made April 28, 1949. Irradiation, 3,900 r, was directed to an enlarging right cervical lymph node in 1951.

c. The patient became asymptomatic and lymph node enlargement disappeared. A follow-up chest roentgenogram made October 22, 1953, showed soft infiltration of the left upper lung parenchyma. Tuberculosis was excluded.

d. A roentgenogram made April 16, 1954, showed progressive infiltration with probable atelectasis. Bronchial fixation encountered in bronchoscopy and failure of filling of the left upper bronchus was believed to be due to probable obstruction from hilar lymph nodes. The patient in 1954 was still asymptomatic except for generalized pruritus.

ever, in significantly reducing the pleural effusions due to pleural infiltration by Hodgkin's disease.

Although our primary resource is external roentgen therapy, we have used nitrogen mustard in selected cases and found it helpful. In this work we have been assisted by Dr. James Crosbie. In general, preference has been given to nitrogen mustard administered intravenously rather than to triethylene melamine given orally. The intravenous route is for certainty of dosage and prompter effect.

Chemotherapy has been used under the following conditions: (1) When roentgen therapy is no longer useful because of a disease too widespread for irradiation, or in previously heavily irradiated regions with infiltration and fibrosis, nitrogen mustard may help. The general condition of the patient, and particularly his blood, must be able reasonably to support the toxic effects of nitrogen mustard, or by transfusions the blood must be brought to levels which support the drug's use. (2) In patients who either initially or later present the clinical picture of anemia secondary to bone marrow replacement by Hodgkin's disease or associated hemolytic anemia, provided they have sufficient blood and supportive agents, nitrogen mustard may cause a temporary improvement in the anemia with resulting benefit to well being. (3) The intractable itching of Hodgkin's disease may be relieved for varying periods by nitrogen mustard. Some

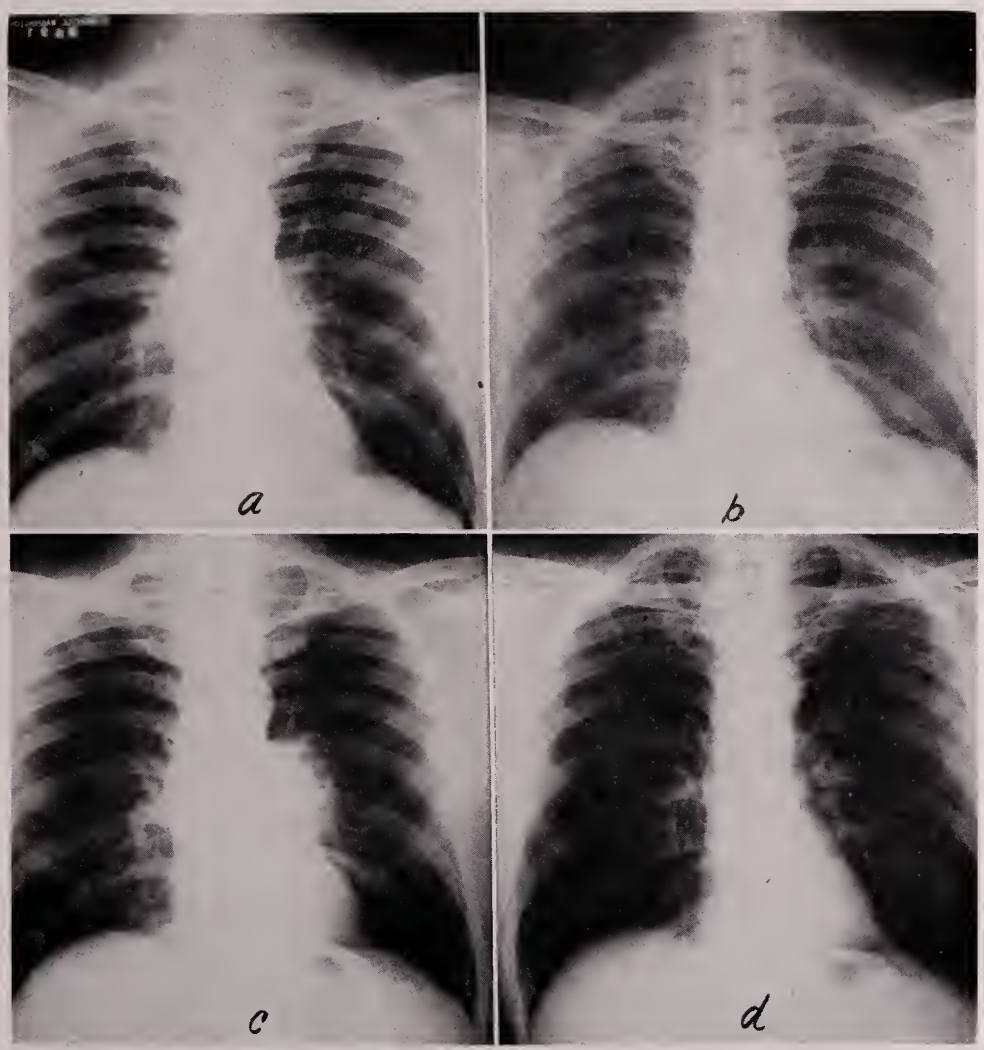

FIG. 4a. A 49 year old man had had bilateral supraclavicular swelling with enlarged lymph nodes for two months prior to November 6, 1950, when this roentgenogram was made. His general condition was good; no anemia was evident. Bilateral hilar lymph node enlargement was diagnosed as Hodgkin's disease upon biopsy of one of the nodes which was removed. Radiation was administered bilaterally to the cervical regions, 3,750 r to each, and to the midmediastinum, 3,250 r, over a period of thirty-eight days.

b. Roentgenogram of the patient's chest December 27, 1950. His general condition was excellent; there was no clinical evidence of disease.

c. By August 7, 1951, the patient still was asymptomatic, but a chest roentgenogram showed a large area of disease in the previously irradiated left hilar area. An additional 4,300 r was directed to the midmediastinum.

d. Roentgenogram made April 27, 1954, at which time the patient's general condition remained excellent and no clinical evidence of disease had appeared.

patients' relief is only temporary but may be sufficiently long to warrant use of the agent, particularly when the pruritus is generalized. Roentgen therapy in minimal dosage to the nodular cutaneous infiltrations of Hodgkin's disease also can relieve the localized itching. Generalized pruritus also at times may be relieved by irradiation of deep infiltrations. Chemotherapy offers a more prompt relief, and we have used it before irradiation of localized and symptomatic infiltrations to give the patient respite from sleeplessness and continued irritation of the pruritus. (4) We have used chemotherapy in parenchymal pulmonary infiltrations, but usually with no more than temporary regression of pulmonary fossae. (5) The fever associated with generalized Hodgkin's disease often can be promptly reduced by nitrogen mustard. In such patients we have used it as a preirradiation measure with considerable improvement of the general condition and ability to support roentgen therapy.

It has been our observation that the responsiveness of Hodgkin's disease to nitrogen mustard is shorter lived than to adequate irradiation.

Pain is often a symptom in Hodgkin's disease, and its cause is not readily found by clinical examination alone. Involvement of bone is common and at times may be seen by roentgen examination. As in the common cancer metastasis to bone from breast the pain may long precede roentgenologic evidence of bone disease, and radiation has been given for pain presumed to be in bone when clinical signs point to this. The appearance of bone invaded by Hodgkin's disease is usually that of destruction. However, it may simulate other forms of bone malignancy, both osteolytic and osteoblastic. We have seen spinal fusions done for "back pain" which in reality represented Hodgkin's disease of the vertebrae and could have been diagnosed as such by more careful clinical appraisal. Flank or abdominal pain associated with paravertebral and retroperitoneal pressure from Hodgkin's disease cannot always be demonstrated by palpation or by roentgenologic examination. Gastrointestinal and renal roentgen-ray studies may be helpful in demonstrating displacement of stomach, bowel, or ureter. Pain is at times the first manifestation of Hodgkin's disease, and the diagnosis is made only at laparotomy. In a patient with known Hodgkin's disease such pain usually can be relieved by adequate irradiation to paravertebral and retroperitoneal structures.

Thoracic involvement is most commonly mediastinal lymph node enlargement. Its progression may be slow and even at times asymptomatic. Respiratory embarrassment, however, may become rapidly progressive and call for prompt but cautious irradiation of the mediastinum. The complications are those due to pressure, producing pain and obstruction to the great vessels. Edema of the supraclavicular fossae and later neck, producing the Stokes color associated with severe dyspnea and venous dilatation, is not uncommonly seen. Deviation and compression of the trachea simulating cancer of the thyroid or lung may be noted. Esophageal obstruction by external pressure is likewise seen. Bronchial obstruction with atelectasis may result in a problem simulating cancer of the lung, chronic bronchiectasis with abscess, or tuberculosis. Of interest is the absence of vocal cord paralysis from recurrent laryngeal involvement, as is commonly seen in cancer of the lung and thyroid. Pleural effusion may result either from pressure or pleural infiltration.

In the absence of peripheral lymphadenopathy from which to secure a lymph node for microscopic study, and if the patient is not acutely dyspneic, we prefer to know the pathologic nature of the mediastinal lymph nodes whenever possible. In such a patient a lymph node usually can be secured by the simple surgical procedure of entering the superior anterior mediastinal space through the supraclavicular fossae. Even small lymph nodes of not more than 1 cm. in size so obtained have proved diagnostic. When the patient is acutely dyspneic and no peripheral lymph nodes are removed, we proceed with roentgen-ray therapy and attempt to judge the nature of the adenopathy by the degree of response to irradiation. In general the most responsive are the lymphatic leukemias (in an aleukemic phase diagnosis cannot always be made from blood or bone marrow); the giant follicle lymphomas are the most responsive of the lymphoma group other than the leukemias. Usually lymphosarcoma requires more irradiation than giant follicle lymphoma, but less than Hodgkin's disease. It is rare that later in the disease's course the opportunity does not present to secure tissue for pathologic examination from an accessible lymph node if this has not been possible prior to irradiation of the mediastinum.

Mediastinal involvement by the nature of its visibility by roentgen-ray examination affords a good opportunity to judge both the degree of response and the dose of irradiation required to reduce regression. In treating abdominal and retroperitoneal infiltration one cannot see and follow the results so readily, and the response must be judged by clinical evidence unaided by visualization. This has caused us to re-treat reappearing mediastinal enlargement as long as one year after an initial dose in the mediastinal tumor in excess of 3,000 r, and by addition of 3,000 r to 4,000 r in the mediastinum by the second series. Supervoltage roentgen therapy (800 kilovolts) has per-

mitted us to do this without injury to skin or lung. It can be done with 200 to 400 kilovolts through the selection of appropriate fields of irradiation. These experiences have caused us to use greater doses initially than are more commonly advocated in the irradiation of Hodgkin's disease. We likewise have learned that, unless the whole of the mediastinum is irradiated, there is a likelihood of reappearance of lymph nodes peripheral to the irradiated volume.

We have not successfully irradiated parenchymal pulmonary infiltration of Hodgkin's disease and its associated atelectasis. In 2 patients in whom this was attempted after the failure of nitrogen mustard, both had rapid generalization of the disease, of which the pulmonary involvement was clinically prominent. In neither did it significantly alter the course.

Gastrointestinal manifestations of Hodgkin's disease are important entities. The sites of predilection are gastric and ileocecal. Although the diagnosis of Hodgkin's disease of the stomach at times may be made by roentgenologic methods and aided by gastroscopy, the findings are usually those of exploratory laparotomy. A thick-walled, edematous stomach, with or without associated regional lymph nodes, should cause suspicion of a lymphoma and lead to visualization of the lumen of the stomach at surgery. Exten-

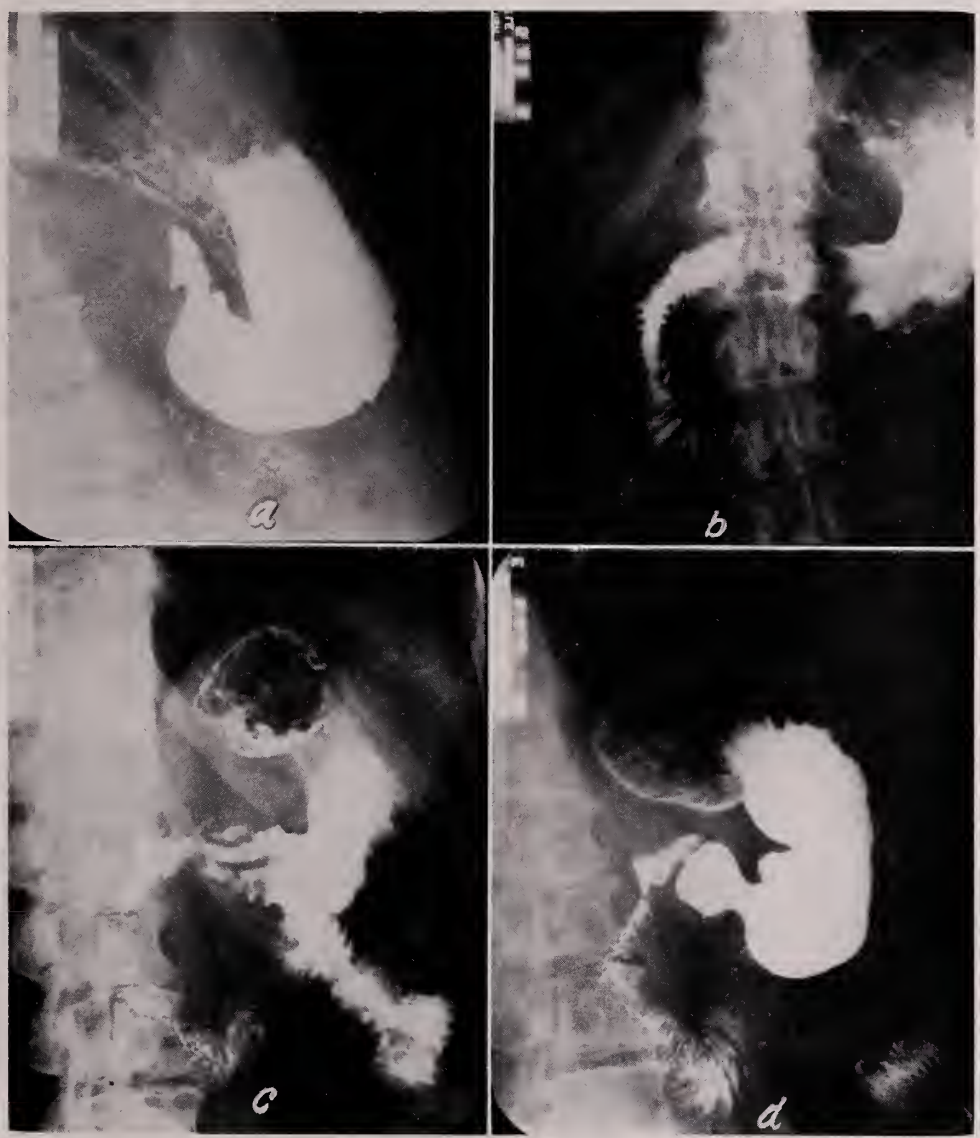

FIG. 5a. Prelaparotomy roentgenogram (May 11, 1948) of a patient thought to have gallstones.

b. Roentgenogram made June 9, 1948, after the laparotomy and after Hodgkin's disease of the stomach had been established by biopsy of tissue removed at operation.

c. A postirradiation film made December 21, 1948.

d. Another postirradiation roentgenogram made October 9, 1951. The patient continued in 1954 to be well after 4,500 r of supervoltage irradiation to the stomach.

sive submucosal infiltration with minimal ulceration may be noted. Tissue from the stomach and regional lymph nodes should be secured for examination. The pathologist may be able to confirm the diagnosis by frozen section. Patients with both Hodgkin's disease and lymphosarcoma of the stomach have lived for long periods following gastrectomy when other regional involvement was not present. Depending upon the degree of extragastric disease and the general condition of the patient, one may elect to do a gastrectomy alone or to follow gastrectomy by regional irradiation.

In 1 such patient examined surgically for gallstones (fig. 5) diagnosis of Hodgkin's disease of the stomach was made by tissue removed for study. At surgery no other lymphatic or hepatic lesion was noted. The patient refused gastrectomy and now is asymptomatic after six years following roentgen therapy alone. A dose of 4,500 r to the stomach was given without complication other than transitory leukopenia. This was done with supervoltage irradiation. Nitrogen mustard in 1 case of Hodgkin's disease of the stomach associated with disease in the liver gave only transitory palliation.

We have not accomplished complete arrest of disease in ileocecal Hodgkin's disease discovered at surgery. The few cases we have seen were associated with abdominal lymphatic spread. Surgical resection (usually for intussusception or obstruction) followed by irradiation has given limited palliation.

In summary, Hodgkin's disease is ubiquitous and should be regarded as such. In its treatment by irradiation our aim is to produce arrest of local regional infiltration whenever indicated by the symptomatology and in the absence of demonstrable generaliza-

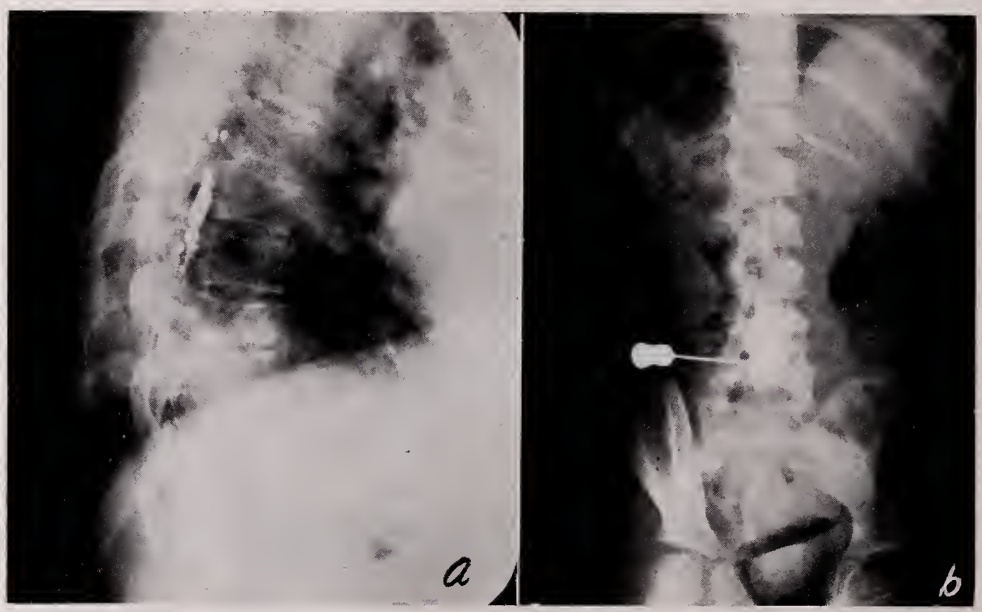

FIG. 6a. Myelogram showing complete blockage in a 59 year old man who had suffered pain in the lower dorsal spine for three months and then sudden loss of motor activity in the lower extremities. Laminectomy was performed; destruction of the involved vertebral segments with extramedullary lymphosarcoma was evident. The patient died suddenly from pulmonary embolism.

b. A child 4 years of age had a tumor of the soft parts in the lower lumbar region which was diagnosed as lymphosarcoma. Two weeks postoperatively the patient developed paralysis of the lower extremities. A myelogram showed complete block. Cord compression was not relieved by roentgen therapy (2,900 r in two weeks). Laminectomy was performed and intraspinal lymphosarcoma observed contiguous with the originally noted lumbar mass. The patient died from pulmonary metastasis five months after onset of the disease.

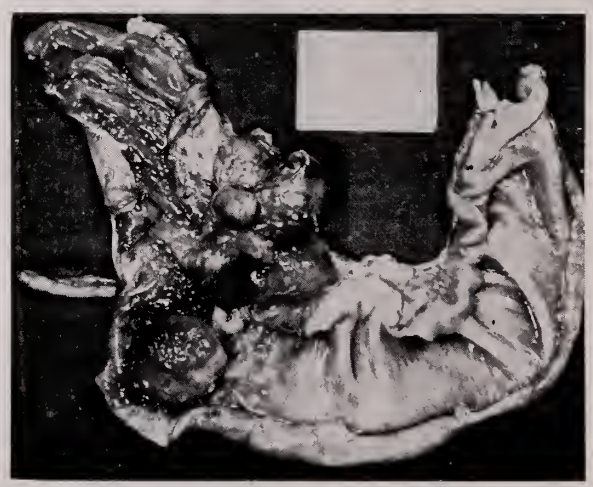

FIG. 7. Acute intussusception of the terminal ileum was observed in a 7 year old child in 1947. Resection of the tumor in the ileum and where it was invading the cecum and of the regional mesentery containing lymph nodes was done. Complete resection of all the gross regional lymphadenopathy was not attempted. Lypmphosarcoma of the ileocecal region with lymphosarcoma in some of the resected lymph nodes was diagnosed. No irradiation therapy was given. The patient was well and asymptomatic in 1954.

tion. When the disease has advanced to involve more than one or contiguous regions, irradiation judiciously used may keep the patient in a reasonably efficient state for periods of several years. There are those who may survive for long periods seemingly controlled. In our experience chemotherapy is a useful adjunct to irradiation, and particularly in cases presenting fever, itching, or anemia or when irradiation is no longer applicable.

LYMPHOSARCOMA

Lymphosarcoma is perhaps more capable than Hodgkin's disease of involving any or all tissues and thus producing clinical manifestations of all degrees of complexity. Although Hodgkin's disease may be seen in childhood, lymphosarcoma is more common than Hodgkin's disease in the early ages. It lacks the phenomenon of pruritis associated with Hodgkin's disease, yet in all other respects it may be clinically indistinguishable. Unlike Hodgkin's disease, it is seen in the accessory nasal sinuses, nasal pharynx, tonsil, and base of tongue—all sites rich in lymphoid tissue. Like Hodgkin's disease, it is found in the stomach and ileocecal region as an apparent primary focus. We have encountered lymphosarcoma infiltrating the rectum and clinically simulating cancer of the rectum. It responds readily to external irradiation with relief from bleeding, pain, and debilitation. That these are not all simple rectal lymphoid hyperplasia is evidenced by 2 cases with other organal involvement by lymphosarcoma. In 1 the initial diagnosis was made at laparotomy for splenectomy, and the other patient later succumbed to gastric lymphosarcoma. In these cases the rectal involvement is no doubt a magnified picture of lesser (or perhaps only hidden) disease throughout the gastrointestinal tract.

Certain forms of lymphosarcoma are relatively benign, as for example the lymphosarcoma of the parotid and lacrimal glands. Lymphosarcoma of the skin (lymphoma cutis) may be relatively benign for long periods. The entity of mycosis fungoides, responsive as a cutaneous manifestation to roentgen-

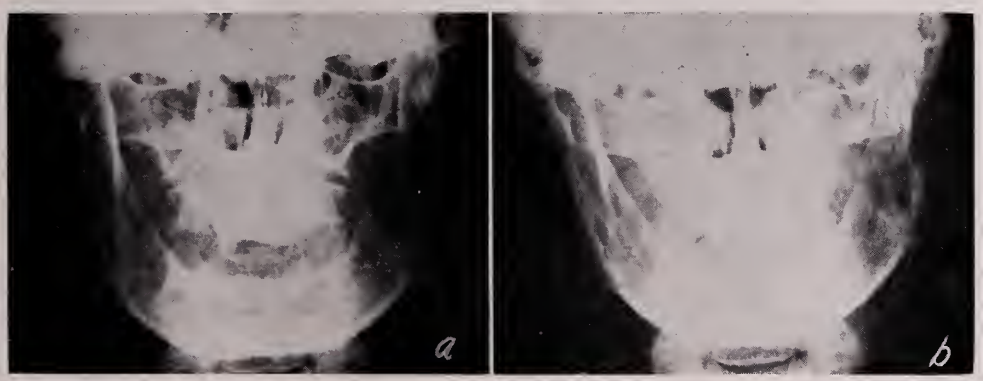

FIG. 8a. Lymphosarcoma of the mandible, evident in the roentgenogram made August 14, 1942, was the presenting disease.
b. This roentgenogram made February 2, 1943, showed bone healing after irradiation. The patient developed lymphosarcoma of the ileum six months later, however, and although this lesion was resected, he died April 4, 1943.

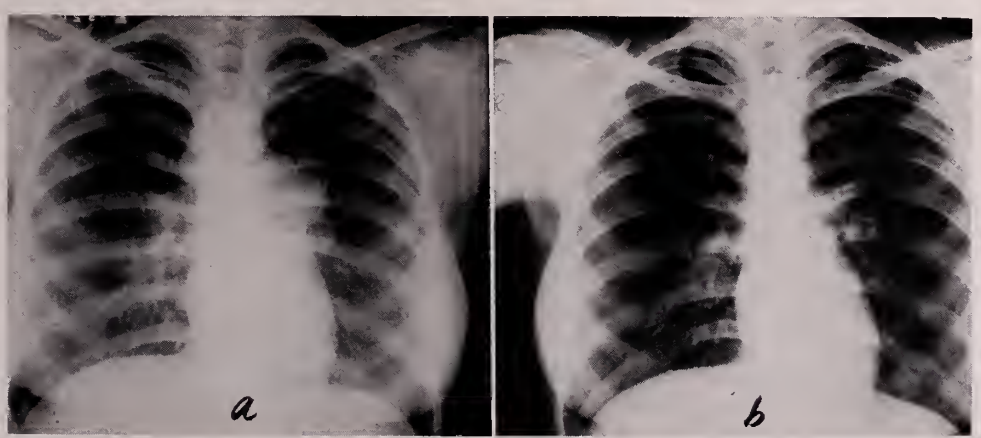

FIG. 9a. Roentgenogram made of a 16 year old girl July 21, 1952, and revealing an entirely asymptomatic mediastinal lymph node enlargement. No peripheral adenopathy, anemia, or other signs were observed. Biopsy of a lymph node obtained from the anterior superior mediastinum was diagnostic of lymphosarcoma. Roentgen therapy, 3,150 r to the midmediastinum, was administered during forty days.
b. The patient was well and without clinical evidence of lymphosarcoma when this roentgenogram was made April 8, 1954.

irradiation, invariably ends by generalized involvement of visceral organs. In other respects lymphosarcoma may be rapidly malignant by widespread infiltration of important visceral organs. In the more slowly developing forms it ends in lymphatic organal and skeletal infiltration. With so many possibilities of clinical forms it is beyond the purview of this discussion to do other than present examples of the disease which are within the scope of irradiation, and in which worth-while and, at times, long palliation may be accomplished.

In children the disease is usually a fulminating one, although we have seen children with lymphosarcoma limited to one peripheral regional group of lymph nodes who, following irradiation, have remained well. Our more common experience is the massive mediastinal or abdominal involvement temporarily regionally controlled by irradiation, but with progression to lung and other organs. Intraspinal lymphosarcoma with cord paralysis (fig. 6 b) has been encountered but with later pulmonary spread. In all of these more massive forms in children, irradiation used cautiously will afford some relief of pressure and add to an all too brief span of life. In our experience it has not controlled the total disease.

We call attention to one particularly interesting form of lymphosarcoma observed in childhood (fig. 7). This is the ileocecal lymphosarcoma in which both grossly and microscopically the disease is indistinguishable from the more clinically highly malignant forms, and yet, following resection, may permit an unexpectedly long survival. In the case cited we did not follow resection with irradiation despite the presence of removed regional lymph nodes, pathologically indistinguishable from lymphosarcoma. Dr. Paul Lund, pathologist of the Swedish Hospital, has called attention to this unusual lesion from other similar cases which he has observed.

In the adult, lymphosarcomas of the stomach or ileocecum may be at times a primary and solitary form. They represent the bona fide reported cases of long survival following resection. We have seen these forms only in association with regional or more advanced disease and treated them both by irradiation alone and by surgery and irradiation. In 1 patient with ileocecal involvement found at laparotomy for obstructive intussusception and with regional lymphatic spread, resection and irradiation gave symptomatic relief from the abdominal disease until the patient died five years later from pulmonary infiltration. Also of interest in this respect is the patient (fig. 8) with the presenting disease as a destructive lesion of the mandible which was responsive to irradiation. Six months later he developed intestinal obstruction from a lesion in the ileum, which on resection was found to be lymphosarcoma and similar histologically to the tissue removed from the mandible. The patient died of other abdominal spread.

As in Hodgkin's disease the initial complaint may be due to the destruction of bone (fig. 8). In later and more generalized disease bone rarely escapes some degree of infiltration that does not add to the clinical problem.

Massive peripheral lymphadenopathies of lymphosarcoma are not uncommon but in our experience are only prodromal to a rather fulminating general-

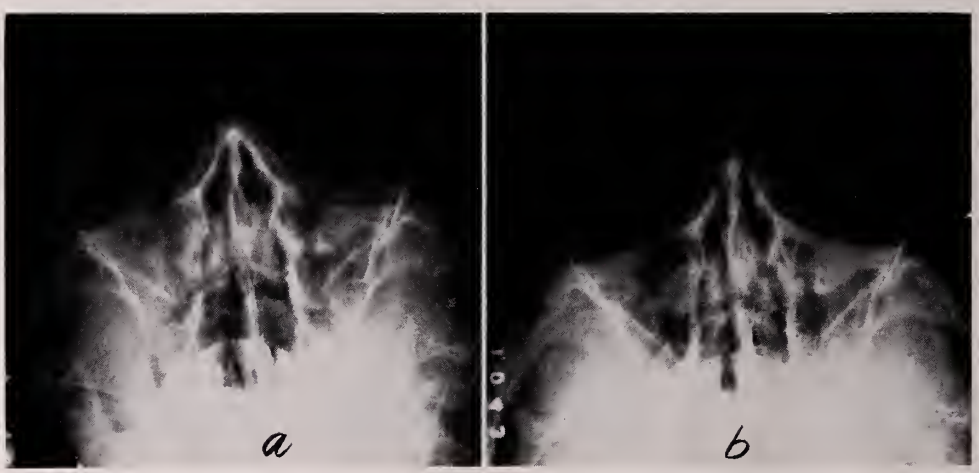

FIG. 10a. A 42 year old man suffered rapid swelling of the right side of the face for three months. Tissue obtained by incision through the tumor of the facial soft parts on the right was diagnosed as lymphosarcoma. A roentgenogram made October 23, 1950, showed a defect in the lateral inferior wall of the left antrum secondary to a shrapnel wound. Opacity of the right antrum with partial destruction of the medial, lateral, and anterior walls was evident. Tumefaction of the soft parts was palpable through the upper right gingival buccal sulcus. Roentgen therapy was applied, 800 kilovolts, 4,800 r minimal throughout the right maxillary region in forty-nine days.

b. A roentgenogram March 29, 1952, showed bone regeneration of the medial and lateral walls with aeration. The status of the patient was unchanged by 1954.

ized disease. As in Hodgkin's disease, mediastinal lymph node enlargement is common, and here also we have resorted to exploratory surgery of the superior anterior mediastinum to secure lymph nodes for diagnosis when peripheral lymph nodes were not available (fig. 9).

Lymphosarcoma of the tonsil, unilateral or bilateral, may be encountered as a primary complaint. In our experience it is more often seen in the elderly, producing a painless obstruction to swallowing, and may or may not be associated with cervical lymph node involvement. Although we have irradiated these patients sufficiently to produce complete regression of the tonsillar and lymph node masses, none have survived later visceral lymphosarcoma. The same sequence of events has followed the lymphosarcomas of the nasopharynx which we have irradiated. One patient with massive involvement of a maxillary sinus with bone destruction (fig. 10) has had apparently complete arrest of this seemingly primary focus for a period of four years. Despite a pathologic fracture in one rib two years after the original therapy, which was likewise irradiated, the patient's general condition still remains excellent. Later complications are anticipated.

In the irradiation of lymphosarcoma the volume of tissue irradiated in general is as large as can be tolerated and consistent with a dose within the involved structures of a minimum of 2,400 r to 3,000 r in three to four weeks. This is somewhat less than we attempt in Hodgkin's disease, but must be varied according to the individual status of each patient. As in Hodgkin's disease, as the patient advances in more generalized lymphosarcomatosis, it is important to give supportive treatment for anemia, fever, and infection and to use irradiation only for those complaints in which it can add to the patient's welfare without detracting from his energies and general condition.

As a striking example of supportive chemotherapy in lymphosarcoma, we may cite 1 case of a man, aged 46, who, three years after irradiation to multiple regional lymphosarcoma, entered a stage of severe anemia associated with massive enlargement of the liver. The patient has been kept going for an additional two years by cortisone; three episodes of severe bone marrow depression have been converted by transfusions and ACTH. During this period he has been able to work and live comfortably. Such a response as Dr. Crosbie has obtained in this patient is not usual, but the individual patient is not interested in statistics.

In relation to the hematologic picture in lymphosarcoma, one always must bear in mind that certain of these patients eventually develop leukemia, which in general has a rather rapidly fatal course.

GIANT FOLLICLE LYMPHOMA

I shall discuss only briefly giant follicle lymphoma, yet it is a syndrome of great interest and importance among the lymphomas. Its importance lies in its relatively benign natural course and the prognosis for many years of life which it may have. The pathologist can readily distinguish the microscopic form and thus initially alert the radiologist to the course which he may anticipate. The disease is also of interest in that it may be found in many and unexpected tissues and be highly susceptible to local control by external irradiation in minimal dosage. One not infrequently sees the patient with a history of painless, peripheral lymph node swelling for years which either may gradually enlarge to produce pressure and pain or later undergo rapid enlargement, finally bringing the patient to the physician. One also learns that the swellings may spontaneously diminish in size as we have observed by following certain cases objectively. Associated with peripheral lymphadenopathy one may find asymptomatic abdominal or hilar masses.

We have seen the disease on the cervix associated with cervical, inguinal, and hilar lymph node enlargement, but in a patient who initially sought help for pain in the mandible which was due to infiltration of bone by giant follicle lymphoma. She has since received irradiation to multiple fossae of skeletal, abdominal, thoracic, and cutaneous involvement, and yet six years after the onset of the disease remains in a relatively efficient condition. A patient, aged 72, treated in 1939 for a massive unilateral, cervical lymphadenopathy of giant follicle lymphoma, returned thirteen years later with the disease involving the nasopharynx and palate, and these were likewise controlled by irradiation. At age 87, he may still die of senility rather than lymphoma. A patient treated in 1938 for a large cervical mass died in 1952 under our care with extensive skeletal involvement by giant follicle lymphoma. For the majority of the intervening years she had lived comfortably.

As in the other lymphomas we do not attempt to irradiate all manifestations of involvement by giant follicle lymphoma unless they produce symptoms of pressure or pain. Irradiation is for symptomatic relief. The dose required to any one focus may not be more than 1,000 r to 1,500 r, and in many instances considerably less.

Giant follicle lymphoma is a disease par excellence for the beginning radiotherapist to establish his reputation among his colleagues, but he must be willing to accept the clinical care and repeated irradiation over periods of years which certain of these patients will require. He also must be willing, if he outlives

the patient, to carry him through a long and difficult end, which may be that of intestinal obstruction, uremia, or bone marrow failure. To a greater degree than lymphosarcoma certain of these patients end with leukemia.

Lastly (and it pertains to the management of the lymphomas in general and by whatever therapeutic agent), the physician responsible for the care of the patient must at the outset establish confidence. This he can best do if he discusses with the patient something of the general nature of the disease and assures him that though there may be reappearance of problems later, his condition is one which may receive help for long and unpredictable periods. It is only right to lend this encouragement, and by so doing the physician treats the patient as well as his disease.

ROENTGEN EXAMINATION OF THE UPPER GASTROINTESTINAL TRACT

J. E. MILLER, M.D., Dallas, Texas

THE diagnostic value of the roentgenologic examination of the upper gastrointestinal tract is recognized by the internist, the surgeon, and the radiologist. The general practitioner must be included in this group if this examination is to give maximum benefit to the largest number of people. There is no doubt this examination is the easiest to perform, discommodes the patient the least, costs less, and gives more information concerning the upper gastrointestinal tract than any other modality at our disposal. For this reason the four categories of physicians mentioned should know as much about the technical and interpretive phases of the examination as time will permit them to learn in one lifetime.

There is no more fascinating story in the annals of human endeavor than the discovery of x-ray. The development of this, the most important single method of physical diagnosis, to its present status is a subject for lifetime study to the radiologist. Roentgen's strange phenomenon announced on December 28, 1895, was destined to revolutionize the world. It is one of the ten most important scientific discoveries of all times.

Haschek and Lindenthal[3] in January of 1896, only one month after the publication of Roentgen's article, injected radiopaque material into the brachial artery of a dead body. They made the following observation: "Should it be possible through technical improvement to radiograph other portions of the body, this would open up a new field in diagnosis for the healing of the sick." It was apparent even then that diagnosis is of paramount importance if one is to heal the sick.

Hemmeter[4] in 1896, less than one year after Roentgen's original article, said: "I do not consider the use of the Röntgen method on account of its complexity and long duration of exposure as practical for determining the size and location of the stomach." Many men deserve credit for the remarkable advances in the examination of the gastrointestinal tract. Dr. Cannon[2] as a first year student at Harvard Medical School began his work on the upper gastrointestinal tract within a year of Roentgen's announcement of his discovery.

Physicists and engineers are responsible for the technical improvements which permit the diagnostic accuracy this examination now enjoys. One does not need to know all of the details regarding the structure of the roentgen apparatus. The details of the conduct of the examination, however, should be known to those who propose to perform it. Such information is usually given as generalizations and specific details are difficult to find. The real purpose for this paper is to discuss step by step one method of performing the "G I series."

There are three phases of the upper gastrointestinal tract examination which must be considered, namely, (1) technical performance of the examination, (2) recognition of abnormality, and (3) interpretation of abnormal findings.

The technical performance of the examination is the most important, since if it is inadequate, the last two will not be adequate. The acquisition of visual dexterity to observe the abnormality requires several years' experience and many mistakes. The ability to ascertain the exact nature of the lesion together with its histologic pattern is never adequately achieved, nor indeed is it always necessary. Since the technical aspects of this examination are inadequately performed by most physicians including many radiologists, I will dwell on this aspect of the problem.

Read as part of a symposium on lesions of the upper gastrointestinal tract before Section B (Surgical), Texas Medical Association, Annual Session, San Antonio, May 5, 1954.

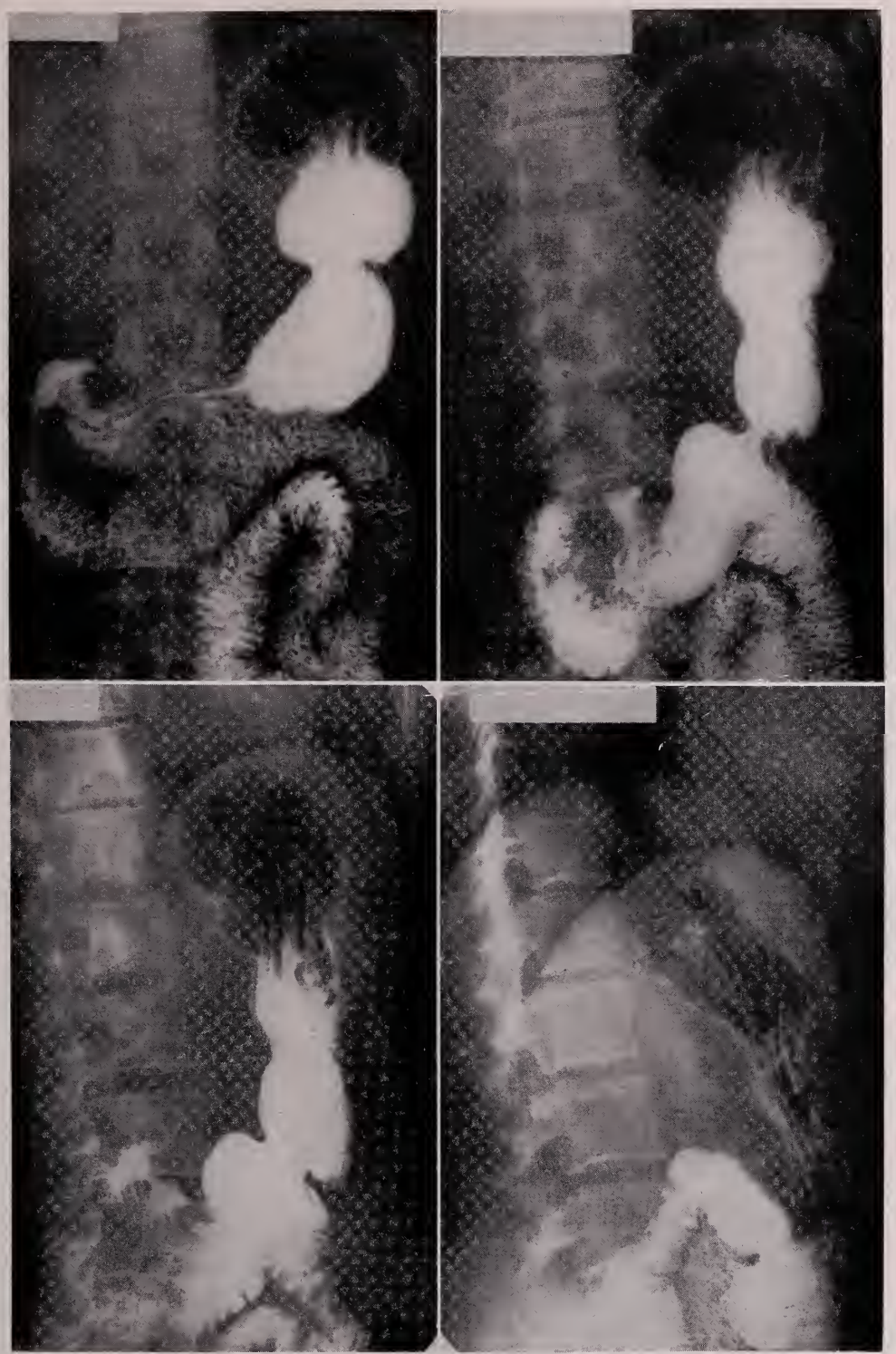

FIG. 1. Four roentgenograms made at the beginning of an examination of the upper gastrointestinal tract: a postero-anterior film *(upper left)*, two films of different obliquity *(upper right* and *lower left)*, and a right lateral film *(lower right)*.

TECHNIQUE

At 8 o'clock in the morning the patient who has had nothing by mouth since midnight is given 4 ounces of a mixture containing one part barium and two parts water. Within two minutes after the ingestion of the barium a series of four 10 by 12 inch films is started. After a straight postero-anterior film of the stomach, two films of different obliquity are made with the right side of the patient down, and then a true right lateral film of the stomach is obtained. After these four films are made, the patient is placed supine for a moment. The right side is then elevated about 15 to 30 degrees and the anteroposterior film of the stomach is made. All of these five films should be obtained in less than ten minutes from the time the patient ingests the barium. If the duodenal bulb does not fill during the course of this series of films, one may presume that pylorospasm

FIG. 2. An anteroposterior roentgenogram showing double contrast of the stomach and duodenal bulb.

or some other abnormality of the pyloric canal or the duodenal bulb exists.

Figure 1 shows the four films which are obtained initially. One notes that the mucosal folds throughout the stomach and duodenal bulb are well visualized since the proper amount of barium has been used. If one completely fills a hollow viscus with radiopaque material, one is likely to miss even a large lesion in this viscus. Too much barium in the stomach, therefore, will cause one to overlook many lesions. No more than 4 ounces of barium mixture should be placed in the stomach at any time. A measuring cup should be available and the technician instructed to have 4 ounces of barium in the cup. Figure 2 shows the anteroposterior film with double contrast of the stomach and the duodenal bulb. The barium gravitates to the fundus of the stomach and outlines the fundus well.

Immediately following these films, eight views of the distal end of the stomach and duodenal bulb are obtained on two 10 by 12 inch films. This is done by means of a polygraph board. This easily made simple device is of great importance in the performance of the examination. This board is a piece of lead which may be encased in plywood if desired, in the center of which a 5 by 6 inch aperture is cut. This piece of lead should be as wide as the table top and should be about 24 inches long. The patient is placed in the prone position on the polygraph board or "polyboard" as the technicians frequently call it. The technician should attempt to place the duodenal bulb over the 5 by 6 inch rectangular aperture as nearly as he possibly can. Then with the aid of the fluoroscope the duodenal bulb is placed directly in the middle of the polygraph aperture. The patient is turned to the desired obliquity and then turned flat in order to ascertain that the duodenal bulb and the distal end of the stomach will remain within the aperture during these maneuvers. The patient is then placed in the oblique projection and asked to remain in this position until four exposures of the duodenal bulb are made on one 10 by 12 inch film. This is accomplished by moving the cassette in the cassette tray beneath the table in such a manner that the four quadrants of the 10 by 12 inch film are placed beneath the aperture of the polygraph board. This is a simple technical procedure and is quickly mastered by the technician. The patient then rolls to the prone position and a second polygraph is obtained. If this procedure has been done correctly, the duodenal bulb and distal end of the stomach still will be within the aperture, since this has been tested with fluoroscopic control. Here on two 10 by 12 inch films the most vital area of the gastrointestinal tract is obtained with eight exposures in two different projections.

The total elapsed time thus far should be no longer than twenty minutes. If it is necessary to add more barium for the polygraphs, the person doing fluoroscopy will see this need immediately and ask the patient to take 2 ounces.

Moving the cassette for the polygraphs in the bucky tray may require a little experimentation by the technician. Since most trays are not quite long enough it may be necessary to move the entire tray a slight amount after two exposures have been made at one end of the film. Accurately to place one quadrant under the aperture in the polygraph board a block of wood cut to the proper width may be placed next to the cassette in the tray and the lock engaged. On the second exposure if the block of wood is placed

on the other side of the cassette, the second quadrant will be in proper position.

Figure 3 shows one polygraph of the duodenal bulb and distal end of the stomach obtained by this technique.

These seven 10 by 12 inch films are processed and are available for inspection within an hour of the time the last film is made. Fluoroscopic examinations are started at 10 o'clock about two hours after the ingestion of the barium. Much of the disease that is found in the upper gastrointestinal tract thus will be already apparent to the person who is to do the fluoroscopy. There may be some criticism that one who sees the roentgenograms before the fluoroscopy will be prejudiced. This challenge implies that the fluoroscopist does not examine all areas with equal care. There should be a reasonable routine for the fluoroscopic examination of the upper gastrointestinal tract. After this routine has been accomplished the fluoroscopist should concentrate on the area which may be in question from an objective inspection of the films. I am glad to be criticized for examining certain areas more in detail since this has saved many repeat examinations which have to be done when the fluoroscopic examination precedes the radiographic examination. The screen examina-

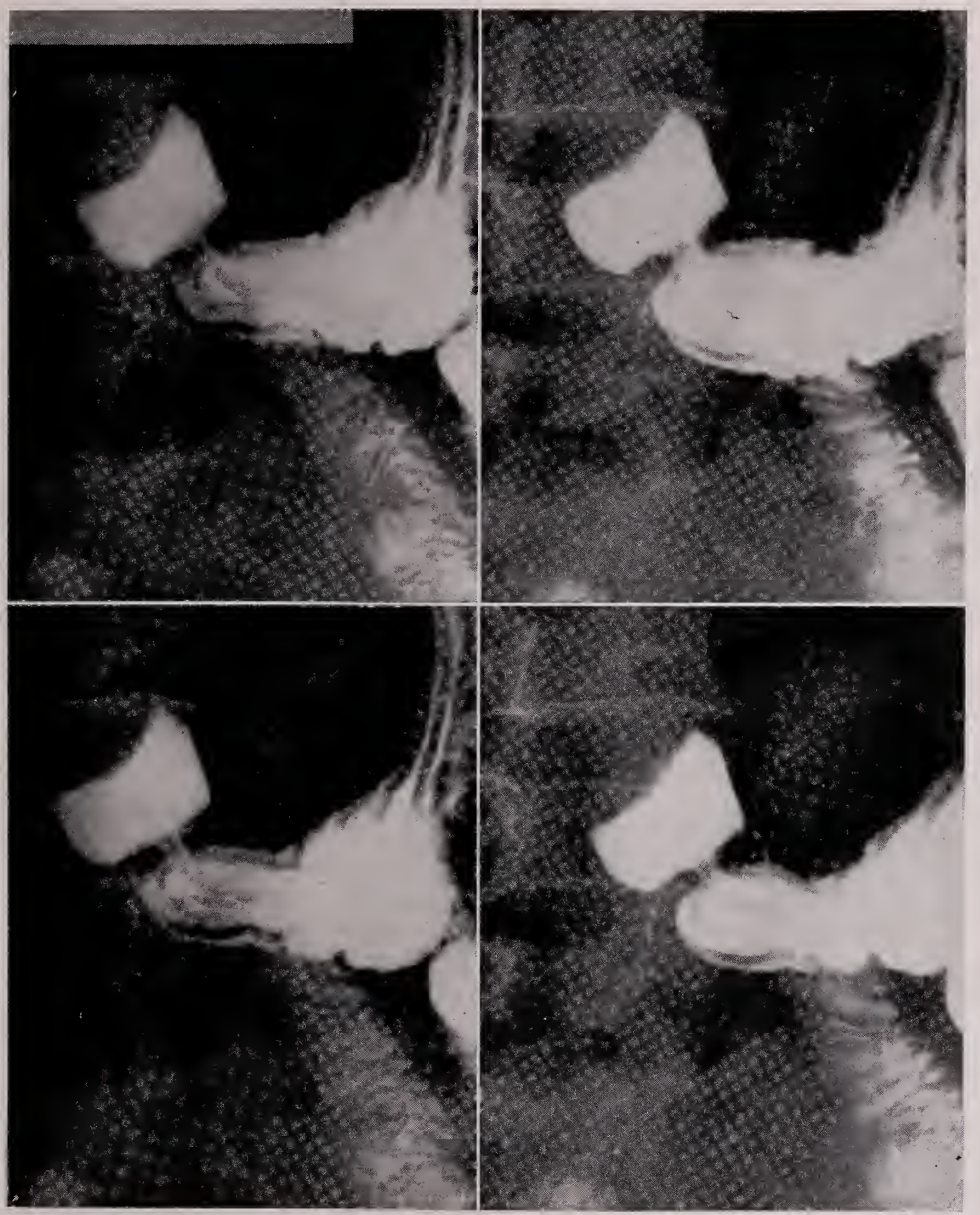

FIG. 3. One of two polygraphs of the duodenal bulb and distal end of the stomach. This series was made with the patient in an oblique position. A second series of four pictures on a single 10 by 12 inch film is made with the patient prone.

tion immediately gives more information concerning the physiology of the upper gastrointestinal tract than is obtained with antecedent fluoroscopy. Most of the small bowel will be visualized at this time some two hours after the administration of the barium. If any retention is present in the stomach, this can be noted and its significance evaluated. At the time of fluoroscopy again only 4 ounces of barium is permitted in the cup.

During the screen examination one should be able to obtain spot films of what is seen. It is also desirable to have pressure spot films. Many physicians who do the gastrointestinal tract examination do not have a spot film device, and most of those who do, have inadequate devices. This spot film device should be used to confirm what one sees or what one thinks one sees during the screen examination. I do not believe that one should talk about a lesion he has seen fluoroscopically unless he can demonstrate it on film. It seems impractical to obtain spot films of the entire gastrointestinal tract. If there is any suggestion of abnormality in an area, one should not hesitate to obtain as many spot films as seems reasonable.

The stomach is usually empty at the beginning of fluoroscopy. The patient is asked to take a small swallow of barium and this is watched from the time it enters the mouth until it enters the stomach. This swallow is usually taken with the patient facing the

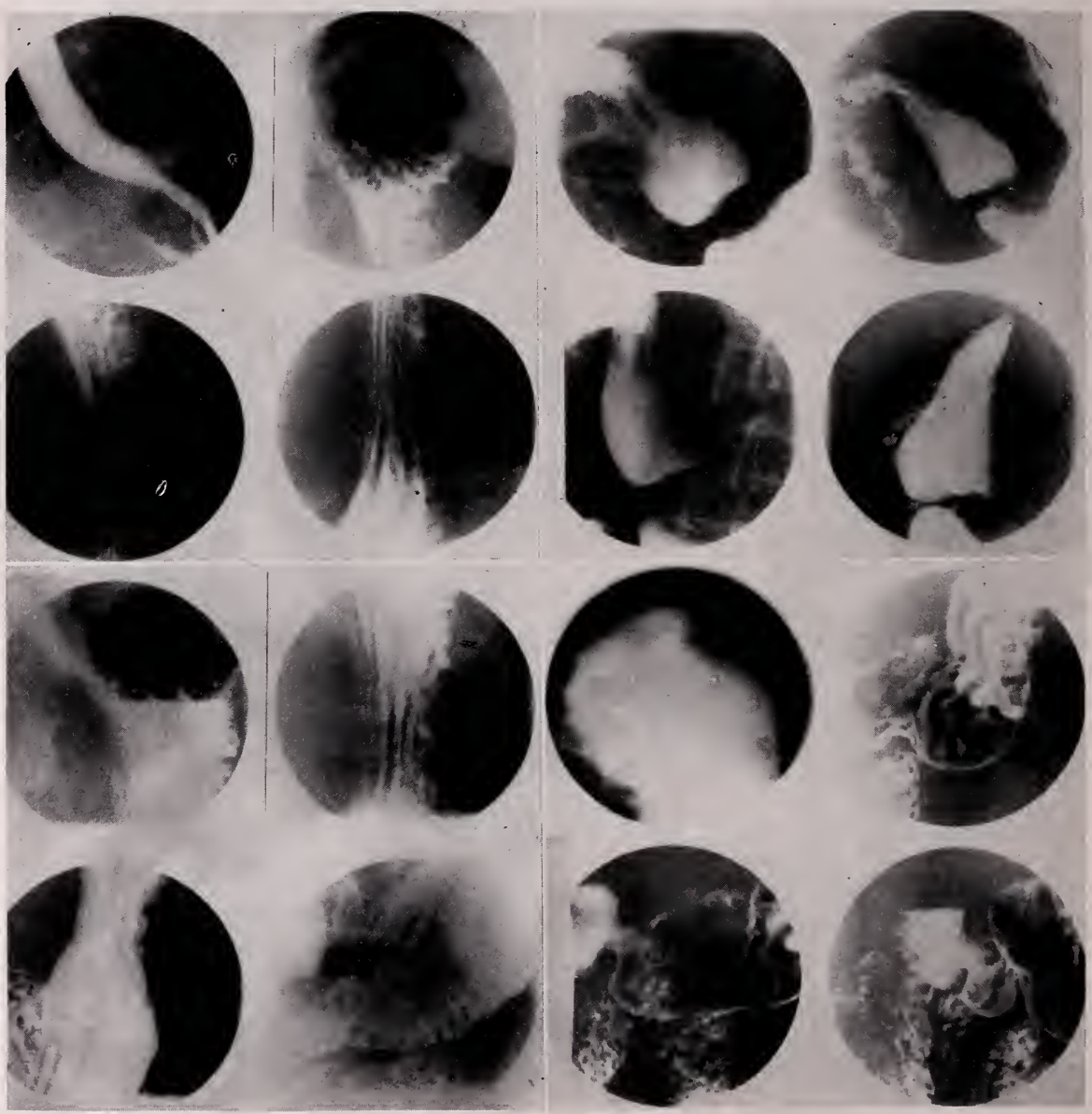

FIG. 4. Spot films of the esophagogastric junction, the stomach, and the duodenal bulb made during the fluoroscopic examination.

fluoroscopist. The patient is then turned into a right anterior oblique projection and a second swallow is observed as it passes through the mouth, the pharynx, and the esophagus. The detail of esophageal visualization is so good that films are not obtained unless there is an indication from the clinical story or from the fluoroscopic visualization. The patient is examined by fluoroscopy in the upright and horizontal positions. In fact it is routine to place the head down slightly and observe whether or not a hiatus hernia can be seen. Various maneuvers are used to try to visualize a hiatus hernia. If such a hernia is suspected clinically, polygraphs of the esophagogastric junction are obtained in the same manner as those which are obtained of the duodenal bulb. The only difference is that a thick barium paste is used so that it will stick in the esophagus. Figure 4 shows a series of spot films of the esophagogastric junction, the stomach, and the duodenal bulb that are usually obtained as a routine.

FIG. 5. Final roentgenogram of the examination showing a postero-anterior view of most of the small bowel.

After the fluoroscopic examination a 14 by 17 inch film of the abdomen made postero-anteriorly is obtained. This can be made immediately after the fluoroscopic examination, but it is desirable to wait about thirty minutes. The patient is given an additional 2 ounces of barium before this film is made. By this technique the barium given originally in the morning is usually in the terminal ileum, the cecum, and ascending colon. That given during the screen examination is filling the jejunum. Since information concerning the retention of barium already has been obtained during the screen examination another 2 ounces is given in order to obtain an additional film of the stomach. This film is made slightly high to show the diaphragm. On this film have been seen many hiatus hernias which were missed during the entire series of films and during the screen examination. Hence, it is advisable to take the film high enough to show the fundus of the stomach and the esophagogastric junction.

The entire course of this examination usually consumes about three hours of the patient's time and hardly ever more than four hours. For survey purposes the small bowel examination obtained on the 14 by 17 inch film is usually adequate. If there is a clinical indication, however, a 14 by 17 inch film should be obtained every hour until the cecum is visualized. I see no purpose in returning the patient for further films, and certainly the twenty-four hour film so frequently made does not have enough value to warrant the patient's return.

Figure 5 shows the 14 by 17 inch film made at the end of the examination with a fairly good visualization of most of the small bowel.

SUMMARY

A brief history of the development of the upper gastrointestinal tract examination is given. Its paramount importance in diagnosis of lesions of the upper gastrointestinal tract is stressed. Technical details for performing an adequate upper gastrointestinal tract examination are given. A technician following instructions given in this presentation can produce a set of roentgenograms adequate for interpretation by anyone competent to do so.

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Baylor University Hospital.

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PEPTIC ULCER IN CHILDREN

LESLIE L. LEMAK, M. D.; PALMER E. WIGBY, M. D.;
and JOHN E. MARTIN, M. D., Houston, Texas

THERE is ample evidence of peptic ulcer in children, as is well indicated by numerous articles in the literature on the subject. The purpose of this paper is to present 6 cases of peptic ulcer in children. Etiology and pathology are not considered in detail. These 6 cases demonstrated roentgen evidence of the disease on initial examination. A follow-up of 2 of these cases is presented. One case showed complete clearing of the disease, both clinically and on roentgen examination. The other case showed roentgen evidence of persistence of the disease despite intensive medical therapy.

CASE 1 (fig. 1).—A. G., a 10 year old girl, offered the chief complaint of vague pain in the abdomen. The history showed that she had been somewhat nervous and irritable the past few months and was finicky about her food. Initial examination on November 6, 1953, showed duodenal ulcer; a second examination November 23 showed no evidence of ulcer.

CASE 2 (fig. 2).—P. B. was a 10 year old girl whose chief complaint was pain in the stomach for three weeks. Past history showed she had had a dietary problem for two years. She would vomit on occasions when upset. Initial roentgen examination on October 29, 1953, showed a deformity of the duodenal cap with a duodenal ulcer. The condition was still in evidence November 28.

The following four cases show roentgen evidence of duodenal disease. Follow-up studies have not been made as yet.

CASE 3 (fig. 3).—C. A. G., 7 years old, presented a history of pain in the stomach for two years, and vomiting the week prior to examination.

CASE 4 (fig. 3).—P. I., 10 years old, offered the chief complaint of pain in the lower part of the abdomen. The patient would have attacks about once a day, lasting from two to four hours. The first examination was February 12, 1954.

CASE 5 (fig. 4).—D. S., 10 years old, presented as the chief complaint pain in the upper part of the abdomen. The patient was a very nervous child and had morning nausea with occasional vomiting. The initial examination was February 2, 1954.

CASE 6 (fig. 4).—D. C., 12 years old, had pain in the epigastrium. Nausea and vomiting occurred every day for a week prior to examination.

An interesting parallel of the first 2 cases is the psychosomatic background. Both girls were nervous and irritable on initial examination, whereas only the second patient showed no change in her personality on the follow-up examination. The longstanding history of the second patient as to dietary habits and maladjustments to her family problems indicate the psychosomatic element. This girl probably would benefit more from psychiatric care. The first girl's symptoms and roentgen evidence of disease were relieved by medical management and possibly may have had a dietary cause.

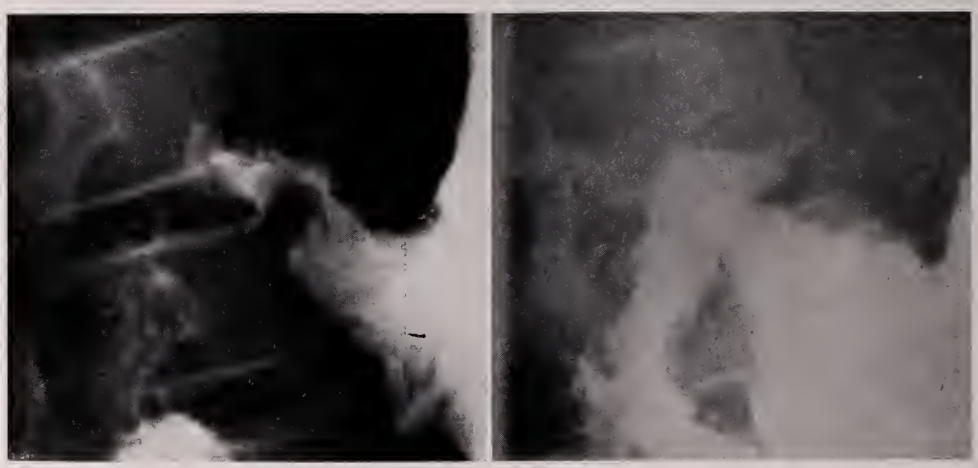

FIG. 1. Case 1. Evidence of duodenal ulcer in a 10 year old girl in a roentgenogram made November 6, 1953 *(left)*, has disappeared by November 23 *(right)*.

DISCUSSION

Peptic ulcer in infancy (newborn to 2 years of age) may have an acute onset with minimal premonitory signs. The majority of the lesions in this age group either bleed profusely or perforate. The literature we covered showed that there was no consistency in the symptoms of children with this dis-

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ease. Bird and his co-workers have shown that in early infancy the ratio of gastric to duodenal ulcers is approximately 2 to 1. We found this even higher in a review of 18 cases of peptic ulcer in 6,500 admissions in Children's Hospital of Michigan in Detroit in 1950. In children older than 2 years duodenal lesions occur from three to five times more often than gastric ulcers. Bird also found that bleeding, perforation, stenosis, and pain, in that order of frequency, may be expected in patients younger than 2 years. After the age of 2 years the evidence of bleeding and perforation diminishes and symptoms are more in line with those of chronic duodenal ulcer in the adult. The symptomatology in peptic ulcer in children, in general, follows a less distinct pattern than in the adult.

The most frequent complaint as reported by Jenkins was vague upper abdominal pain in the great majority of 80 cases. This also was the predominating complaint in the cases we are presenting.

In Alexander's series, 3 of the patients previously had been operated upon for appendicitis (as reported by Dr. R. H. Morgan). In these 3 patients the episodes of nausea and vomiting were frequently severe and the anorexia was sufficiently prolonged to produce weight loss.

The differences in the symptom complex between ulcer in childhood and in the adult might be due to the fact that the erosion of the ulcer in childhood is usually shallow and superficial, whereas in the adult it is undoubtedly deeper and frequently penetrates or perforates. This is obvious when one considers the comparative anatomy of adults and children. In children and infants the stomach wall is thinner and the ulcer naturally more shallow. In adults the greater thickness of the stomach would allow for a deeper ulcer crater and therefore more chronicity of symptoms before perforation.

FIG. 2. Case 2. Deformity of the duodenal cap with a duodenal ulcer in a 10 year old girl, evident upon initial examination October 29, 1953 *(left)*, continues to show on roentgenograms made November 28 *(right)*.

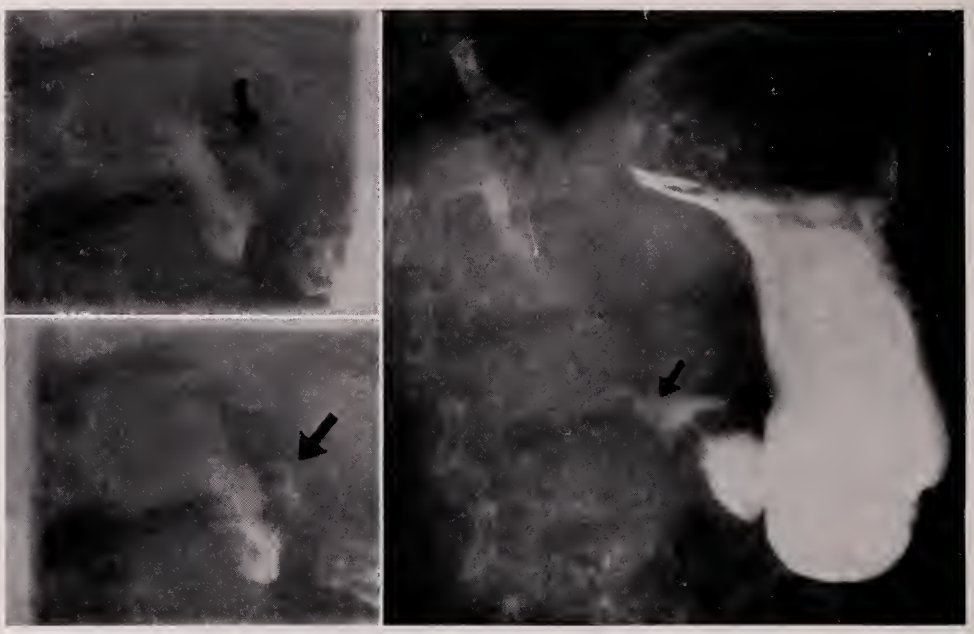

FIG. 3. Cases 3 and 4. Evidence of ulceration in a 7 year old patient in films made March 23, 1954 *(left)*, and in a 10 year old patient in a film made February 12, 1954 *(right)*.

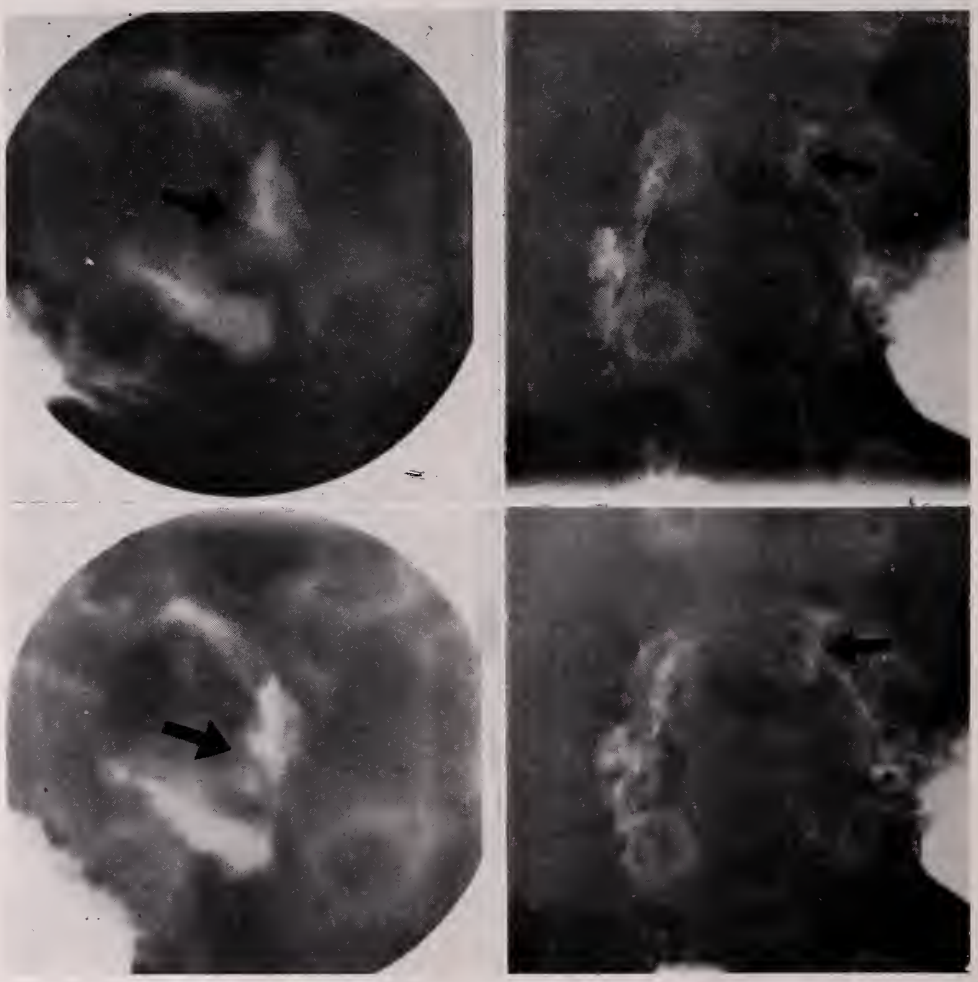

FIG. 4. Cases 5 and 6. Evidence of ulceration in a 10 year old child in roentgenograms made February 2, 1954 *(left)*, and in a 12 year old child in films made January 11, 1954 *(right)*.

The diagnosis of peptic ulcer in children is primarily a roentgenologic procedure with the technique similar to that used in adults. Difficulties in the examination, however, will be frequently encountered from the standpoint of patient cooperation. We believe that spot films are necessary, but they sometimes are difficult to obtain. It is probable that a good many duodenal ulcers in children have been missed in the past because the examiner failed to obtain spot films. Another reason why the usual care in examination is not exercised is that some examiners do not realize that there is a relatively high occurrence of peptic ulcer in children and so do not go to the trouble of making a careful examination, including spot films. All of the illustrations in this paper are based on spot film demonstrations of the ulcer crater.

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Dr. Lemak, 613 Medical Arts Building.
Dr. Wigby, 506 Hermann Professional Building.
Dr. Martin, 613 Medical Arts Building.

ABSTRACT OF DISCUSSION

DR. A. G. BARSH, Lubbock: In discussing duodenal ulcers in children, I will give primarily my experience, which has been in examining a relatively large number of children from the ages of 4 to 12 years for possible duodenal ulcer since the pediatricians referring work to me have been rather conscious of that possibility. In a report in 1952, Dr. Arthur Jenkins[3] referred to 85 positive cases of duodenal ulcers. It was my privilege to do most of these examinations.

I find that the differential points for the diagnosis of duodenal ulcers in children vary some from adults in that the deep ulcer niche is not observed as it is in adults in most cases. There is an occasional perforating type of ulcer, but most of the cases are superficial ulcers. The proof of the presence is primarily in finding the ulcer and, after a course of treatment, in a reexamination being negative. Obviously, autopsy reports are not available for proof of the diagnosis. I find too that the mobility of the small child's intestine is such that the retention of barium in superficial craters is relatively more difficult than in adults. The matter of cooperation on the part of the patient also makes the examination more difficult. It has been my experience that few of these cases have recurrences; I make that comment because of the relatively few reexaminations I do after the patient has once recovered.

I would like to call attention to one youngster who happened to be a pediatrician's only son on whom I made a diagnosis of a duodenal ulcer. This pediatrician was not completely convinced, and the child was reexamined in St. Louis Children's Hospital with confirmation of the diagnosis. Under therapy this youngster recovered; however, the primary part of this therapy was getting the home situation corrected. The father was in military service and the family was moving about with the father; the home situation was very unstable. When the patient was brought back to the permanent family home and kept there under proper care, the duodenal ulcer responded satisfactorily. I make that point because I think we must recognize that the emotional factor in children is probably much more important than any "acid factor" which we consider so important in adults. We do not think of stress and strain in a child in the same terms of that produced in an adult, but we do have it created by psychologic circumstances.

I would like to mention another case of duodenal ulcer in a 7 year old child who had a mother with marked impairment of her hearing. This child had to do the listening for the mother, who could read his lips although she was not able to read the lips of other people. Consequently he was the interpreter for this woman in all her daily affairs in running a home. This put undue strain on the child, as one could readily see, and produced a duodenal ulcer. The correction of this situation has not been so simple.

I am much aware of the possible family conflicts being a causative factor in duodenal ulcers, and I always like to report these to the referring physician if I may sense anything irregular in the conduct of the child in relation to the family or in the misconduct of either parent. I am convinced that the psychosomatic approach in this problem outweighs the organic element as we think of it in the adult case.

I have had one child go on from the original diagnosis of ulcer at the age of 12 years in 1941 to perforation into the pancreas in 1949. He had a partial resection of the stomach and has done well since that date.

NEW USE FOR CORTISONE

Cortisone has been found useful in treating two serious infectious diseases, three articles in the October 2 *Journal of the American Medical Association* reported.

Physicians in Bombay, India, working with an American visiting professor, Dr. Roger A. Lewis, Baltimore, found that cortisone helped reduce spasms, breathing difficulty, muscle rigidity, fever, and deaths from tetanus. The American doctor, a member of the World Health Organization, working with Drs. Rajaninath S. Satoskar, Gopalkrishna G. Joag, Bhalchandra T. Dave, and Jamnauas C. Patel, all of Bombay, treated 20 cases of severe, quick-acting tetanus with cortisone and hydrocortisone. Eight patients survived, and only 3 of 20 similar patients not given these hormones survived, they reported.

Three Philadelphia physicians said that cortisone helped reduce such symptoms as fever, mumps-like swelling, and eye inflammation accompanying sarcoidosis. They reported the most dramatic response to cortisone in patients with swelling and fever, and the response of those with eye infections "was almost equally prompt and striking." They noted that their study may help in finding clues to the cause of the disease. This study was made by Drs. Harold L. Israel, Maurice Sones, and Dick Harrell.

Three Cleveland physicians, Drs. Paul H. Curtiss, Jr., William S. Clark, and Charles H. Herndon, sounded a warning note about prolonged treatment with cortisone and corticotropin. They said they believed bone fractures suffered by 4 patients studied were the result of overlong treatment with the hormones, which tended to remove minerals from the skeleton.

MANAGEMENT OF RECTAL POLYPS

JOHN P. HEANEY, M. D., F.A.C.S., and ASA BEACH, M. D., F.A.C.S., San Antonio, Texas

THERE has been a widespread tendency in the past to rely on the use of roentgen-ray study to determine the presence or absence of polyps in the large bowel and rectum. This tendency has been carried to the point that even simple digital rectal examination is too often omitted. The use of the sigmoidoscope in some institutions has been confined to cases in which the patient had compelling signs and symptoms which pointed to a rectal disorder. These are a sense of incomplete evacuation, tenesmus on defecation, and passage of bright red blood in large quantity either with the stool or immediately after evacuation. Failure to perform an adequate rectal examination either by digital means or by use of the sigmoidoscope has been due in part to lack of appreciation of the limitations of roentgen-ray diagnosis and in part to frank haste and/or laziness on the part of the examiner.

There are accumulating data to make one realize that careful sigmoidoscopic examination should be performed with greater frequency both in the infant[5, 6] and in the adult.[4, 9] Welch[10] has stated that one should not treat a patient with chronic anemia, hemorrhoids, or chronic diarrhea without a careful, complete examination of the entire gastrointestinal tract. This of necessity requires examination of the rectum by means of the index finger and the sigmoidoscope. Still another group of patients should be included in this category, that is, the group of patients with vague, ill defined abdominal symptoms which point to no special anatomic system.

There is further ample evidence to indicate that the yield from careful examination of this type is gratifying in terms of disease detection and cancer prevention. Swinton[9] has noted that in a consecutive series of 150 patients, exactly 15 were found to have benign polyps within reach of the sigmoidoscope. Fifty-two per cent of all polyps of the large bowel are within reach of the standard instrument, according to the autopsy figures presented. These polyps occur in both sexes and at all ages, being slightly more common in adult males. They are true tumors and constitute the source of origin of a high percentage of malignant lesions of the colon and rectum.[9]

If the lesions are dealt with in the precancerous stage, ablation of polyps is simple, whereas if they are left until cancer has developed, necessitating loss of the rectum, the morbidity and mortality are magnified many times.

Boehme[3] in 1950 described a new "suction-cautery" technique for eradication of polyps within reach of the sigmoidoscope. His method is simple but effective and deserves wide adoption. By this method, the dual purpose, metallic suction tip is used to grasp the polyp. Thus held, the tissue is fulgurated with the suction tip which also serves as the electrode. Even when the adenoma is small and sessile, the presence of a well developed, loose submucosal stratum permits the lesion to be pulled away from the wall in such a fashion that a pedicle or fold of normal mucous membrane is created. Instead of applying pressure with the cautery, the lesion is gently drawn into the scope away from the underlying stratum of the bowel wall and fulgurated while in that position. The advancing margin of the zone of electronecrosis can be readily seen as it ascends the pedicle and radiates circumferentially at its base. Smoke is evacuated simultaneously through the suction apparatus. The extent of fulguration can be controlled with great accuracy (fig. 1).

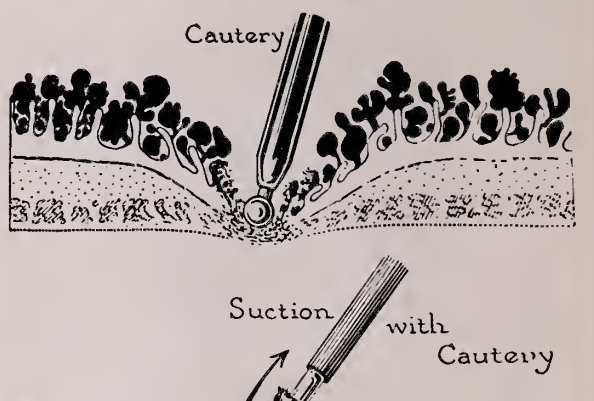

FIG. 1. The upper sketch illustrates conventional ball-point fulguration. Destruction may include adjacent mucosa and bowel wall as the polyp is pushed about by the electrode. The lower sketch shows destruction of a polyp while it is held away from the bowel wall by the "suction-cautery" technique. The apparatus used is an ordinary bronchoscopic suction instrument insulated except at each end by a sheath of plastic or rubber tubing. (After Boehme, E. J.: Surgical Treatment of Familial Polyposis of Colon, Report of Seven Cases, Six in One Family, Ann. Surg. *131*:519-533 [April] 1950.)

Whereas the monopolar current has been used with satisfaction by Boehme and by others,[3, 8] we have used, after work in the animal laboratory, a

bipolar, mixed fulguration and high frequency cutting current. This type of current is stronger in terms of tissue destruction and therefore must be used cautiously. We believe that it is better to destroy a small peripheral zone of normal tissue than to destroy the adenoma incompletely. There is scarcely any danger of bowel perforation when Boehme's technique is employed.

Most polyps of the rectum can be treated by fulguration without biopsy.[9] To us it has seemed simple, with use of appropriate forceps, to obtain a biopsy specimen in order to be certain that the lesion is an adenomatous mucosal polyp. It is then obliterated by means of the technique described. If there are multiple polyps, only one or more of the largest are subjected to biopsy. There is a tendency, however, if one relies solely on the microscopic picture of these lesions, to overgrade them in the malignant direction and recommend unnecessarily radical operative procedures. The gross appearance of the lesion usually will serve to distinguish the adenomatous polyp from the more dangerous villous, papillary type of polyp.[1, 9] This appearance combined with the microscopic picture usually will settle the issue wisely in favor of the more conservative treatment plan.

Electrical ablation of polyps of the rectum in the precancerous stage has been found to be so satisfactory that it is now agreed by most authorities that even patients with familial polyposis of the colon, which is acknowledged to be a 100 per cent precancerous disease, should have a total excision of the part of the large bowel above reach of the sigmoidoscope, followed by an end-to-end ileoproctostomy.[2,3,8] Later, polyps within the rectum are controlled by means of periodic sigmoidoscopic examination and electrofulguration.

SUMMARY

A plea is made for more frequent use of the sigmoidoscope in examination and treatment. The conditions in which this is desirable are listed. An improved technique for the destructon of rectal polyps is presented.

REFERENCES

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2. Black, B. M., and Hansbro, G. L.: Symposium on Abdominal Surgery; Treatment of Familial Polyposis of Colon, S. Clin. North America *30:*1013-1023 (Aug.) 1950.

3. Boehme, E. J.: Surgical Treatment of Familial Polyposis of Colon, Report of Seven Cases, Six in One Family, Ann. Surg. *131:* 519-533 (April) 1950.

4. Cattell, R. B.: Surgical Treatment of Polyps of Large Intestine Am. J. Surg. *76:*733-747 (Dec.) 1948.

5. Kennedy, R. L. J.: Polyps of Rectum and Colon in Infants and in Children, Am. J. Dis. Child. *62:*481-488 (Sept.) 1941.

6. Paulson, M.: Rectosigmoidoscopy in Infancy and in Childhood—Non-Surgical Procedure; Indications, Instruments, Technic and Appearance of Distal Part of Colon, Am. J. Dis. Child. *52:*1430-1444 (Dec.) 1936.

7. Schaffer, R. C.: Familial Colonic Polyposis; Review of Literature and Report of Four Cases, Am. J. Surg. *84:*477-483 (Oct.) 1952.

8. Smith, N. D., and Hill, J. R.: Multiple Polyposis; Results of Fulguration of Polyps in Distal Portion of Colon After Ileosigmoidostomy and Colectomy, J.A.M.A. *148:*440-443 (Feb. 9) 1952.

9. Swinton, N. W.: Polyps of Rectum and Colon, J.A.M.A. *154:*658-662 (Feb. 20) 1954.

10. Welch, S. C.: Cancer of Colon and Rectum; lecture delivered before Postgraduate Medical Assembly of South Texas, Houston, July 21, 1952.

Dr. Heaney, 1525 Nix Professional Building.
Dr. Beach, 205 Camden Street.

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, Fort Worth, April 24-27, 1955. Dr. F. J. L. Blasingame, Pres.; Mr. N. C. Forrester, 1801 North Lamar Blvd., Austin, Executive Secy.

American Medical Association, Miami, Fla., Nov. 30-Dec. 3, 1954. Dr. Walter B. Martin, Norfolk, Va., Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice, Los Angeles, March 28-31, 1955. Dr. W. B. Hildebrand, Menasha, Wis., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 14, 1954. Dr. Bayard Carter, Durham, N. C., Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology, New York, Sept. 17-24, 1955. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics. Dr. Roger L. J. Kennedy, Rochester, Minn., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Atlantic City, N. J., April 24-26, 1955. Dr. Edward S. Welles, Saranac Lake, N. Y., Pres.; Dr. Paul C. Samson, 3959 Happy Valley Rd., Lafayette, Calif., Secy.

American Association of Genito-Urinary Surgeons, Monterey, Calif., May 22-25, 1955. Dr. Fletcher H. Colby, Boston, Pres.; Dr. John A. Taylor, 2 E. 45th St., New York 22, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 8-10, 1955. Dr. Thaddeus L. Montgomery, Philadelphia, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Chicago, April 25-30, 1955. Dr. Homer Prince, Houston, Pres.; Dr. Fred W. Wittich, 423 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, Atlantic City, N. J., June 2-5, 1955. Dr. William A. Hudson, Detroit, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Philadelphia, April 25-29, 1955. Dr. C. C. Sturgis, Ann Arbor, Mich., Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 11-12, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons, Atlantic City, N. J., Nov. 14-19, 1954. Dr. Frank Glenn, New York City, Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress on Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chairman.

American Congress of Physical Medicine and Rehabilitation, Detroit, Aug. 28-Sept. 2, 1955. Dr. William D. Paul, Iowa City, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Belleair, Fla., April 17-21, 1955. Dr. Richard S. Weiss, St. Louis, Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, Atlantic City, N. J., June 4-5, 1955. Dr. Dwight L. Wilbur, San Francisco, Pres.; Dr. H. Marvin Pollard, University Hosp., Ann Arbor, Mich., Secy.

American Gynecological Society, Quebec, Canada, May 23-25, 1955. Dr. Philip F. Williams, Philadelphia, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, New Orleans, Oct. 26-30, 1955. Dr. E. Cowles Andrus, Baltimore, Pres.; Mr. Irving Hexter, 44 E. 23rd St., New York 10, Secy.

American Hospital Association, Atlantic City, N. J., Sept. 19-22, 1955. Dr. Frank R. Bradley, St. Louis, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Hollywood, Fla., March 15-17, 1955. Dr. Kenneth M. Day, Pittsburgh, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Chicago, June 13-15, 1955. Dr. Percival Bailey, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, W. Sulphur Springs, W. Va., June 2-4, 1955. Dr. Everett L. Goar, Houston, Tex., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, W. Sulphur Springs, W. Va., June 19-22, 1955. Dr. J. Warren White, Honolulu, Hawaii, Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Quebec, Canada, June 13-17, 1955. Dr. Alfred H. Washburn, Denver, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, New York, June 1-4, 1955. Dr. A. W. Martin Marino, Brooklyn, N. Y., Pres.; Dr. Karl Zimmerman, 3500 Fifth Ave., Pittsburgh 13, Secy.

American Psychiatric Association, Atlantic City, N. J., May 4-5, 1955. Dr. Alfred P. Noyes, Norristown, Pa., Pres.; Dr. William Malamud, 80 E. Concord St., Boston 18, Secy.

American Public Health Association. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Philadelphia, April 27-29, 1955. Dr. John H. Gibbon, Jr., Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, Los Angeles, May 16-19, 1955. Dr. W. Joseph McMartin, Omaha, Neb., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Pittsburgh, Pa., April 14-16, 1955. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 185 N. Wabash Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive, Chicago, Secy.

National Tuberculosis Association, Milwaukee, May 23-27, 1955. Dr. John H. Skavlem, Cincinnati, Pres.; Mrs. Morrell DeReign, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, St. Louis, Nov. 8-11, 1954. Dr. Alphonse McMahon, St. Louis, Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nashville, Pres.; Dr. George Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association, El Paso, Nov. 17-19, 1954. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress. Dr. Philip B. Price, Salt Lake City, Pres.; Dr. C. R. Rountree, 1227 Classen Drive, Oklahoma City 3, Secy.

Tri-State Medical Society, Texarkana, September, 1955. Dr. William B. Harrell, Texarkana, Pres.; Dr. Karlton Kemp, 408 Hazel, Texarkana, Ark., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas, Corpus Christi, Dec. 4-5, 1954. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice. Dr. L. Bonham Jones, San Antonio, Pres.; Dr. Woodson W. Harris, 308 W. 15th St., Austin, Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 11-12, 1954. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association. Dr. J. S. Minnett, Dallas, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, Fort Worth, April 24, 1955. Dr. Howard E. Smith, Austin, Pres.; Dr. John Wiggins, 1707 Medical Arts Bldg., Fort Worth, Secy.

Texas Club of Internists. Victor E. Schulze, San Angelo, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, Fort Worth, April 24, 1955. Dr. Paul H. Power, Waco, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, Fort Worth, April 24, 1955. Dr. George M. Jones, Dallas, Pres.; Dr. Hugo Engelhardt, P. O. Box 2180, Houston, Secy.

Texas Division, American Cancer Society. Mr. Travis Wallace, Dallas Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Geriatric Society. Dr. Henry H. Niehuss, Longview, Pres.; Dr. Frank V. Mondrik, 214 Bramlette Bldg., Longview, Secy.

Texas Heart Association, Fort Worth, April 25, 1955. Dr. George R. Herrmann, Galveston, Pres.; Mr. Edgar M. Brown, Jesse H. Jones Library Bldg., 1133 M. D. Anderson Blvd., Houston, Executive Director.

Texas Hospital Association, Houston, April 12-14, 1955. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association. Dr. Edgar S. Ezell, Fort Worth, Pres.; Dr. Bruce H. Beard, 1519 Pennsylvania, Fort Worth, Secy.

Texas Orthopedic Association, Fort Worth, April 25, 1955. Dr. Brandon Carrell, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Galveston, October, 1955. Dr. M. C. Carlisle, Waco, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society. Dr. Jack Kerr, Dallas, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 13-16, 1955. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Houston, Jan. 21-22, 1955. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, Fort Worth, April 25, 1955. Dr. Raleigh White, Temple, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred W. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Mineral Wells, 1955. Dr. Charles N. Burrows, San Antonio, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 3, Executive Secy.

Texas Society of Anesthesiologists, Fort Worth, April 24, 1955. Dr. Frank O. Barrett, El Paso, Pres.; Dr. Milton M. Rosenzweig, 200 Wildwood Dr. E., San Antonio, Secy.

Texas Society of Gastroenterologists and Proctologists, Fort Worth, April 25, 1955. Dr. Charles Hardwicke, Austin, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, Dallas, Jan. 30, 1955. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Galveston, April 15-16, 1955. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 2406 Manor Rd., Austin, Executive Secy.

Texas Urological Society, Corpus Christi, Feb. 27-28, 1955. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg., Corpus Christi, Secy.

West Texas Surgical Society, Dec. 8, 1954. Dr. J. A. Shapira, Midland, Pres.; Dr. Milton J. Loring, 304 North N St., Midland, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society. Dr. John R. Mast, Midland, Pres.; Dr. M. J. Loring, 304 North N St., Midland, Secy.

Third District Society, Borger, April, 1955. Dr. M. C. Overton, Jr., Pampa, Pres.; Dr. William Klingensmith, 215 Fisk Bldg., Amarillo, Secy.

Fourth District Society, Brownwood, October, 1955. Dr. James N. White, San Angelo, Pres.; Dr. Joe B. Stephens, Bangs, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 7-9, 1955. Dr. John J. Sloan, Corpus Christi, Pres.; Dr. E. Jackson Giles, Medical Center, Suite 42, Corpus Christi, Secy.

Seventh District Society, Austin, Feb. 17, 1955. Dr. William McLean, Austin, Pres.; Dr. John Rainey, 1709 San Antonio, Austin, Secy.

Eighth District Society, Galveston, 1955. Dr. George E. Glover, Jr., Victoria, Pres.; Dr. York Lancaster, Port Lavaca, Secy.

Ninth District Society, Houston, March 17, 1955. Dr. Thomas H. Giddings, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society, Port Arthur, Nov. 16, 1954. Dr. John M. White, Port Arthur, Pres.; Dr. Rider Stockdale, Jasper, Secy.

Eleventh District Society, Dr. Porter Bailes, Tyler, Pres.; Dr. Hugh F. Rives, Jacksonville, Secy.

Twelfth District Society. Dr. Neil Buie, Marlin, Pres.; Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society, Abilene, March 2, 1955. Dr. Mal Rumph, Fort Worth, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteeoth District Society. Dr. J. David Thomas, Denton, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Mount Pleasant, 1955. Dr. R. L. Johnson, Mount Pleasant, Pres.; Dr. R. L. Hardman, Mount Pleasant, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 14-17, 1955. Dr. Lawrence B. Sheldon, Dallas, Pres.; Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco. Dr. Ross Shipp, Waco, Pres.; Dr. Milton Spark, 3805 Herwal, Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 7-10, 1955. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas. Dr. Edward T. Smith, 906 Hermaon Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls, April, 1955. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences, Austin. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, Dec. 2-4, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

TEXAS RHEUMATISM ASSOCIATION TO MEET

A day-long scientific session featuring Dr. Joseph J. Bunim, director of the National Institute of Arthritis and Metabolic Diseases, Bethesda, Md., will be held by the Texas Rheumatism Association, December 10 in Galveston. Dr. Alfred W. Harris, Dallas, president of the organization, will preside.

Interested physicians may write the secretary of the Texas Rheumatism Association, Dr. Charles H. Cornwell, Marlin, for additional information.

Medical Expedition Through Africa

The first medical expedition through Africa is being organized by Sabena Belgian Airlines and will last from January 4, 1955, to March 17. The group will be guided by Dr. Neville H. Romain and Dr. Ronald H. Abbott, both of Riverside, Calif. Both physicians have spent many years in Africa, Dr. Romain having been born and reared there. He became a naturalized citizen of the United States in 1945. Dr. Abbott, a member of the American Medical Association, is a fellow of the American and International College of Surgeons and is thought to be the only medical doctor in the United States who is a foundation member of the Association of Surgeons of East Africa. He is the author of "Dark Continent," and has spent fifteen years there as a medical missionary.

The expedition, consisting of a limited number of the medical profession, will visit places of interest in Ethiopia, the Belgian Congo, Kenya, Tanganyika, Rhodesia, and the Union of South Africa, with complete cooperation of the governments and medical associations of each country. They will be shown research centers throughout the continent and will visit field-jungle units of the various areas of Central Africa. Two highlights of the expedition will be an invitational visit to the annual meeting of the East Africa Medical Association at Kampala, Uganda, in January, and at the end of the trip, a specially-arranged seminar at the Institute of Tropical Medicine, Antwerp, Belgium. Information can be obtained through the Sabena Airlines, African Safaris and Research Expeditions, Dallas.

Personals

Dr. George R. Herrmann, Galveston, was a presiding officer of the Second World Congress of Cardiology held in Washington, D. C., September 12-17. He and his associates also presented a paper, "Clinical Studies of Newer Diuretics: Desidron (SU 1775), Dicurin, and Diamox."

Dr. Austin E. Hill, Houston, spoke on the nutritional needs of school children for the American School Health Association, which met as a related organization during the eighty-second annual meeting of the American Public Health Association, October 11-15, in Buffalo, N. Y.

Dr. G. V. Brindley, Sr., Temple, was elected vice-president and president-elect of the American Cancer Society at its October meeting. Dr. Brindley, who will take office as president a year from now, will be the first Texan to serve in that position.

Dr. James N. Walker, Fort Worth, on October 5 was elected governor of the Texas-Oklahoma District of Kiwanis International for 1955. Dr. Walker was lieutenant governor of Division I of the district this year and will be succeeded in that position by *Dr. Joseph L. Guffy,* Hillsboro.

Dr. Marjorie J. Williams, Temple, and Miss Mary P. Clapp, Temple bacteriologist, showed the exhibit "Nocardiosis" at the International Congress of Clinical Pathology in Washington, D. C., in September.

Currently serving as members of the nineteen examining boards in the medical specialties, as reported in the October 2 *Journal of the American Medical Association,* are the following Texans: *Dr. Harvey C. Slocum,* Galveston, American Board of Anesthesiology; *Dr. Bedford Shelmire,* Dallas, advisory member of the American Board of Dermatology and Syphilology; *Dr. Willard R. Cooke,* Galveston, American Board of Obstetrics and Gynecology; *Dr. James T. Mills,* Dallas, chairman of the American Board of Plastic Surgery; *Dr. Truman G. Blocker, Jr.,* Galveston, American Board of Plastic Surgery; *Dr. Robert J. Rowe,* Dallas, American Board of Proctology; *Dr. Jack Kerr,* Dallas, associate member of the American Board of Proctology; and *Dr. Curtice Rosser,* Dallas, member of the advisory council of

the American Board of Proctology; and *Dr. Michael E. DeBakey,* Houston, Board of Thoracic Surgery (an affiliate of the American Board of Surgery).

Dr. Wendell H. Nickell was named president of the newly organized Goodfellow Flying Club at Goodfellow Air Force Base near San Angelo.

Dr. E. L. Clark, Cleburne, spoke to the Cleburne Optimist Club on poliomyelitis at its August 24 meeting.

Dr. E. P. Powell, Centerville, celebrated his seventy-fifth birthday in August at a dinner party for family and a few friends.

Dr. E. D. McKay's mother died at his home in Amarillo September 23. She resided in Oklahoma City.

Dr. Frank P. Sainburg and Mrs. Constance Smith Nance were married August 5 at the home of the bride's parents in Longview, where the couple will live.

Four Fort Worth couples have announced the birth of sons recently: *Dr. and Mrs. J. W. Collier,* September 5; *Dr. and Mrs. Will Horn, Jr.,* July 11; *Dr. and Mrs. William W. McKinney,* August 20; and *Dr. and Mrs. H. W. Thomas, Jr.,* August 12.

Dr. and Mrs. Leo Duflot, Galveston, are parents of a girl born August 17, and *Dr. and Mrs. John L. Jackson,* Wichita Falls, of a girl born in September.

A boy was born August 31 to *Dr. and Mrs. Thomas O. Shindler,* Houston.

Dr. and Mrs. John Witt, Amarillo, are parents of a daughter born September 20.

Pathologists Campaign for Medical Examiners

The Texas Society of Pathologists has begun a campaign to have a system of medical examiners take over the coroner duties now held by the justices of the peace in Texas. The present state coroner law empowers justices of the peace to rule how a person dies and to sign death certificates in cases in which they conduct inquests.

At a meeting in San Antonio the society voted to sponsor a scholarship at the Institute for Forensic Medicine, University of Texas, Austin, with the intention of studying ways to overhaul the state's coroner law. At the society's January meeting in Dallas, a symposium on the campaign will be given.

The society has listed six ways in which murder can fool a layman coroner. These are death by poisoning, murder by suffocation, murder by a hard blow on the back of the head which may leave no external marking if death is not instantaneous and the skin is not broken, murder by drowning, murder by inserting air into the veins, and murder by injecting excessive amounts of insulin into the veins. The pathologists believe that many of the deaths in Texas which are listed as being from "natural causes" have behind them foul play which could be detected by medical examiners but is not discovered by laymen.

Internists Meet in Atlanta

The Texas Club of Internists met November 1-5 in Atlanta, Ga., with the Emory University School of Medicine as host. Approximately fifty members attended the five day meeting. Members of the auxiliary of the group were invited to a buffet on October 31 in honor of the charter members Dr. David W. Carter, Jr., Dallas; Dr. Alvis E. Greer, Houston; Dr. Robert B. McBride, Dallas; and Dr. Charles T. Stone, Galveston. This was the thirtieth anniversary of the Club.

Speakers included Drs. R. Hugh Wood, Dean of the School of Medicine, Arthur J. Merrill, Albert A. Brust, Walter Lyon Bloom, Eugene B. Ferris, J. Gordon Barrow, H. S. Weens, Spalding Schroder, R. Bruce Logue, Osler A. Abbott, Charles M. Huguley, Carl C. Pfeiffer, Walter H. Sheldon, Luther G. Fortson, Morris Tager, Charles A. LeMaistre, and Walter Lynch Bloom.

Also, Drs. Thomas C. Hill, Jr., John H. Peters, Walter H. Thiele, Israel R. Berger, Walter H. Cargill, James C. Crutcher, E. Napier Burson, Ralph B. Hogan, Donald S. Martin, Sidney Olansky, Joseph S. Wilson, Gerald R. Cooper, Edward W. Hook, Milton J. Krainin, James A. Hagans, and Marion M. Brooke, Sc. D., and Libero Ajello, Ph. D., Alfred E. Wilhelmi, Ph. D.

A buffet supper honoring the hosts was given on November 4. Auxiliary entertainment included a one day trip to Ida Cason Callaway Gardens and return trip by way of Warm Springs and a visit to the Little White House, and a tour of points of interest and beauty in Atlanta.

UNIVERSITY OF TEXAS MEDICAL BRANCH

Visitors from foreign countries recently speaking at the Medical Branch were *Dr. A. Francescetti,* Geneva, Switzerland. Director of the Ophthalmology Clinic of the University of Geneva, he gave the annual John McReynolds Lecture in Ophthalmology for 1954, speaking on "Cataract in Relation to Hereditary Skin Disorders," on October 15. *Dr. Francis E. Camps,* professor of forensic medicine at the University of London, conducted conferences and seminars relating to the coordination of medical, legal, and scientific personnel in connection with medical legal problems. *Dr. Neville F. Stanley,* director of epidemiology in the Public Health Service of New South Wales, Australia, spoke on October 18 on "Newer Trends in Poliomyelitis Research." He also gave a series of conferences and seminars on technical aspects of handling poliomyelitis virus in relation to epidemics.

A special seminar on "Advances in Neuro-Pathology" was given on November 9 by *Dr. Webb Haymaker,* neurologist of the Armed Forces Institute of Pathology.

Another out-of-state speaker during October was Dr. Walter J. Meek, emeritus professor of physiology at the University of Wisconsin, who gave a series of lectures and seminars at the Medical Branch. A special seminar on "The Role of Potassium in Cardiac Irregularities" was included in the lectures, as was a discussion for members of the staff on "The Gentle Art of Poisoning."

Dr. R. Anliker, Department of Organic Chemistry, Federal Institute of Technology, Zurich, Switzerland, spoke at the Medical Branch on November 2 on "Synthesis in Vitro and Vivo of Cortisone."

General Elbert DeCoursey, director of the Armed Forces Institute of Pathology, Washington, D. C., spoke on Radiation Injuries on November 3.

EXAMINATION FOR MEDICAL OFFICERS

A competitive examination for appointment of medical officers to the regular corps of the United States Public Health Service will be held throughout the country February 15-17, 1955. Requirements for both assistant and senior assistant surgeon are United States citizenship, the age of at least 21, and graduation from a recognized school of medicine. To be an assistant surgeon, at least seven years of collegiate and professional training and appropriate experience are needed, and for senior assistant surgeon, at least ten years of collegiate and professional training and appropriate experience are needed.

Application forms, which must be completed and returned by January 12, may be obtained from the Chief, Division of Personnel, Public Health Service, Department of Health, Education, and Welfare, Washington 25, D. C.

National Meetings

The sixth *American Congress on Obstetrics and Gynecology* will be held in the Palmer House, Chicago, December 13-17. The meeting is sponsored by the American Committee on Maternal Welfare, Inc., and the American Academy of Obstetrics and Gynecology. Dr. William F. Mengert, Dallas, will be installed as president of the Academy on December 16. The program is designed for physicians, nurses, public health officials, and hospital administrators concerned with mother and baby care; it will consist of approximately thirty papers, twenty-two panels and symposiums, luncheon discussion groups, round-table discussions, and scientific and technical exhibits.

The thirteenth annual meeting of the *American Academy of Dermatology and Syphilology* will be held December 4-9 in the Palmer House. In addition to two new round-table panels added this year, seven special courses will be held the first two days at Northwestern University, the University of Illinois College of Medicine, and at Billings Hospital of the University of Chicago. The courses will include histopathology, mycology, roentgen-ray and radium therapy, bacteriology and virology of the skin, anatomy and embryology, and special problems in dermatohistopathology. Special lectures, symposiums, and scientific and technical exhibits will round out the program.

Practical Electrocardiology Course

A course in Practical Electrocardiology will be given December 6-10 in Houston. Lecturers will be Dr. Demetrio Sodi-Pallares, chief of the Department of Electrocardiology, National Institute of Cardiology, Mexico, D. F., and members of the faculty of the University of Texas Postgraduate School of Medicine and Baylor University College of Medicine. These schools are sponsoring the course in association with the Houston Heart Association, Texas Medical Association, Texas State Department of Health, Houston Society of Internal Medicine, and the Houston Academy of General Practice. All lectures, except on the evening of December 7, will be given in the Auditorium of the M. D. Anderson Hospital, the Tuesday evening one to be given in the Auditorium of the Jesse H. Jones Library.

In addition to Dr. Sodi-Pallares, local faculty will include Drs. Hugh D. Bennett, Edward W. Dennis, E. Ghent Graves, Clifton D. Howe, Abbe A. Ledbetter, Robert G. McConn, Dan G. McNamara, and B. F. Smith, all of Houston. Coordinator is Dr. Sidney Schnur, Houston.

The registration fee of $45 entitles the registrant to attend all or any part of the course. Medical students, interns, residents, and military personnel will be admitted without charge. Formal credit of thirty hours will be given by the American Academy of General Practice.

Doctor Draft

To make certain that enough doctors who have residency training in certain fields are in the armed forces after the expiration of the "Doctor Draft" act next July 1, a new program has been worked out by Dr. Frank Berry, assistant secretary of defense for medical affairs, and the officers assisting him.

A plan called the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program has been put in effect; it applies only to interns who have had no prior military service and who therefore have a two year obligation for service under the regular draft.

By October 10, the plan's first deadline, the young physicians were to have sent to the Defense Department a form stating their first, second, and third choices among the services; whether they want additional deferment for residencies, and, if so, choice of hospitals; and their preferred specialties. Any in this group not applying for reserve commissions will be subject to the regular draft, will not be considered for residency deferments, and will not have a choice of services.

Because it is estimated that about half of the interns will want residency deferments and only a quarter can be deferred if the Army, Navy, and Air Force are to get their quotas of physicians, a lottery is being used. Those winning deferments will stay in the reserves and be called up for duty as their specialties are needed after the completion of their residencies. Those losing will be called as needed at the end of their internships. The half not asking for deferments will be allowed a choice of the month to be called up, a privilege not accorded the others.

American College of Surgeons

The American College of Surgeons will have a sectional meeting January 17-19, 1955, at Galveston. The program will consist of early morning hospital clinics and hotel sessions which will include scientific reports, panel discussions, and surgical motion pictures.

Texas doctors on the program other than local physicians will be Drs. Albert W. Hartman, San Antonio; William D. Seybold, John M. Howard, and Luke W. Able, Houston; John R. Cochran, Fort Worth; and Ben J. Wilson, Ernest E. Muirhead, and J. Warner Duckett, Dallas.

Out-of-state speakers include Drs. Frederick A. Coller, Ann Arbor, Mich.; Harry H. McCarthy and Leon S. McGoogan, Omaha, Neb.; Kenneth W. Warren, Boston; Justin J. Stein, and Ian MacDonald, Los Angeles; Robert L. Sanders, Memphis, Tenn.; Jesus Lozoya Solis, Mexico, D. F.; Frank McDowell, St. Louis; William H. Frackelton, Milwaukee; Richard H. Mellen, Colorado Springs; Harry Wilkins, Oklahoma City; William L. Valk, Kansas City; Willis E. Brown, Little Rock; and Conrad G. Collins, New Orleans.

Dr. Robert M. Moore, Galveston, is chairman of the Committee on General Arrangements.

MEDICAL WRITING AND JOURNALISM COURSES

Four year courses in medical journalism and medical writing, which have been approved by the American Medical Writers' Association, have been inaugurated at the Schools of Journalism, University of Oklahoma, University of Illinois, and University of Missouri. The Writers' Association is seeking funds to establish a Visiting Lectureship on Medical Literature for American medical colleges and teaching hospitals and also to augment its Medical Journalism Scholarship Fund for needy students studying in the new four year courses. After students have graduated from one of these courses, medicine and its allied sciences and fields will have people especially trained in medical journalism and writing just as it now has laboratory technicians, health educators, hospital administrators, and other nonmedical graduates.

GP REVIEW

A six day postgraduate course, General Practice Review, will be given at the University of Colorado Medical Center during the week of January 17-22, 1955. Each day a separate area of practice will be presented. Monday, medicine will be reviewed; Tuesday, pediatrics; Wednesday, surgery; Thursday, anesthesiology; Friday, obstetrics and gynecology; and Saturday, trauma.

Hotel reservations will be made through the Office of Graduate and Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20, prior to December 20. Those wishing reserva-

tions for evening performances of the Western National Stock Show, which will be held concurrently, may make them through this office also.

ESSAY CONTEST OPENS

The fifteenth annual essay contest of the Mississippi Valley Medical Society, offering a cash prize of $100, a gold medal, and a certificate of award, has been announced. Contestants, who must be residents and citizens of the United States and be members of the American Medical Association, are asked to submit an unpublished essay on any subject of general medical interest and practical value to the general practitioner of medicine (medical economics and education included) by May 1, 1955. The winner will be invited to present his contribution before the twentieth annual meeting of the Society, September 28-30, 1955, at St. Louis.

Dr. Harold Swanberg, secretary, announced that the paper must be submitted in five copies and must not exceed 5,000 words. Additional information can be obtained from Dr. Swanberg, 209-224 W. C. U. Building, Quincy, Ill.

Postgraduate Course in Anatomy

A course in surgical and applied anatomy, which began November 2 and will last through June, 1955, is being given in Houston by the University of Texas Postgraduate School of Medicine and Baylor University College of Medicine.

LIBRARY SECTION

BRONCHOSCOPY

Bronchoscopy has been defined by Jackson and Jackson as "the endoscopic examination and treatment of the tracheobronchial tree and lungs, by means of the bronchoscope used as a speculum." Bronchoscopy is distinctly in the category of an art. The dramatic nature of the operative procedure has been exploited in the daily newspapers to a wide extent; hence the public at large is aware of this procedure.

Gustav Killian, professor of laryngology and rhinology at the University of Frieburg, was the first to show the possibilities of the use of the bronchoscope. In March, 1897, he removed a bone from the trachea of a patient. This led to the exploration of the bronchi, and on July 24, he showed the local medical society that he was able to introduce tubes freely into the air passages.

By his experiments he learned that the bronchi were freely movable, and by turning the patient's head he could explore the right or left ramifications of the bronchi. The lack of knowledge on the part of the medical profession that this was an examination which could be carried out with safety and with minimal discomfort to the patient prevented the use of the bronchoscope for several years.

There are many indications for bronchoscopy other than its special field of usefulness in removing foreign bodies. Bronchoscopy is indicated in any case of pulmonary disease of unexplained origin, the location of tumors, the collection of bronchial secretions for cytologic and bacteriologic study, chronic or persistent cough, carcinoma of the lung, and many other conditions.

The Memorial Library of the Texas Medical Association has purchased a copy of the motion picture film "A Bronchoscopic Clinic" from the Jacques Holinger Memorial Fund and is now making it available to the membership.

BOOKS RECEIVED IN OCTOBER

Alvarez, Walter C.: *Nervousness, Indigestion and Pain,* New York, Harper and Brothers, 1954.

Andrews, George Clinton: *Diseases of the Skin,* ed. 4, Philadelphia, W. B. Saunders, 1954.

Bower, Albert G.: *Diagnosis and Treatment of Acute Phase of Poliomyelitis and Its Complications,* Baltimore, Williams and Wilkins, 1954.

Brown, James Barrett, and McDowell, Frank: *Neck Dissections,* Springfield, Ill., Charles C Thomas, 1954.

Clark, Randolph Lee: *Book of Health—A Medical Encyclopedia,* Houston, Elsevier Press, 1953.

Flitter, Hessel Howard: *An Introduction to Physics in Nursing,* ed. 2, St. Louis, C. V. Mosby, 1954.

Freud, Anna: *The Ego and Mechanisms of Defense,* New York, International Universities Press, 1946.

Gillilan, L. A.: *Clinical Aspects of the Autonomic Nervous System,* Boston, Little, Brown and Company, 1954.

Hopkins, Edward Scott, and Schulze, Wilmer Henry: *The Practice of Sanitation,* ed. 2, Baltimore, Williams and Wilkins, 1954.

Jonas, Karl C.: *Babcock's Principles and Practice of Surgery,* ed. 2, Philadelphia, Lea and Febiger, 1954.

Kauvar, A. J., and Goldner, Martin G.: *Hypoglycemia and the Hypoglycemic Syndrome,* Springfield, Ill., Charles C Thomas, 1954.

McAuley, W. F.: *Concept of Schizophrenia,* New York, Philosophical Library, 1954.

Reddish, George F.: *Antiseptics, Disinfectants, Fungicides, and Chemical and Physical Sterilization,* Philadelphia, Lea and Febiger, 1954.

Russell, Lord: *The Scourge of the Swastika, A Short History of the Nazi War Crimes,* New York, Philosophical Library, 1954.

Sarton, George: *Galen of Pergamon,* Lawrence, Kan., University of Kansas Press, 1954.

Schiff, Leon: *Clinical Approach to Jaundice,* Springfield, Ill., Charles C Thomas, 1954.

Steinberg, Charles LeRoy: *Arthritis and Rheumatism,* New York, Springer, 1954.

Yater, Wallace Mason: *Fundamentals of Internal Medicine,* ed. 4, New York, Appleton Century-Crofts, 1954.

CONTRIBUTIONS TO THE LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library for the following recent gifts:

Dr. D. W. Brown, Jr., Fredericksburg, 312 journals.

Dr. Dan B. Hamill, Corsicana, Davis' "Gynecology and Obstetrics."

Dr. D. B. Harmon, Austin, 26 journals.

Dr. J. O. S. Holt, Jr., Dallas, 7 journals.

Dr. J. Edward Johnson, Austin, 3 books, 22 journals, 422 reprints and pamphlets.

Dr. Georgia Legett, Austin, 75 journals.

Mr. Philip R. Overton, Austin, 1 book, 111 journals, 45 reprints and pamphlets.

Dr. N. L. Schiller, Austin, 35 journals, 22 reprints and pamphlets.

Dr. Joseph Selman, Tyler, 1 book.

Dr. C. H. Standifer, Austin, 70 journals.

Terrell's Laboratories, Fort Worth, 2 journals.

MOTION PICTURES FOR LOAN

A Bronchoscopic Clinic

16 mm., silent, color, 33 minutes. Prepared by Drs. Paul H. Holinger, Kenneth C. Johnston, and Frank J. Navak, Ill.

This film portrays the value of and the indications for bronchoscopy in the study of diseases involving the tracheobronchial tree. It clearly and beautifully demonstrates the bronchoscopic appearance of a variety of lesions. A short abstract of the clinical history of each patient, presented in association with roentgenograms of the thorax and the pathologic findings, adds greatly to the teaching value of the film. The technique employed for the performance of intratracheal and intrabronchial photography is demonstrated. The film clearly shows that skill and infinite and painstaking care must have been extended to obtain such excellent photography.

This is a motion picture that should be studied by all physicians interested in diseases of the chest and in bronchoscopy; it should be available to all medical schools for student teaching. It demonstrates visually factors that otherwise are hard to grasp. It is certainly suitable for any type of medical meeting and should be of interest to all physicians. The photography is outstanding.

When You Choose Nursing

16 mm., sound, 20 minutes. Prepared by the Committee on Careers in Nursing; available through courtesy of the Woman's Auxiliary to the Texas Medical Association.

Designed primarily for student nurse recruitment, the film presents four major fields in nursing: pediatrics, education, industry, and public health. Students and graduates are shown at work and play, with several scenes in the nurses' residence.

The film ends with a montage which presents nursing opportunities other than the four portrayed. The narrator says, "No matter which branch you choose, you can be assured of a full, interesting life; the opportunity to alleviate pain and suffering; and to help others when they need you most. A career in nursing is a career with a future. Sometime, somewhere, everyone of us needs a nurse. The nursing profession, now more than ever before, wants qualified young men and women to prepare for a nursing career."

BOOK NOTICES

[1]First Aid and Resuscitation

LT. CARL B. YOUNG, JR., M.P.H., *Instructor, Emergency First Aid, Former Assistant Director, Harris County Emergency Corps, Inc., Houston; Member, International Rescue and First Aid Association, First Lieutenant, Medical Service Corps, U.S.A.R. 338 pages. $8.50. Springfield, Ill., Charles C Thomas, 1954.*

The thoughtfulness of the author in the dedication of this book to fire rescue squads and volunteer life saving organizations is commendable and deserves comment. It is also worthy of note we should be aware of the fine work that is being carried on in Harris County and the Houston area.

In this book the fundamentals of first aid such as control of bleeding, resuscitation measures for those who are not breathing, treatment for those who have taken poison, prevention and treatment of shock, proper care of burns and other wounds, immobilization of fractures and dislocations, care in handling, and proper transportation are all taken up and given their proper discussion.

Other things such as acute heart emergencies, acute indigestion, cerebral vascular accidents, injuries to the air passages and chest wall, acute alcoholism, and acute drug intoxication are treated with practical suggestions for their emergency handling.

In the discussion of the transportation of the seriously ill and injured and emergency ambulance service, the author discusses the advantages of municipally operated ambulance services. He omitted one part which he might have related ---some of the sordid conduct of funeral homes who engage in body chasing runs and their reckless handling of patients, which results in fatalities.

The sections on oxygen therapy and the importance of records and statistics being accurate are well done. The chapter urging cooperation of the first aid crews with physicians, police officials, and utility companies is well evaluated and places the medical profession in the proper perspective, but at the same time physicians must reciprocate in the management of the sick and injured.

A well illustrated book, it deals realistically with the subject matter.

[1]*Joe C. Rude, M. D., Austin.*

[2]The Jealous Child

EDWARD PODOLSKY, M. D., *Department of Psychiatry, Kings County Hospital, Brooklyn, N. Y. 147 pages. $3.75. New York, Philosophical Library, 1954.*

This book takes up not only the problem of jealous children but also problems of the lefthanded child, the diabetic child, the obese child, the deaf child, the unwanted child, and the child from divorced parents. It is full of philosophical comments with little practical advice concerning the management of the jealous child.

Menorrhalgia—Menstrual Distress

WILLIAM BICKERS, M. D., *Diplomate, American Board of Obstetrics and Gynecology; Attending Gynecologist to Retreat for Sick, Sheltering Arms, Richmond Community, and Evangeline Booth Hospitals, Richmond, Va. Edited by* E. C. HAMBLEN, B. S., M. D., F.A.C.S., *Professor of Endocrinology and Associate Professor of Obstetrics and Gynecology, Duke University School of Medicine, Durham, N. C. 97 pages. $2.75. Springfield, Ill., Charles C Thomas, 1954.*

This book is an excellent exposition of its subject. The author speaks with authority since he has been interested in menorrhalgia for many years. Each chapter is followed by a list of references. The various forms of treatment are discussed with special emphasis on Dr. Bickers' own.

Oestrogens and Neoplasia

HAROLD BURROWS *and* ERIC S. HORNING *with contributions by* W. C. J. ROSS *and* C. W. SHOPPEE. *189 pages. $6.75. Springfield, Ill., Charles C Thomas, 1952.*

The authors are distinguished pioneers in the field of cancer research. This authoritative review of the scientific literature on the effects of estrogens as a cause of cancer is clearly presented. There are discussions on the effect of estrogens on tumors of the ovary, pituitary glands, testes, adrenal glands, and urogenital organs. The hereditary factors in mammary cancer are discussed, and many charts are presented on the subject. It was not the intention of the authors to have this monograph used as a guide to therapy but as an aid to the interested physician and the research worker. The complex data are skillfully presented. The references are in alphabetical order by author, but the titles have been omitted; there is an excellent index.

[2]*A. L. Exline, Jr., M. D., Austin.*

[3]**Doctor at Sea**

RICHARD GORDON. *191 pages. $3. First American edition. New York, Harcourt, Brace and Company, 1954.*

This is an amusing book about the adventures of a company physician on a British merchant ship. The young doctor leaves his socialized medical practice in England on the advice of a psychiatrist to avoid an unfortunate marriage. Aboard the Lotus he finds that the crew is suspicious of him because of a long line of alcoholic predecessors. He manages to work around the inadequate medical chest and finds his place among the crew by becoming a relaxed alcoholic. "Doctor at Sea" presents many humorous incidents and makes good light reading.

[4]**Practical Electrocardiography**

HENRY J. L. MARRIOTT, M. D., *Associate Professor of Medicine, University of Maryland; Assistant Cardiologist, Mercy Hospital, Baltimore. Illustrated by Marcie Ethridge Perry. 171 pages. $5. Baltimore, Williams and Wilkins Company, 1954.*

All of the intricate, uninteresting, and detailed electrophysiology that is usually written in books on electrocardiology have been omitted from this book. It is to be used primarily as a manual and for quick reference for the beginner in electrocardiology.

The summary at the end of each subject matter, given in a clear cut and concise manner, is excellent. These summaries are especially good in the section on cardiac arrhythmias.

Many types of precordial leads are advocated; this may cause the beginner some concern. Using the Wilson V lead for all precordial leads reduces variations in potentials common with these other precordial leads. These variations can become confusing even to the well trained observer.

It is true that the augmented unipolar leads are not essential for the reading of an electrocardiogram. The use of all frontal plane leads, however, makes a better interpretation of the electrocardiogram possible.

The terms "left axis deviation," "right axis deviation," and "ventricular strain" used by the author have lost their meaning in present day electrocardiography.

This is a short, clear cut, and concise manual. It has been presented well and has a place in the library of the beginner in electrocardiography.

[5]**The Uncommon Heart Diseases**

NATHANIEL E. REICH, M. D., F.A.C.P., F.C.C.P., *Clinical Assistant Professor of Medicine, State University of New York College of Medicine; Associate Attending Physician, Kings County Hospital; Attending Physician in Cardiology, Veterans Administration; Attending Cardiologist, Jewish Sanatorium and Hospital for Chronic Diseases. 516 pages. $10.50. Springfield, Ill., Charles C Thomas, 1954.*

This book constitutes a new and novel approach to this subject. Rich in pathologic physiology of the heart, it has many valuable points. It has a few but well chosen references at the end of each chapter.

Subjects such as the fungus diseases of the heart, barely mentioned in standard texts, are clarified in this book. The collagen disorders are made as clear as they may be made; the study of enzymes and their importance is emphasized. This is a good source of information on the subject of myocarditis.

Being the product of one man makes the book's contents more valuable than if many men had contributed a chapter each. It is a "must" for the library of the cardiologist, internist, or general practitioner.

[3]*A. L. Exline, Jr., M. D., Austin.*
[4]*Lang F. Holland, M. D., Austin.*
[5]*James R. O'Neill, M. D., and Henry N. Leopold, M. D., San Antonio.*

ORGANIZATION SECTION

AMERICAN MEDICAL ASSOCIATION

AMA Clinical Meeting in Miami

The American Medical Association Clinical Meeting will be held in Miami, Fla., November 29-December 2. The House of Delegates will convene Monday, November 29, in the McAllister Hotel; and the scientific meetings and scientific and technical exhibits will be held in the Dinner Key Auditorium.

Scientific programs will be given Monday afternoon, Tuesday and Wednesday mornings and afternoons, and Thursday morning. More than one hundred physicians will present scientific papers or participate in panel discussions. The meeting is directed toward alleviating the everyday medical problems of the physician. Even though specialties of surgery, medicine, obstetrics and gynecology, pediatrics, and neuropsychiatry are represented at the meeting, the program is directed toward the general practitioner who has to face these problems. The opening general assembly will be on Monday morning, at 10:25 o'clock.

Motion pictures will be shown from Monday morning through Thursday noon, as will color television. Programs originating from Miami's Jackson Memorial Hospital will be brought directly into the lecture hall. Leading surgeons and obstetricians will be available at the scientific exhibit for conferences with individual doctors on problems in fracture cases and deliveries. The technical exhibit will have more than one hundred thirty organizations participating.

Registration Bureau will be at the Dinner Key Auditorium, and an information booth will be there also. All those registering early on Monday will have their names and Miami addresses included in the issue of the *Daily Bulletin* appearing the next day, and this will enable visiting physicians to find friends who have registered. Presenting the 1954 American Medical Association membership pocket card will enable members to register without delay. General officers and members of the House of Delegates may register for the Scientific Assembly near the entrance to the Flagler Ballroom in the McAllister Hotel on Monday. They can also register on Saturday, November 27, or Sunday, November 28, in the office of the secretary of the Association, which will be located near the Flagler Ballroom.

Preceding the clinical meeting, Dr. Elmer Hess, President-Elect, will conduct the Association's Seventh National Medical Public Relations Conference. This will begin at 10 a. m. Sunday in the Flagler Ballroom of the McAllister Hotel. The meeting will feature panel discussions on implementation of the AMA's policy on veterans' medical care, on professional management consultants, and of public relations tools and aids available from the Association's Public Relations Department. A special screening of the new television film, "A Life to Save," has been scheduled.

The Woman's Auxiliary to the Dade County Medical Society will maintain a Courtesy Corner in the Columbus Hotel. The auxiliary will give visiting ladies information about places to visit in Miami and has planned one special tour, a cruise to Villa Vizcaya, the palatial estate of the late James Deering, now maintained as a county-operated museum. The auxiliary will arrange other tours if desired.

Invitations from the Jamaica Branch of the British Medical Association and the Medical Association of Haiti have come to encourage members of the AMA attending the conference to visit them after the Miami meeting. The Jamaica association will meet in Kingston, on Saturday, December 4, and will hold a reception in the evening. A meeting of the Haiti association will be held at Port-au-Prince on Saturday, December 4. A special series of social and entertainment events will be planned for those who come to the medical session. Travel information about these can be obtained from the American Express Company in Miami.

Texas physicians appearing on the scientific program include Dr. Alvis E. Greer, Dr. Denton A. Cooley, and Dr. Michael E. DeBakey, Houston; Dr. Charles L. Martin, Dallas; and Dr. Hamilton Ford, Galveston. Four groups of Texans will present scientific exhibits as follows: Drs. Edward W. Dennis, Robert L. Herschberger, John H. Moyer, and Ralph V. Ford, Houston, "The Medical Management of Hypertension"; Drs. DeBakey, Cooley, and Oscar Creech, Jr., Houston, "Aneurysms and Thrombo-Obliterative Disease of the Aorta—Surgical Considerations"; Drs. B. F. Boylston and Roland Carroll, Houston, "Normal and Abnormal Roentgenograms of the Cervical Spine"; and Drs. Gilbert H. Fletcher, Jacob W. Old, and George S. Loquvam, Houston, "A Topographic Approach to the Roentgenologic and Pathologic Examination of Laryngopharyngeal Tumors."

The following five physicians from the Surgical Research Unit of Brooke Army Medical Center, Fort Sam Houston, will also present a scientific exhibit: Drs. Curtis P. Artz, Harry S. Soroff, Alvin W. Bronwell, Eric Reiss, and John H. Davis, on "Treatment of Burns."

Standard Nomenclature Institute

Sponsored for the first time by the American Medical Association will be a three day Standard Nomenclature Institute February 7-9, 1955, at AMA headquarters, Chicago. The short course will offer expert instruction and helpful suggestions on the correct way of utilizing "Standard Nomenclature of Diseases and Operations" in the hospital, doctor's office, or clinic.

The course will be divided into three parts: (1) lectures covering basic principles, construction, and installation plus discussion on the tumor and operation sections and handling of specific problems; (2) anatomy as it pertains to the topographic section; and (3) practice in coding, to be offered at two evening sessions.

With registration limited to 150, application blanks will be distributed after December 1.

DEADLINES FOR JUNE AMA MEETING

The deadline for those planning to participate in the Atlantic City meeting of the American Medical Association, June 6-10, 1955, has been announced by the Council on Scientific Assembly. Deadline for section papers is December 15, 1954, and deadline for scientific exhibits is January 10.

Applicants should communicate with the secretary or the representative to the scientific exhibit of the section in which they are interested. Additional information can be obtained from the secretary, Council on Scientific Assembly, A.M.A., 535 North Dearborn St., Chicago 10.

TEXAS MEDICAL ASSOCIATION

Williston New Executive Secretary

C. Lincoln Williston became executive secretary of the Texas Medical Association on November 1.

Coming to the Association on April 2 as assistant executive secretary, Mr. Williston had been manager of public relations for the University of Illinois Medical Center in Chicago since 1947. He was also chairman of the Medical Schools Section, American College Public Relations Association; lecturer in public relations, Northwestern University; and chairman, Section on Public Relations, Tri-State Hospital Assembly.

C. LINCOLN WILLISTON

He was graduated from the University of Illinois in 1942 with a bachelor of science degree and served as a captain in the United States Air Force on Guam during World War II.

Mr. Williston is married and has two daughters, Christine, 5, and Jayne Ann, 4, and a son, C. Lincoln, who was born last July.

VISITATIONS FOR DECEMBER

Officers and members of the central office staff of the Texas Medical Association will visit the following county medical societies in December: Kimble-Mason-Menard-McCulloch Counties, December 8; Angelina County, December 9; Bexar County, December 14; Hardin-Tyler Counties, December 21; and Comal County, date not determined.

COUNTY SOCIETIES

Cameron-Willacy Counties Society

October 18, 1954

(Reported by Harry A. Miller, Secretary)

Subarachnoid Hemorrhage—Robert C. L. Robertson, Houston.

The Cameron-Willacy Counties Medical Society met on October 18 at Harlingen with eighty-four doctors and guests present. Evan B. Hume, Brownsville, chairman of the tumor clinic committee, reported that attendance is good at the Tumor Clinic, which is held bimonthly. After Howard E. Tewell, Jr., Harlingen, called the x-ray survey of South

Texas counties to the attention of the membership, it was voted to ask the mobile unit to include Willacy County in the tuberculosis survey.

Elected to membership in the society were Hendrik Evart J. Kruisheer, Harlingen, and David W. Flory, Brownsville.

After a discussion about the advisability of having all members of the Cameron-Willacy society listed as such in a specified section of the telephone directory, the problem was referred to the committee on public relations. This committee was to discuss the matter with the telephone company and report its findings at the next meeting.

Lamar County Society

October 7, 1954

(Reported by Harold E. Hunt, Secretary)

Present Medical Treatment of Tuberculosis—H. Frank Carman, Dallas.

The Lamar County Medical Society met in Paris on October 7 with sixteen members and six guests present. After dinner, the above scientific program was held. It was announced that the program for the November 4 meeting would be provided by an officer and a member of the central office staff of the Texas Medical Association.

Lubbock-Crosby Counties Society

September 7, 1954

(Reported by Richard K. O'Loughlin, Secretary)

Problems of Obstetrics and Gynecology in General Practice—Allen T. Stewart, Lubbock.

Discussion—Ewell Hunt, Frank Hudgins, John Selby, and Marie Shaw, Lubbock.

Hemorrhage now exceeds infection and toxemia as the most formidable complication of obstetrics, Allen T. Stewart told members of the Lubbock-Crosby Counties Medical Society when they met September 7 in Lubbock. Dr. Stewart amplified on the physiology of bleeding from the reproductive tract and stressed the importance of early detection of malignancy of the uterus by the general practitioner.

Members of the society were encouraged to donate books for the medical reading room of the new library. They approved classified headings for medical specialists for use in the telephone directory. Dr. Roy Sheffield was appointed representative to attend a meeting of the Welfare Board later in the month.

Potter County Society

September 13, 1954

Injuries Around the Elbow in Children—E. M. Cowart, Houston.

After a three months vacation the Potter County Medical Society met September 13 in Amarillo for a dinner, program, and business session.

A visiting orthopedic surgeon, E. M. Cowart of Houston, presented a scientific paper, after which the society unanimously voted to invite the Negro doctors of Amarillo to attend its regular meetings and dinner; accepted a report from the Citizens Committee on Health, Recreation and Welfare Service of Amarillo; heard four proposed amendments to the constitution and by-laws; and acted on several membership matters.

Visitors from the staff of the Amarillo Air Force Base hospital and from Panhandle were present.

Tarrant County Society

September 21, 1954

(Reported by S. W. Wilson, Secretary)

Clinical-Pathological Conference—Robert Mitchell, Fort Worth, Moderator.

Discussion of the Case—DeWitt Neighbors, T. H. Thomason, and Robert Moreton, Fort Worth.

Pathological Findings—John Wallace, Fort Worth.

Organization of a softball team to play the Fort Worth Amputee Club during National Employ the Physically Handicapped Week, October 3-9, was begun at the September 21 meeting of the Tarrant County Medical Society. In answer to a letter from the Amputee Club's president challenging the physicians to a game, Robert Stow and Louis Levy were named to organize a team.

Four physicians were elected to membership upon application; four on transfer.

Seventy-four members and three visitors heard the program outlined.

October 5, 1954

(Reported by S. W. Wilson, Secretary)

Venous Diseases—Leroy J. Kleinsasser, Dallas.

The Tarrant County Medical Society met in Fort Worth on October 5 and heard the above scientific program. Ernest E. Anthony, Jr., Fort Worth, reported for the legislative committee on social security, and a resolution requesting repeal of Section 106 of Public Law 761 was adopted.

Elected to membership in the society were M. W. Brous, Harold R. High, Joanne Kenner, James R. McKinney, and Charles A. Rush, Jr.

Tom Green-Eight County Society

October 4, 1954

(Reported by Joe L. Cornelison, Secretary)

Chest Pain—Julian H. Acker, Wichita Falls.

The Tom Green-Eight County Medical Society met October 4 in San Angelo. After a short business meeting, the above scientific paper was heard.

DISTRICT SOCIETIES

Fourth District Society

October 21, 1954

(Reported by James N. White, Secretary)

Abdominal Tumors in Childhood—Luke W. Able, Houston.

Surgical Emergencies of Newborn—Dr. Able.

Roentgen-Ray Diagnosis of Urologic Conditions—Palmer E. Wigby, Houston.

Roentgen-Ray Diagnosis of Nonmalignant Diseases of Chest—Dr. Wigby.

Management of Rh Patient—Warren M. Jacobs, Houston.

Indications for Hysterectomy, Vaginal and Abdominal—Dr. Jacobs.

Sexual Precocity and Retardation—Mavis P. Kelsey, Houston.

Management of Thyroid Tumors—Dr. Kelsey.

The Fourth District Medical Society met October 21 in San Angelo and heard the program as outlined above. The group also heard a speech by F. J. L. Blasingame, Wharton, President of the Texas Medical Association, at a luncheon attended by one hundred. Mr. C. Lincoln Williston, assistant executive secretary of the state organization, gave a resumé of the activities and plans of the central office in regard to district and county meetings. Other visitors present for the luncheon were Mrs. Joseph H. McCracken, Jr., Dallas, President-Elect of the Woman's Auxiliary to the Texas Medical Association; Mrs. A. B. Pumphrey, Fort Worth, chairman of the Auxiliary Committee on Mental Health; Mrs. Oscar N. Mayo, Brownwood, council woman for the Fourth District; Mrs. Arleen Draker, Austin, Auxiliary executive secretary; Mrs. Cecil M. French, San Angelo, president of Tom Green-Eight County Auxiliary; and Mrs. Perry J. C. Byars, San Angelo, chairman of the State Auxiliary's Essay Contest Committee.

Newly elected officers are James N. White, San Angelo, president; Oscar N. Mayo, Brownwood, vice-president; and Joe B. Stephens, Bangs, secretary. Oran H. Chandler, Ballinger, was nominated for councilor for 1955.

The program was put on by the University of Texas Postgraduate School of Medicine.

AUXILIARY SECTION

EXECUTIVE BOARD MEETING

The Executive Board of the Woman's Auxiliary to the Texas Medical Association met in the Sam Thompson Room of the Texas Medical Association headquarters building, Austin, at 1 p. m., Wednesday, September 22, 1954, with the President, Mrs. Mark H. Latimer, Houston, presiding.

Mrs. P. R. Denman, Houston, Chaplain, gave the invocation and a short devotional on prayer. The group repeated the Auxiliary pledge in unison.

Mrs. Latimer greeted those present and introduced Mrs. S. W. Bohls, Austin, president of the Woman's Auxiliary to the Travis County Medical Society, who welcomed members and guests to Austin. She introduced Mrs. G. G. Zedler, Austin, president-elect of the Travis County Auxiliary and local arrangements chairman for the meeting. Mrs. O. M. Marchman, Dallas, responded.

Mrs. G. V. Brindley, Temple, introduced the past state presidents attending the meeting. These included Mesdames Brindley; E. W. Coyle, San Antonio; P. R. Denman, Houston; Joseph B. Foster, Houston; S. M. Hill, Dallas; F. F. Kirby, Waco; O. M. Marchman, Dallas; A. B. Pumphrey, Fort Worth; and O. W. Robinson, Paris. Mrs. Brindley then presented the state committee members, county presidents and presidents-elect, and other visitors.

Mrs. John H. Wootters, Houston, moved that notes be sent to those past state presidents unable to be present. The motion was carried.

In the absence of Mrs. William M. Palm, Houston, Corresponding Secretary, Mrs. Arleen Draker, Austin, Executive Secretary, announced that letters or telegrams had been received from several members who could not be present. A letter from Mrs. George Turner, El Paso, expressed her thanks for the $101 gift to the American Medical Education Foundation given in her honor by the Texas Auxiliary when she was installed as President of the Woman's Auxiliary to the American Medical Association and for the courtesies extended her.

Mrs. J. Guy Jones, Dallas, moved that a telegram regretting Mrs. Turner's absence be sent to her, and the motion was carried.

Mrs. Latimer expressed regret that Dr. F. J. L. Blasingame, Wharton, President of the Texas Medical Association, could not be present. Mrs. F. Paul Burow, Killeen, moved that a cablegram of greetings be sent Dr. Blasingame, who was in Rome, Italy, attending a meeting of the World Medical Association. The motion passed.

The President then called for reports and recommendations from the state officers, committee chairmen, and council women. In place of a formal report, Mrs. Latimer referred members to her column which appears in each issue of the *News Letter* and reiterated her intention of trying to meet personally with as many county auxiliaries as possible during the year. She asked that these meetings be kept simple and said she hoped the smaller groups would adopt at least one project in which to engage and thereby become a vital force in the community for the betterment of health.

Officers of the Woman's Auxiliary to the Texas Medical Association: President, Mrs. Mark H. Latimer, Houston; President-Elect, Mrs. Joseph H. McCracken, Jr., Dallas; First Vice-President, Mrs. Mal Rumph, Fort Worth; Second Vice-President, Mrs. Harold Lindley, Pecos; Third Vice-President, Mrs. Howard R. Dudgeon, Jr., Waco; Fourth Vice-President, Mrs. Troy A. Shafer, Harlingen; Fifth Vice-President, Mrs. August J. Streit, Amarillo; Recording Secretary, Mrs. P. M. Kuykendall, Ranger; Corresponding Secretary, Mrs. William M. Palm, Houston; Treasurer, Mrs. J. C. Terrell, Stephenville; Publicity Secretary, Mrs. A. H. Neighbors, Jr., Austin; Parliamentarian, Mrs. John E. Hill, Marshall.

Mrs. Joseph H. McCracken, Jr., Dallas, President-Elect, expressed her appreciation for having been sent to the national convention in San Francisco. She gave a brief resumé of the meeting and announced that Mrs. Mason G. Lawson, Little Rock, who was endorsed by the Texas Auxiliary at its Executive Board meeting in San Antonio on May 5 for the nomination as President-Elect of the National Auxiliary, had been elected to that office.

Reports were given by Mrs. Mal Rumph, Fort Worth, First Vice-President, and chairman of the Organization and Membership Committee; Mrs. Harold Lindley, Pecos, Second Vice-President; Mrs. Howard R. Dudgeon, Jr., Waco, Third Vice-President; and Mrs. Troy A. Shafer, Harlingen, Fourth Vice-President.

Mrs. J. C. Terrell, Stephenville, Treasurer, reported a State Auxiliary membership of 4,761 and a balance on hand of $18,563.94. She requested that all contributions to the Auxiliary's philanthropic funds—American Medical Education Foundation, Library, Memorial, and Student Loan —be sent directly to the chairmen of these funds. January 15 to March 1, 1955, were the dates announced for payment of annual state dues.

Other officers reporting were Mrs. P. M. Kuykendall, Ranger, Recording Secretary; Mrs. A. H. Neighbors, Jr., Austin, Publicity Secretary; and Mrs. John E. Hill, Marshall, Parliamentarian.

Mrs. Joseph B. Foster, Houston, chairman of the Advisory Committee, announced her committee had been asked to review the custom of annually awarding blue ribbons to county auxiliaries for work done in certain fields. She stated the committee agreed that some adjustment should be made —either by doing away entirely with awards or by making only ones which could be decided on the basis of statistics. If awards are to be continued, the committee felt that a more effective plan for their distribution could be worked out. Mrs. Foster moved that the Board consider the problem of awards and that the Historical Committee and President be empowered to study the problem further and act accordingly. The motion was carried.

Mrs. J. V. Blair, Corpus Christi, Civil Defense chairman, announced Mrs. Grace M. Martin, College Station, State Coordinator of Women's Activities in Defense and Disaster Relief, was attending the Board meeting as her guest.

Upon motion by Mrs. John H. Wootters, Houston, chairman of the Historical Committee, the Board authorized the purchase of uniform filing binders and directed this committee to place the materials presently in the past presidents' books in the archives in these binders because the binders used heretofore have been too large to permit satisfactory filing. The Board also passed Mrs. Wootters' motion to have the Historical Committee select and purchase a binder and present it to the president each year.

In the absence of Mrs. Jacob F. Schultz, Houston, Mental Health chairman, the committee report was read by Mrs. A. B. Pumphrey of Fort Worth, co-chairman. Following the reading of this report, Mrs. Pumphrey called the Board's attention to some projects suggested for Auxiliary members and incorporated in the material being sent out by the mental health chairman of the National Auxiliary. A discussion of these suggestions followed. Mrs. Guy E. Knolle, Houston, moved that the Board leave it up to the discretion of the local groups as to which material is used. The motion was carried.

Mrs. William D. Nicholson, Freeport, Nurse Recruitment chairman, presented a draft of a proposed manual for members of Future Nurses Clubs in Texas. She recommended

that the Auxiliary publish and distribute the proposed manual, which was written with the help of the State Committee on Careers in Nursing. The recommendation was approved. It was voted also to print and distribute to Texas high schools a brochure on nursing schools in Texas which previously had been compiled and distributed by the State Committee on Careers in Nursing.

Mrs. Guy E. Knolle, Houston, Program Chairman, introduced Miss Pauline Duffield, Austin, librarian for the Memorial Library of the Texas Medical Association, who stated that the use of films available from the Library has increased because of requests by Auxiliary members.

Mrs. Knolle moved that the Auxiliary purchase two or three films, after they have been previewed and passed on by the Program Committee, total cost not to exceed $250. The motion was carried. Also upon a motion by Mrs. Knolle, the Board voted to adopt a resolution favoring "A Family Doctor for Every Doctor's Family" and to send copies of the resolution to the Woman's Auxiliary to the American Medical Association and the American Academy of General Practice.

Mrs. Milton Spark, Waco, *Today's Health* chairman, recommended that the Auxiliary send subscriptions of *Today's Health* to the two United States Senators and the Governor and Lieutenant Governor of Texas. This was approved. Mrs. Spark announced that any organized county auxiliary in Texas which is able to get renewals from unorganized areas will receive credit for these renewals. She suggested the Finance Committee follow the recommendations of the past year's chairman when allocating funds for this committee's work.

Mrs. Ridings E. Lee, Dallas, Public Relations chairman, displayed a foldertype mailing piece being distributed by the National Auxiliary and giving county auxiliary objectives, the Auxiliary pledge, and a brief history of the Auxiliary and its program and projects. The Board approved Mrs. Lee's motion that enough money be voted to have orientation folders similar to the one shown printed for the State Auxiliary membership.

Mrs. Ramsay H. Moore, Dallas, reporting for the Revisions Committee in the absence of Mrs. T. H. Thomason, Fort Worth, chairman, recommended that the Board vote to have the newly revised By-Laws put into printed booklet form. This recommendation was approved.

Other committee chairmen reporting were Mrs. V. M. Longmire, Temple, Finance; Mrs. F. Paul Burow, Killeen, Legislation; Mrs. E. W. Coyle, San Antonio, Nominating; Mrs. J. L. Jinkins, Galveston, American Medical Education Foundation; Mrs. Allan Shields, Victoria, Library Fund; Mrs. J. Guy Jones, Dallas, Memorial Fund; Mrs. Charles V. Bintliff, Texarkana, *Bulletin;* Mrs. Haskell Hatfield, El Paso, *News Letter;* Mrs. Lynn Hilbun, Henderson, Reference; and Mrs. R. C. Bellamy, Liberty, Workshop. Mrs. Edward T. Smith, Houston, read the report of the Student Loan Fund Committee in the absence of Mrs. J. Charles Dickson, Houston, chairman. The report of the Essay Contest Committee as filed by Mrs. Perry J. C. Byars of San Angelo, chairman, was read in her absence by Mrs. Draker.

The following council women gave reports: Mrs. William C. Barksdale, Borger, District 3; Mrs. Andrew J. Magliolo, Dickinson, District 8; Mrs. C. M. Hansen, Navasota, District 9; Mrs. C. H. Stripling, Jacksonville, District 11; Mrs. W. Frank Armstrong, Fort Worth, District 13; Mrs. Emmett Essin, Sherman, District 14; and Mrs. Charles J. Wise, Naples, District 15.

Mrs. Latimer asked the Board to act upon the letter of resignation which had been received from Mrs. Scott C. Applewhite, San Antonio, member of the Revisions Committee. The Board voted to accept with regret Mrs. Applewhite's resignation.

Mrs. Longmire, reporting on recommendations of the Finance Committee, moved that funds be set aside for revising the State Auxiliary handbook and for the purchase of two wrought iron flower stands to be presented as a gift to the Texas Medical Association for the Sam Thompson Room. The motion was carried.

Mrs. Rumph read the report of the Courtesy Resolutions Committee in the absence of Mrs. Cecil O. Patterson, Dallas, chairman. The report expressed appreciation and thanks to Mrs. Mark H. Latimer, President; Mrs. S. W. Bohls, president of the Travis County Auxiliary; Mrs. G. G. Zedler, president-elect of the Travis County Auxiliary and chairman of the local arrangements committee; Mrs. R. C. Bellamy, Workshop chairman; N. C. Forrester, Executive Secretary of the Texas Medical Association and other members of the central office staff, particularly Mrs. Arleen Draker, Executive Secretary of the Auxiliary; and to the firm of Syers-Pickle & Winn, public relations counsel for the Association.

Mrs. Rumph moved the adoption of the committee's report, and the motion was carried.

Mrs. Latimer announced that the Southern Medical Auxiliary's annual convention will be November 8-11 in St. Louis. The Texas Auxiliary will be represented at the meeting by Mrs. McCracken.

After hearing other announcements, the President declared the meeting adjourned.

On Wednesday evening, September 22, Executive Board members boarded the Riverboat Commodore for a 10 mile ride up Lake Austin to the Greenshores Picnic Grounds, where a barbecued chicken supper was served.

On Thursday, September 23, Mrs. R. C. Bellamy, Liberty, conducted the Workshop for County Presidents and Presidents-Elect. Following the opening invocation, panel discussions on organization, program, public relations, philanthropic funds, and publications were held, with approximately thirty-five members taking part. N. C. Forrester, Executive Secretary of the Texas Medical Association, was introduced and in turn presented the central office staff members, describing the job of each. At noon a buffet luncheon was served in the Association building. Staff members were the guests of Mrs. Latimer at this luncheon.

Following the luncheon, motion picture films were shown. Guest speaker for the afternoon session was John H. Lane, Jr., field representative for the Texas Society for Mental Health, who spoke on "The Epidemic Nobody Talks About."

Approximately ninety-five attended the two day meeting in Austin.

MRS. P. M. KUYKENDALL, Ranger,
Recording Secretary.

WOMAN'S AUXILIARY CONFERENCE IN CHICAGO

The eleventh annual Conference of State Presidents, Presidents-Elect, and National Committee Chairmen of the Woman's Auxiliary to the American Medical Association is being held November 16-18 in Chicago. Mrs. Mark H. Latimer, Houston, President of the Woman's Auxiliary to the Texas Medical Association, and Mrs. Joseph H. McCracken, Jr., Dallas, President-Elect, are official delegates from Texas. Theme of the conference, which expected to draw about 200 state representatives and national leaders, is leadership in community health.

The program consists of panels on organization, legislation, program, publications, *Today's Health,* public relations, mental health, nurse recruitment, and Auxiliary finances, and a talk on the World Medical Association.

MRS. TURNER GOES TO EUROPE FOR CONFERENCE

Mrs. George Turner, El Paso, President of the Woman's Auxiliary to the American Medical Association, was one of

the seventy-six persons chosen to be a guest of the American Heritage Foundation to join an inspection tour of Radio Free Europe. In the interest of its Crusade for Freedom project, the foundation selected presidents or representatives of leading national organizations to be its guests on the tour and for conferences in Munich, Berlin, and Paris. The party flew from New York on October 20 and returned October 29.

COUNTY AUXILIARIES

The *Dallas County Auxiliary* sponsored a Nurse Recruitment Week the first week in September. To call attention to the importance and advantages of the nursing profession, television programs, posters, and store window displays were used during the week. Almost every high school in the county will have an auxiliary-sponsored future nurses club this year.

An art show with works done by members and their families featured the first meeting of the season held by *Tarrant County Auxiliary*. The show was in connection with a luncheon October 8 in Fort Worth at which a local artist, Mrs. Thelma Park, demonstrated several art media.

The *Navarro County Auxiliary* heard a review of the history of the Woman's Auxiliary to the American Medical Association by Mrs. Dan B. Hamill when it met September 3 in the home of Mrs. A. L. Grizzaffi, Corsicana. "The Patient's Watchdog," an article from *Today's Health*, was reviewed for the group by Mrs. Paul H. Mitchell October 1 at the home of Mrs. G. H. Sanders, Kerens. Committee reports were heard at both meetings, and attention was called to radio and television shows of special interest to auxiliary members.

DEATHS

W. J. McCREIGHT

Dr. William Joseph McCreight died in Anson, Texas, on August 17, 1954, from cancer of the lung.

Dr. McCreight, born November 29, 1888, in Stephens County, was the son of Joseph Samuel McCreight and Jane Elizabeth (Sharman) McCreight. Receiving his medical degree from the old Southern Methodist University Medical Department, Dallas, in 1914, Dr. McCreight interned at Parkland Hospital, Dallas. He practiced in Anson from

DR. W. J. McCREIGHT

that time until his death with the exception of his military service. Dr. McCreight served during World War I from January, 1918, to May, 1919, as a first lieutenant in the Army Medical Corps in France and with the Army of Occupation in Germany.

A member of the American and Texas Medical Associations almost continuously since 1916 through Taylor-Jones Counties Medical Society, Dr. McCreight served as president of his county society in 1930-1931. He was a member of the Southern Medical Association and was elected an honorary member of the Texas Medical Association in 1953. Dr. McCreight had served several times as city and county health officer and was county health officer at the time of his death. He was a member of the Masonic Lodge and the Baptist Church. Examining physician for Jones County local selective service board during World War II, Dr. McCreight was recognized with a certificate from the President of the United States for his work in that capacity.

Dr. McCreight and Mrs. Annie Hale King were married on June 21, 1915, in Anson. Surviving are his wife; three sons, W. J. McCreight, Jr., Abilene; Dr. Henry H. McCreight, Winters; and Charles T. McCreight, Lubbock; a step-daughter, Mrs. John L. McQuigg, Birmingham, Mich.; three brothers, Lloyd McCreight, Comanche, Okla.; Sherman McCreight, Oklahoma City; and Sidney McCreight, Duncan, Okla.; two sisters, Mrs. Mintie Clayton, San Francisco, and Mrs. Nell Holden, San Antonio; and eight grandchildren.

L. F. TAYLOR

Dr. Lafayette F. Taylor, Haskell, Texas, died July 7, 1954, at his home after an illness of more than two years.

Born May 12, 1873, in Denton County, Texas, Dr. Taylor was one of eight sons of a Baptist minister, the Rev. John J. Taylor, and Mrs. Taylor, three of whom became ministers and four doctors. He was graduated in 1894 from Memphis Hospital Medical College, now the University of Tennessee College of Medicine. After practicing in Pendletonville for three years, Troy for three years, and Eldorado for five years and also in Ozona and Hereford, Dr. Taylor moved in 1909 to Haskell, where he practiced until 1951, when he had a stroke and was confined to his bed. In 1952 the doctor was honored with the presentation of a Golden T Award from his medical school for more than fifty years of active practice.

A member of the Texas and American Medical Associations first in 1908 through the Randall-Deaf Smith-Parmer-Castro-Oldham Counties Medical Society and more recently through the Baylor-Knox-Haskell Counties Medical Society, Dr. Taylor had served as city-county health officer of Deaf Smith and Hereford Counties. He had helped organize the Haskell County Hospital and served on its staff for many years. He was on the school board at Haskell and on the board of directors of the Haskell National Bank. He be-

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

longed to Woodmen of the World Lodge and was a deacon of the First Baptist Church, Haskell.

Dr. Taylor and his wife, the former Miss Edna Pearl Bernero of Cedar View, Miss., whom he married on June 5, 1899, were among the first settlers of Bailey County, living on a ranch, and one of their sons was the first child born in the county. Mrs. Taylor preceded her husband in death in 1950. Dr. Taylor's survivors include two sons, Dr. Floyd Taylor and Bailey F. Taylor, both of Abilene; six daughters, Mrs. Richard E. Sherrill, Pittsburgh, Pa.; Mrs. T. M. French, Austin; Miss May Bell Taylor, a Baptist Missionary to Brazil but in Haskell on leave since 1951; Mrs. Edwin Fisher, Longview; and Mrs. G. H. Henshaw and Mrs. W. H. Carrothers, both of Abilene; twelve grandchildren; and five great-grandchildren. He is also survived by one sister, Mrs. Sam Williams, Scottsdale, Ariz., and three brothers, the Rev. Sam D. Taylor, San Saba; the Rev. W. W. Taylor, Phoenix, Ariz.; and the Rev. Gordon Taylor, Burnet.

J. D. WILLIAMSON

Dr. James Dorsey Williamson died on September 2, 1954, at his home in Castroville, Texas, of coronary occlusion.

Born in Learned, Miss., on March 13, 1912, Dr. Williamson was the son of Dr. and Mrs. R. D. Williamson. Dr. Williamson attended public schools in Castroville; Texas Military Institute, San Antonio; and the University of Texas, Austin, before entering the University of Arkansas School of Medicine, Little Rock, from which he was graduated in

DR. J. D. WILLIAMSON

1938. He interned at Santa Rosa Hospital, San Antonio, until 1939, when he organized the Castroville Clinic and Hospital. Dr. Williamson ran the clinic until the time of his death.

A member of the Texas and American Medical Associations continuously since 1942 through Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Medical Society, Dr. Williamson was secretary of his county society in 1949 and president in 1950 and had served as delegate. He was past president of the Bexar County chapter of the Heart Association; was a member of the Texas Academy of General Practice, Private Clinics and Hospitals Association of Texas, and Texas Hospital Association; and was health officer for Castroville. He had served on the staff of the Santa Rosa Hospital for sixteen years. Dr. Williamson was a member of the Travis Park Methodist Church, San Antonio. His main hobbies were fishing and swimming.

The former Miss Dorothy Mae Yerger and Dr. Williamson were married in Little Rock on June 6, 1939. She survives, as do two daughters, Dorothy Anne and Mary Louise Williamson; and one son, James Robert Williamson, all of Castroville, and one brother, Robert Edward Williamson, Little Rock.

S. A. KING

Dr. Stephen Allen King, Karnes City, Texas, died on July 13, 1954, in a San Marcos hospital of apoplexy after an illness of a year.

Dr. King, the son of H. P. and Emma (Bryan) King, was born in Shelby County on February 2, 1868. He attended the old Coronal Institute, San Marcos, and was

S. A. KING

graduated from the Hospital College of Medicine, Louisville, Ky., in 1890. He began practicing in Centerville, and in 1895 he moved to Karnes City, where he was a general practitioner until his retirement in 1953.

An early member of the Texas Medical Association, Dr. King held membership in that organization for approximately fifty years. He was also a member of the American Medical Association and the Karnes-Wilson Counties Medical Society, having served as president of the county society in 1940. County health officer for twelve years, he was active in civic and church work, being a member of the Baptist Church. In November, 1948, the citizens of Karnes City honored him and his wife with a "Dr. and Mrs. King Day" in recognition of their service to the community and of his more than fifty years of practice in Karnes City.

In 1897 Dr. King married the former Miss Bennie Makamson of Leona. She died in 1949. He is survived by a son, Dr. Allen D. King, Wilmington, Del.; two grandchildren, Miss Ernestine Loeffler King and Allen D. King, II, also of Wilmington; a brother, Henry P. King, San Marcos; and five sisters, Mrs. Annie Kennard, Miss Ola King, and Miss Sara King, all of San Marcos; Mrs. W. B. Taylor, Shawnee, Okla.; and Mrs. G. R. Cox, Bryan.

President's Page

YOUR DUES DOLLARS

The year 1954 is drawing to a close; and we look forward to 1955.

It is the season to pay our annual Association dues of $50. I think it is timely to discuss the manner in which this money is used and to point out the benefits and returns which members receive.

As you perhaps know, the dues are allocated as follows: General Fund, $30; Building Fund, $15; TEXAS STATE JOURNAL OF MEDICINE, $3; Woman's Auxiliary, $1; Medical Defense, $1.

This year the General Fund amounted to approximately $185,000, which provided about $76,000 for salaries to 23 employees. Other major expenditures from the General Fund were public relations ($12,000), legal services ($12,000), purchase of books, journals, and bindings for library ($10,000), operation and maintenance of building ($9,200), insurance and taxes ($9,000), public education (legislation) ($6,000), office supplies ($6,000), annual session ($3,600), and a few other minor expenditures.

The allotment of $15 to the Building Fund needs repeated explanation so that more members be kept informed. The central office building originally cost $732,000. This money was obtained by borrowing $120,000 from assets which had accumulated in the General Fund (none of which has yet been repaid), borrowing $61,000 ($30,000 of which has been repaid) from the Medical Defense Fund, and by securing a supplemental loan of $415,000 from the Equitable Life Assurance Society. This mortgage loan has been reduced to approximately $250,000 in a little over three years. The amounts originally borrowed from the General Fund and the Defense Fund, an as yet unpaid total $150,000, will require additional time from dues to repay.

Even though the dues were raised from $35 to $50 to cover the necessary allotment to the Building Fund, it is my considered opinion that the dues should continue at the present figure indefinitely and after retiring our outstanding indebtedness should accumulate a reasonable reserve fund for the future. Such a fund, in my judgment,

should be developed to at least $1,000,000 and perhaps more as our membership increases and as our state grows. After the present debt retirement, this present rate of income from dues, when later channeled into services by our Association, can produce a more effective program for our profession and the public. I believe our members will want this arrangement.

It is apparent that the returns are excellent on the $3 allocated to the TEXAS STATE JOURNAL OF MEDICINE, the $1 to the Woman's Auxiliary, and the $1 to the Medical Defense Fund.

To come to the current year, I should like to mention two things which directly effected financial savings to our members.

Last February the National Bureau of Casualty Underwriters filed an application for an increase of rates in Texas amounting to approximately 183 per cent on malpractice insurance premiums. The Texas Medical Association, through its officers and staff, appeared and testified and supplied facts to the Board of Insurance Commissioners which subsequently held the increase to 50 per cent. The rate of $25 per year for $5,000-$15,000 coverage was raised to only $38 instead of $72.

Collective action with other medical associations earlier this year resulted in the exclusion of the medical profession from social security and amounted to a saving of $126 per year for each physician at present tax rates.

It is impossible to estimate the value to the individual physician and to the public to be gained in having the Texas Medical Association strong and asserting its position and policies effectively. Such dividends may be intangible but are real and important.

Let us pay our Association dues gladly and realize that we obtain a wealth of benefits in return.

Best wishes for a blessed Yuletide and a happy and productive New Year.

J. J. L. Blassingame, M.D.

PR diagnotes

REPORT OF COMMITTEE ON PUBLIC RELATIONS: The second annual Medical Students' Days at Houston and Galveston, December 10 and 11, were enthusiastically received by almost 300 medical students from Baylor University College of Medicine and the University of Texas School of Medicine. Meetings were held in cooperation with Harris and Galveston Counties Medical Societies, respectively. Program's success underscores appreciation of students for information on the socio-economic side of medical practice.

The forthcoming Presidents' and Secretaries' Meeting, Austin, January 22 (see Organization Section of this Journal for complete program) has been enlarged to include society officers-elect, legislative chairmen, public relations chairmen, and delegates. Designed to ease the way for incoming officers with a strong indoctrination program, the 1955 session will feature talks by three out-of-state speakers, Frank G. Dickinson, Ph.D., Chicago, director, Bureau of Medical Economics Research, American Medical Association; Dr. George F. Lull, Chicago, secretary and general manager, AMA; and Edwin J. Faulkner, Lincoln, Neb., one of the nation's leading authorities on health and accident insurance and a strong critic of federal reinsurance legislation. It is vital that the central office be in receipt of names of newly elected officers at the earliest possible moment.

The central office recently has released results in its latest doctor distribution survey. Querying secretaries of the chambers of commerce and mayors of communities with a population exceeding 800 in the Texas Medical Association's District 4, the office reports that it received no

requests from the laymen for doctors. Nevertheless, physicians themselves, apparently, are more concerned with the distribution of doctors than are the key civic leaders, for it was the doctors' belief that excellent opportunity for additional physicians' services were warranted in from five to eight of the West Texas counties.

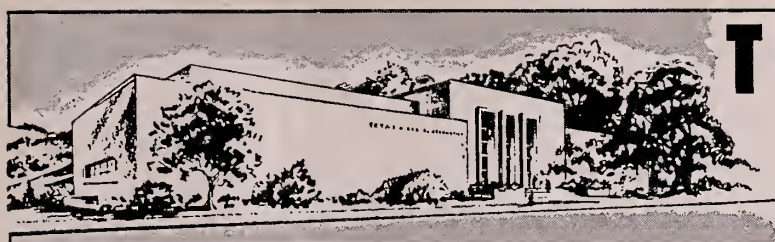
FROM OVER THE STATE: Bexar County Medical Society has entered into agreement with the National Bank of Commerce in San Antonio to facilitate handling of medical loans. Available for lump-sum services, such as obstetrical fees, surgical fees, hospitalization in excess of $75, the loans are drafted in the doctor's office by the secretary and the patient, and the bank clears the application within twenty-four hours. The society finds that this procedure clears secretaries for more valuable work and delegates any disagreeable collection relationships directly to the bank and the patient.

Several societies are sponsoring drop-in ads in their local druggists' ads on Sunday. Their approach is to remind readers that they are enjoying the finest medical care available in the world today, regardless of ability to pay. A well-founded series of this type should help to counteract complaints of the high cost of medical service. Any societies wishing information on this series can write the central office, 1801 North Lamar Boulevard, Austin, marking inquiries, "Attention: PR Diagnotes."

ON THE NATIONAL FRONT: The first comprehensive guide for county medical PR chairmen is just off the presses. Published by AMA Department of Public Relations, the 112 page manual is designed expressly to show county societies how to emulate or adapt to their own needs some of the most successful PR programs used by societies throughout the country. Soon to be available at the central office in Austin, this step-by-step outline of practice is slated for January distribution.

TIP OF THE MONTH

A lending library of TV-tested visual aids has been prepared by the AMA Bureau of Health Education for demonstration purposes. Anatomic charts, three-dimensional relief models, and films are available to medical societies without charge. Put your name on the list at the bureau for supplementary literature which will be issued as these lending library facilities expand.



TEXAS State Journal of Medicine

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION AND PUBLIC HEALTH IN TEXAS

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WORLD MEDICAL MEMBERSHIP

Much has been said and written about organized medicine, from the grass roots level to the national level, but the medical organization extends further. The World Medical Association, although only in its eighth year of existence, plays an increasingly important part in the over-all health picture of the world. An organization interested primarily in the methods by which medical care is provided, the relation between physician and patient, and the freedom of choice of treatment by the physician, the World Medical Association is the only medical organization that is in a position to speak on a voluntary basis at an international level on medical affairs, be they scientific, economic, or political. It is not controlled by any government, the basic difference between it and the World Health Organization.

The WMA's objective of assisting all people of the world to attain the highest possible level of health can and will be reached through promotion of closer ties among national medical associations and doctors, exchange of information on matters of interest to the medical profession, maintenance and protection of the honor and interest of the medical profession, study of and reports on professional problems, and other similar methods which require widespread support.

That doctors the world over are eager to cooperate in providing the best possible medical care for their patients was evident at the WMA's most recent meeting, held in Rome, Italy, September 26 to October 2. Delegates representing more than 600,000 physicians practicing in fifty member-countries discussed their mutual problems and the World Medical Association's major problem, finances. The usual financial struggle accompanying an organization's early growth is further complicated in the WMA's situation. There is a lack of funds on the part of some of the national medical associations and also a difficulty in transferring funds from one country to another.

The American Medical Association in 1947 formed a special committee of leaders in medicine and industry to support the World Medical Association. The United States Committee, Inc., pledged $50,000 a year for five years,

and already contributions from various sources have exceeded $500,000. In 1953 more than 4,000 doctors paid annual dues of $10; more than forty drug and other firms gave $50,000; and about forty medical organizations, foundations, and medical book publishers provided about $24,000. Texas has 158 members, ranking seventeenth among the states.

There are three types of membership in the United States Committee, Inc., World Medical Association, each type bringing with it the following benefits: (1) certificate of membership, (2) the bimonthly *World Medical Journal,* (3) letters of introduction to foreign medical associations and their members, (4) a part in defending the interests of practicing physicians before international groups, and (5) the satisfaction of sharing the advantages of our medical progress with other lands. A member pays dues of $10 a year, a sponsoring member $100 a year, and a life member $500 (no further assessment).

The work of the World Medical Association can be done only with the support of physicians—by giving and by joining. Membership dues and donations are tax deductible and should be included in every doctor's budget for 1955 professional expenses.

Christmas Prayer

Don't give us fame, oh Lord above,
Don't give us riches great.
We beg for peace, we long for love,
That stem from heaven's gate.
Let Christmas be,
Eternally,
The symbol of a world set free.
Not fame, nor pow'r, nor worldly worth,
But peace on earth!

—*Words by Z. Topelius.*
Set to music by Jan Sibelius.
Authorized translation by Eric Posselt:
"The World's Greatest Christmas Stories,"
New York, Prentice-Hall, 1950.

PATIENT CARE EMPHASIZED

Less than a year ago the medical, hospital administrative, and nursing professions of Texas banded together in a Joint Commission for the Improvement of the Care of the Patient to "stimulate, implement, assist in, and sponsor activities which will contribute to the care of the patient." First major activity of this commission, which was preceded by organization almost six years ago of a national commission with essentially the same objectives, was a conference on nursing held November 5 and 6 in Austin and reported at greater length in the News section of this JOURNAL.

Potentially, the Joint Commission for the Improvement of the Care of the Patient can perform a useful role. With representatives from the Texas Medical Association (four), Texas Hospital Association (four), Texas Graduate Nurses' Association (two), and Texas League for Nursing (two), the commission is a logical agency to which the professions concerned can bring information, problems, criticisms, suggestions, and plans with the expectation of receiving attention, help, explanations, advice, and cooperation as justified. The frankness of discussion and the specific recommendations already evident indicate that the current members of the commission are taking seriously the challenge of improving patient care.

Nevertheless, although discussions of mutual problems by even a few doctors, hospital administrators, and nurses are worth while and although workshops such as the nursing conference held recently can elicit important facts, the Joint Commission for the Improvement of the Care of the Patient essentially is limited to the extent that physicians, hospital managers, and nursing personnel working together in individual situations become aware of some of the problems pointed up by the statewide commission and unite to reach the best possible solutions locally.

One of the recommendations arising during

the conference on nursing was that local joint commissions for improvement of the care of the patient, representing at least the three professions on the state commission, be established. It is no more the responsibility of members of the Texas Medical Association than it is of members of the other cooperating state organizations to facilitate establishment of such local commissions, but it would be appropriate and praiseworthy if physicians would take the lead.

For those who plead that multiplicity of organizations already is confusing both the issue and the individual who attempts to understand and do something about it, it might be pointed out that the Joint Commission for the Improvement of the Care of the Patient is a vehicle for clarifying and coordinating thinking and effort which already is being expended but perhaps less effectively than it should be. Too, the central and all important focal point, the patient and his welfare, may have been brushed aside at times to make way for other laudable but tangential goals. It should be a salutary experience to concentrate again on the patient for whose benefit hospitals were built and doctors and nurses were trained.

IMPROVING MEDICAL ASSISTANTS

Stemming partly from the realization by physicians that their office personnel if properly trained can do much to keep patients happy and partly from the desire of doctors' assistants to improve themselves and increase their professional stature, a movement toward the establishment of organizations of medical assistants is under way.

The first such organizations in Texas appear to be in Dallas and Austin, where medical assistants have adopted constitutions, elected officers, and undertaken programs which eventually will embrace specific instruction in how to handle problems in the doctor's office as well as permit fellowship with others engaged in similar activities and informal exchange of questions and answers. The women currently holding membership in the organizations are enthusiastic over their future and what these associations can mean in added efficiency and satisfaction for their members. They also are gratified at the expressions of approval of the projects by their doctor-employers. The Travis and Dallas County Medical Societies and their officials are cooperating in efforts to assure that sound objectives and program are adopted.

Experts in medical public relations have pointed out repeatedly how important to public good will are the persons who work closely with the doctor and his patients. They add parenthetically that good medical assistants can mean the difference between a lucrative practice and one that keeps the doctor just one jump ahead of the bill collector. Although every physician bears the responsibility of explaining his own routine to his employees, most doctors welcome help in getting across to receptionists, secretaries, office nurses, and others who share the daily round of practice the basic differences between mediocre methods and attitudes and truly effective procedures. Organization of medical assistants with the proper motivation and guidance might contribute to this end.

Some have voiced the fear that doctors' assistants might eventually create another ancillary profession which would have to be regulated by law and which might complicate further the definition of practice of medicine. This objection to cooperation by physicians in the organization of medical assistants may have some validity. On the other hand, it seems evident that the medical assistants themselves, like persons in many other occupations, have felt the call toward greater skill, increased recognition, and in some instances adequate pay for a job well done and are not going to be satisfied with the status quo. Recognizing legitimate desires of their employees and acknowledging the worth of adequately trained assistants, physicians can do much in shaping the

pattern of medical assistants' organizations if they will take the initiative or will proffer their cooperation when it is sought.

The Committee on Public Relations of the Texas Medical Association sometime ago prepared material suitable for study by medical assistants. This basic outline has tips on a variety of subjects from how to answer the telephone to how to keep patients' charts, from what not to wear on the job to what to do to avoid malpractice suits. This material plus other information pertinent to the problem may be had from the central office of the Texas Medical Association by county medical societies upon request.

CURRENT EDITORIAL COMMENT

BUYING AND USING HEALTH AND ACCIDENT INSURANCE

After a prospective purchaser of health or accident insurance has decided about the type and amount of insurance he should have, he still needs to know about the specific policy he is considering. His doctor may help him to understand the policy by raising certain questions and helping to answer them. Here are some of the most important:

QUESTION. What are the exclusions and waiting periods, if any?

ANSWER. They vary with each policy. Usually preexistent conditions are not covered. Otherwise a person would not have to buy a policy until he fell ill. The resulting large volume of benefit payments in such a situation would soon force premiums for the healthy policyholder out of the market.

Q. Is a physical examination necessary to buy a policy?

A. Generally it is not. The patient's statements as to his health and history on the application are usually enough, but his medical history sometimes may make an examination advisable. Some companies reserve the right to have him examined when a claim is presented. Noncancellable insurance—that cannot be stopped unless the policyholder fails to pay the premiums—sometimes does require a physical examination to obtain insurance.

Q. What happens if there is an omission or falsification on the application?

A. In the event the status of the applicant's health was intentionally misrepresented, the company may refuse payment of benefits or may cancel the policy. Actually few policies are thus voided, but since the application often becomes part of the insurance contract, an applicant should read and answer everything before signing his name.

Q. What happens if a person is injured while working on the job?

A. Policies are issued which cover the insured on a twenty-four hour basis or provide only nonoccupational coverage, depending on what type of coverage is wanted. Most nonoccupational coverages are purchased by employees who are already eligible for disability payments under a workmen's compensation or occupational disease law.

Q. Can a person get coverage for the remainder of his family?

A. Most companies offer a family hospital-medical-surgical policy which is cheaper than buying individual policies for each family member.

Q. How and when will benefits be paid?

A. The insurance company has to receive proof that the insured person is disabled or has received treatment. A check is made out to the individual or, if authorized, to the doctor or to the hospital, or jointly, whichever way is desired.

Once the policy is bought, the next question likely to arise relates to the problem of the forms on which requests for benefits are made. At times these forms may seem an unnecessary bother to both the doctor and his patient. Uniform claim forms for Texas hospitals have been in use for more than two years. The Hospital-Insurance-Physicians Joint Advisory Committee of Texas was instrumental in drafting and securing acceptance of these forms by most of the hospitals and insurance companies operating in Texas. On a national level the insurance industry already has developed uniform claim forms for group policies and is at work now trying to streamline and unify the others.

Claim forms are necessary and perform two important functions for the patient and his

This department of the JOURNAL *presents editorial comments on current items pertaining to the science, art, and practice of medicine, contributed by members of the Texas Medical Association and others closely associated with the medical profession of Texas. Invitation is hereby extended to any member of the Texas Medical Association to submit such discussions for this department. The discussions preferably should be between 300 and 500 words in length.*

physician; they bring the payment of needed money quickly and they provide the evidence the company needs to make the payment. Unless that evidence is presented, the company cannot tell what it owes or if it owes anything. Thus it is of top priority that all information given be complete and in as much detail as is necessary to establish adequate justification for the payment of the benefits.

One further question may arise if the benefits on the policy are not enough to pay the doctor or hospital bill. A physician may help the patient to recognize the inherent limitations as well as the benefits of health insurance.

In general, it should be remembered that health insurance is primarily a method for helping people finance the costs of needed medical care. In fact, many doctors feel that the insured patient ought to share some part of his medical care costs, if for no other reason than that human nature requires this safeguard against unrealistic demands for professional services. Also, although it is true that the ownership of health insurance may facilitate a patient's ability to pay, the insurance industry does not create new or additional funds to provide benefits to its policyholders. Every dollar paid out for health insurance benefits comes originally from the policyholders, who some day may need health insurance benefits themselves. Thus, any general increase in medical care costs stemming from ownership of health insurance not only would minimize the effectiveness of that insurance but also would penalize the foresight of all the other persons who saw fit to buy it.

In buying a policy, a person gets what he pays for. There is no magic that can provide sweeping protection at unrealistic "bargain" prices. The value of the policy depends on how well its provisions fit the individual's needs. But most important about health and accident insurance is that it gives security and peace of mind against an event everyone hopes will never happen. Fortunate indeed is the man who need never make use of his health insurance benefits, for he enjoys not only the blessing of good health but also the satisfaction of knowing he has, in large measure, safeguarded his family fortunes against the unforeseen.

HEALTH INSURANCE COUNCIL,
Chicago, Illinois.

208 South LaSalle Street.

This is the fourth and last in a series of articles on insurance coverage for doctors and their patients prepared at the request of the Hospital-Insurance-Physicians Joint Advisory Committee of Texas. The other articles appear in the September, October, and November issues of the JOURNAL.

Parkinson's Disease Treatment

It has been claimed that in this country over a million persons, mostly older ones, have paralysis agitans, or Parkinson's disease. Most of them can be treated easily and can even continue to work, Dr. Lewis J. Doshay, New York, said in the October 16 *Journal of the American Medical Association.*

Dr. Doshay said that the most important thing is that the patients remain under a physician's care and learn that employment will not weaken muscles and hasten paralysis. The author expressed the belief that most sufferers from paralysis agitans are easy to treat because "they expect so little and are appreciative of any help rendered," and because they have long periods when the disease is not active. He added that chemical, physical, and psychological treatment must be a continuous process and that with treatment, some patients can live comfortably for ten to thirty years after onset of the disease.

The physician reminded that patients with this condition can be cheered by evidence that they are less susceptible to many other diseases than the average person in the same age group. Paralysis agitans seems to cause most patients to have normal or low blood pressure, to keep those with high blood pressure within safe limits, and to keep all of them from suffering with diseases such as cancer and tuberculosis. Only one proved instance of cancer and not a single case of tuberculosis appeared during twenty years among thousands of patients, the author pointed out. Ulcers are also rarely found in persons who have Parkinson's disease.

Patients should be assured that the entire illness is just rigidity of the muscles, that there is never paralysis in this illness, and that the more they use the muscles the less chance there is for development of shortened and contractured muscles that produce pain and deformity, he stated.

PSYCHIATRIC ASSOCIATION RESEARCH MEETING

The regional research meeting of the American Psychiatric Association will be in Galveston February 18-19, 1955. The theme will be "Physiologic Basis, Values, Limitations, and Hazards of Pharmacologic Products Recently Introduced in the Treatment of Psychiatric Disorders." Physicians interested in presenting papers on this topic at the meeting should contact Dr. Martin L. Towler, 112 North Boulevard, Galveston.

ORIGINAL ARTICLES

ACUTE INFECTIONS COMPLICATING PREGNANCY
Panel Discussion

S. FOSTER MOORE, JR., M. D., San Antonio, Texas, Moderator; A. LOUIS DIPPEL, M. D., Houston, Texas; R. P. McDONALD, M. D., Fort Worth, Texas; WILLIAM F. MENGERT, M. D., Dallas, Texas; and E. STEWART TAYLOR, M. D., Denver, Colorado

DR. S. FOSTER MOORE, JR., San Antonio, Moderator: We have in mind including in this panel discussion the acute infectious diseases complicating pregnancy, particularly rubella, poliomyelitis, and the miscellaneous diseases which are said to have a deleterious effect upon the fetus. In addition, such infections as pyelitis, pyelonephritis, and acute appendicitis and the effect of acute respiratory infections upon maternal morbidity may be of interest. However, any questions pertinent to the subject may be included.

MATERNAL RUBELLA

Dr. Moore: One of the most controversial phases of this whole subject, I think, is the matter of rubella in pregnancy. It is my belief that this needs to be viewed in perspective. Certainly there is no uniform opinion about it, and we may have a difference of opinion concerning it among the members of this panel. Therefore, I am going to give all the panel members time to discuss it if they care to do so.

I would like to present the first question myself and ask Dr. William F. Mengert, Dallas, to answer this: What is the present status concerning rubella in pregnancy?

Dr. Mengert: This is a difficult assignment and a difficult question to answer. There is still a definite idea that rubella is associated with fetal malformation. I think it is well recognized that rubella must occur as part of an epidemic, that the diagnosis of rubella must be made objectively and must not be accepted from the patient's history, and that it must occur during the first half dozen or eight weeks of pregnancy if it is going to cause any trouble to the fetus. It is during the formative period of the embryo that rubella is most likely to cause difficulty. At first it was thought that almost universally the disease would cause fetal malformation. Today we have revised our figures downward. Probably a representative figure would be somewhere around a 10 to 25 per cent possibility of fetal malformation at present.

There is an interesting article which came out a number of years ago from South Africa,[3] where the investigators used trypan blue, the particles of which dye act much as the virus of rubella. They are absorbed onto the albumin fraction of the protein molecule and mechanically interfere with the formation of the fetus. This group of investigators, using a pedigreed colony of rats, was able to produce malformation in approximately one-fifth of the rats. They found also that if the trypan blue was given prior to conception, it was effective. It was not so effective if given immediately after conception and was most effective when given both prior to and immediately after conception.

Dr. Moore: Dr. Dippel, I wonder if you feel as Dr. Mengert does about this incidence of fetal malformation following rubella and also if you consider the possibility that the disease described by Gregg,[4] which allegedly caused congenital anomalies in Australia, perhaps might have been a different disease from the rubella that we recognize epidemically in this country.

Dr. A. Louis Dippel, Houston: In answer to the first question, I probably am even more skeptical than Dr. Mengert about the effect of rubella upon the production of congenital anomalies. The original story coming out of Australia in 1943[6] with the report of 100 per cent congenital anomalies resulting from maternal rubella was hard to believe. As I remember, this was a study of 100 cases of fetal congenital anomalies which could vary from anything from congenital cataracts to congenital deafness to congenital heart disease and microcephaly or any combination thereof—100 per cent of all these. Then the question went back to the mothers; did they have some disease during pregnancy? The diagnosis of rubella is, in my mind, an extremely difficult one to make. I certainly would not want to make it myself. The reports in this country vary from a questionable effect to congenital anomalies in as high as 40 per cent. In my experience, the few cases I have followed

Presented before Section B (Surgical), Texas Medical Association, Annual Session, San Antonio, May 4, 1954.

through have had no congenital anomalies resulting, and those mothers had an authentic diagnosis of rubella made by somebody who knew more about it than I did. The reported high incidence of that first series in Australia, of course, raises the problem of whether it might not have been some other disease or a particularly virulent type of rubella that was involved in the production of the congenital anomaly.

Dr. Moore: It appears that there is a general attitude of conservatism toward this matter of rubella in pregnancy. Each spring I see in consultation perhaps a half dozen patients who have been exposed to rubella or who allegedly have had rubella, and the question comes up of what to do. Of course the intention of the consultation is to consider abortion. We acknowledge that abortion for such a condition cannot be done legally in Texas, but I think it might be well to consider the matter of whether or not an abortion should ever be done or considered for maternal rubella. Dr. McDonald, would you care to comment on that?

Dr. R. P. McDonald, Fort Worth: Obviously, I think, each case should be considered individually. It is hard to establish a general set of rules to cover every case. If I may, I would like to go back a little. We have depended largely on our knowledge from the original articles from Australia. The situation over there is a little different from ours. It is largely a rural country, and during the war years 1939 and 1940 when they had those tremendous epidemics, the people were migrating from the rural areas into camp sites and cities, and reports were rather conclusive. I do not think there was any doubt that the disease in question was rubella, and the Australians have tabulated their results fairly well. As Dr. Mengert says, probably now we are a little more conservative. We think about 25 per cent abnormalities. We in the United States have been handicapped somewhat by a scarcity of concise reports. In the first place, many cases of rubella are so slight as to go unrecognized, and obviously few cases ending normally are reported. Since we have done a considerable number of therapeutic abortions for these cases during the first trimester, we have no way of knowing how such cases might have terminated if they had been allowed to proceed. Now, I think, the consensus in our literature is that therapeutic abortion should be considered in any patient having rubella in the first trimester without trial at immunization.

The only thing for immunization we have, and correct me if I am wrong, is the gamma globulin that is from pooled blood; in Australia they now have and have had for about four years the gamma globulin taken from the serum of convalescent patients having rubella only in epidemics and only in large areas. As Gregg[4] has reported, in Australia 670 women were inoculated, each with 4 cc. of gamma globulin, I believe, and 520 of these have been followed carefully. Among these 520 women receiving gamma globulin, only 7 cases of rubella have been reported; of these, 3 pregnancies terminated spontaneously in abortion, 1 infant was stillborn, and 3 fetuses were normal. I do not believe that we have that type of gamma globulin in the United States yet, and our present gamma globulin, even in large doses, is of questionable value in the treatment of rubella. The literature is confusing. Dr. Bass,[1] a pediatrician in New York, has reported 9 private patients with rubella who received the gamma globulin after being exposed and had no abnormalities.

I certainly feel, getting back to the question, that therapeutic abortion should be considered in the first trimester in proved cases of rubella. I think too that actually the case should be observed by at least two physicians after a definite diagnosis has been made. Also, I certainly would feel more inclined to do a therapeutic abortion on a patient who had four normal children than perhaps in an infertility case with the patient's first pregnancy.

Dr. Moore: Dr. Taylor, how do you in Colorado feel about this question?

Dr. E. Stewart Taylor, Denver: I do not have anything new to add. I am always glad when the problem does not come up. Usually it is this time of year when a physician receives a few telephone calls and has some conversation about rubella, and in order to put the patient's mind at rest, I find out how many weeks pregnant she is. If she is ten weeks pregnant or more when infected or exposed, I say forget it. If the infection occurred before ten weeks of pregnancy, I think we should worry about it. I always quote the risks to the patient; there are approximately 1 in 5 bad results. We did 2 therapeutic abortions last year and 3 the year before in our university hospital, but we are getting away from it.

Dr. Moore: I think we should not leave this subject without getting Dr. Mengert's and Dr. Dippel's views on the matter of abortion in such cases. If we ought to do abortions in any case in which the mother has had rubella, then it probably should be made a legal procedure in Texas,. How do you feel about that, Dr. Mengert?

Dr. Mengert: The best way to find out how a person feels about anything is to ask him what he has done under the circumstances. Of course, the Texas law has to do with the prevention of injury to the mother. The only way that an abortion can be done legally is for the physician to state that the mental trauma to the woman is so great that the

pregnancy is interrupted to avoid this mental hazard to her—the hazard of worrying about whether or not she is going to have a malformed child. I think there are some rigid criteria, all of which have been mentioned here, regarding the question of whether or not we should do therapeutic abortion, but I would like again to summarize those criteria. First, the only time one can be sure of a diagnosis of rubella is during an epidemic; an isolated case of rubella is a difficult thing to diagnose. Second, rubella must be diagnosed objectively by a pediatrician who frequently sees such diseases. The third thing has been emphasized by virtually every member of the panel and it is the timing with pregnancy. The disease must be in the early formative period of pregnancy if any harm is to come to the child, and I would certainly agree with eight or ten weeks as the absolute outside limit.

In view of the work that was done in South Africa with trypan blue, which obviously works the same way, I would be afraid of rubella occurring just before the woman conceived. That is, if she were just getting over the disease when she conceived, it is likely to be more dangerous than if it occurred say at eight weeks of pregnancy. With criteria as rigid as that, you will not find many patients who fall into the category of needing therapeutic abortion.

Dr. Dippel: One of the main things I could do would be to stress again the timing effect which Dr. Mengert has emphasized. The time that the organ system is laid down in the embryo, generally four to eight weeks after conception, is supposed to be the time when the virus of rubella would be most detrimental. I have never produced an abortion, nor been a party to the production of an abortion because of maternal rubella. I do not believe I could be induced to do so. I know of 4 cases in our city in which therapeutic abortion was done for that indication. In each case, the embryo was turned over to an anatomist for microscopic examination. There has been no written report from him, and I presume this means that no abnormality was found.

Dr. Moore: Before we get off the subject, Dr. McDonald, I wonder if you would comment for just a minute about the other miscellaneous infectious diseases and their possible effects, if any, on the embryo.

Dr. McDonald: Well, of course, regular measles or morbilli have been confused with rubella by the laymen, and many patients are confused as to whether the serious condition is the rubella or the morbilli. In the literature, of course, sporadic cases have been reported with morbilli in the first trimester ending in some fetal abnormalities, but there is certainly not enough consistency to this type of report to consider even remotely therapeutic abortion for this condition. We also undoubtedly have heard of other virus diseases affecting the embryo, particularly smallpox, chickenpox, mumps, and infectious hepatitis—conditions of that type—and also, I believe, of some cases of malaria. There is also the rather rare condition toxoplasmosis, I believe they call it. But as with morbilli, I do not think there is any definite proof that these cause fetal abnormalities.

Audience member: Dr. McDonald, if your wife had rubella and you felt that there was a 20 to 40 per cent risk to the fetus, would you go ahead and do an abortion?

Dr. McDonald: Well, this is sort of putting me on the spot but not as much as it would if the case were actually true. In the first place, a doctor would not take care of his wife. I think that one would call for help in making a decision like that. However, with two normal healthy children I would certainly hate to take a 25 per cent chance of bringing an abnormal child into the family. I do not think it is fair to the other two children.

Audience member: Dr. Moore, just as a point then, do you not think that the family involved has to be seriously considered, I mean the desires and wishes of the family?

Dr. Moore: My personal feeling is that at such a time an unemotional decision must be made. I think that it is the responsibility of the physician to make the decision and advise the patient accordingly, but I would like the panel members to comment on that. Dr. Dippel?

Dr. Dippel: Well, I agree with you wholeheartedly on that point, Dr. Moore. I think that is a time when clear thinking is most needed and you want to keep family decision out of it as much as you can. It seems to me that before you can seriously consider doing a therapeutic abortion because of maternal rubella, you have to do something more about proving that it is really responsible for the production of congenital anomalies than has been done up to this time. For example, it would call for a series much larger than most of them reported so far. The study should begin with the accurate diagnosis of rubella in the mother and then should follow all of her children through the early pediatric months, particularly in disclosing the presence or the absence of congenital anomalies, before we can really solve this problem. In many of the published series, the congenital anomalies are not described completely; for example, the congenital heart disease is not described as being of one particular type. I think we have to find out just what role rubella really does play before we can advise.

Dr. Moore: I have not in any case seen a baby

affected by rubella except when the diagnosis of the infection was made in retrospect. It is easy to get a history of rubella from the mother who has just found out that her baby is congenitally deformed because, first of all, she *wants* to find some reason, some tangible explanation for this deformity. As Dr. Dippel has pointed out, we have to make the diagnosis and then follow through a number of these patients. Where this has been done in cases which I have seen, all have been normal babies.

Audience member: How about rubella having occurred in the husband within the period of time preceding conception, that is, within four to six weeks previously?

Dr. Moore: Dr. Taylor, would you care to comment on that?

Dr. Taylor: I have never heard of a case like that. I think that I would be inclined to ignore that possibility as far as the conception is concerned and just not worry about it.

Dr. Mengert: I cannot see that the husband would have anything to do with it. If his wife did not get rubella, I do not see why the man would have anything to do with it. It is not the germ cell which is affected; what is affected is the developing embryo which results after the fusion of the male and female elements.

Dr. Moore: The next question is, In the event of epidemic rubella is it advisable to give the immune globulin? Would you comment on that, Dr. McDonald?

Dr. McDonald: I think that certainly the consensus is yes, that most of the general practitioners and pediatricians who are much more familiar with gamma globulin than I think it advisable to give it. Now, of course, there are several factors in using our gamma globulin; you must use large amounts, I believe 20 to 30 cc., and the expense is no little item. Australian gamma globulin is effective if given within eight days of exposure and the amount is 4 cc. However, I think that definitely when there is a history of exposure and no history of previous rubella, gamma globulin should be used.

Dr. Moore: The question is asked, When you refer to ten weeks of pregnancy, do you refer to ten weeks after the last menstrual period or ten weeks after conception?

Dr. Mengert: I mean eight weeks of pregnancy, not eight weeks after the last menstrual period. It is said that organogenesis is complete at the end of eight weeks so that theoretically there is little chance for any noxious influence to affect the child after that time unless it kills him. Incidentally, I would like to raise a question. Nobody has mentioned anything about the possibility of prophylactic therapy in young unmarried daughters. How many of you think young girls should be exposed to rubella before they get married?

Dr. Moore: I think it has been pointed out that if you intentionally infect the young girl with rubella, she then becomes a public health menace herself and has to be isolated during the course of the incubation period of her disease and the disease. I believe, though, that if this could be done on any large scale, it might offer some hope in the future. Dr. Dippel, would you comment on that?

Dr. Dippel: I had not considered that in the treatment of my daughter, but from a prophylactic point of view it certainly sounds good. Carrying it out would be quite a different problem—like doing a lot of other things on a prophylactic basis. It would call for a rather tremendous program. If we actually get even further into this and prove that there is really a high incidence of involvement of the embryo as a result of rubella, for example if it is at least 25 per cent, then I think a program of that kind would be something that should be seriously considered, even though it does call for isolation of the child for a definite period of time. Getting the girls to have rubella would be an ideal method of eliminating the possibility of congenital anomalies later on in life.

PYELITIS AND PYELONEPHRITIS

Dr. S. Foster Moore, Jr., San Antonio: There are several questions concerning pyelitis in pregnancy. One doctor asks that you discuss the management of recurrent pyelonephritis in pregnancy. Dr. Taylor, would you comment on that, please?

Dr. E. Stewart Taylor, Denver: I will avoid going into the whole management of that, but I think that pyelitis, especially chronic pyelitis, as well as acute pyelitis, is a cause of premature emptying of the uterus. I suppose that people have known that for a long while, but having gone over my own material trying to find out why premature delivery occurs in some cases, it has been reimpressed on me. I have been astonished at the number of times the patient has had a recurrent acute urinary infection or has had a carryover of a chronic urinary infection from an earlier acute one. Just what the mechanism involved in it is, I do not know, but I am convinced that it is important that chronic urinary infections not only be controlled symptomatically but bacteriologically during pregnancy because they are associated with premature deliveries.

Dr. Moore: Dr. Dippel, I know that you have been interested in that problem. Would you care

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to say something about recurrent pyelonephritis in pregnancy?

Dr. A. Louis Dippel, Houston: I look at the problem a little bit differently from the way Dr. Taylor has presented it. I have not been so much impressed with the incidence of premature labor as a result of pyelitis, though there definitely is a correlation. I would be much more concerned with the future of that patient's renal function. These recurrent attacks of acute pyelitis are certainly going to end up with inroads upon the renal parenchyma and pyelonephritis, and renal function obviously will be reduced with each subsequent pregnancy complicated by pyelitis.

We follow much the original plan laid down by Traut and McLane[7] by way of prophylactic treatment of every pregnant patient who has previously had pyelitis either in a pregnant or nonpregnant state, giving her prophylactic therapy with a sulfonamide throughout the pregnancy. It requires a relatively small amount of sulfonamide given a few days out of each month in the great majority of the cases to control totally and prevent the recurrence of the disease. If acute pyelitis appears in such a treated patient or in a person who is not under treatment and who has not previously had the condition, then of course the treatment is exactly the same as with any other patient with acute pyelitis.

Again, agreeing with Dr. Taylor in this problem, we certainly have to treat these patients to get them bacteriologically free and not just symptom free from the disease. We see too much of that in our hospitals today—treating the patient until she is symptomatically free but paying little or no attention to bacteriology. It of course is known that the patient will harbor these organisms in the upper urinary tract for a long time, even after her symptoms are gone, so we must push the treatment so that she actually will be cured of the disease. Follow-up examinations by a competent urologist after the pregnancy is over cannot be stressed too strongly.

Dr. William F. Mengert, Dallas: I would like to know what is meant by the term recurrent pyelonephritis. Do we mean pyelonephritis recurring during the course of a single pregnancy or recurring in a subsequent pregnancy? For purposes of answering this, I would like to take an entirely different approach and define it as recurring in the same pregnancy. I feel that the all important thing is the question of why this infection recurs during a particular pregnancy. The urinary stasis that is necessary for the development of the disease comes about physiologically through dilatation of the kidney pelves and ureters. I have never seen a pregnant woman who would drink the necessary minimum of three quarts of fluid a day and who had no urinary tract disease prior to pregnancy develop pyelonephritis. One of the most important things in prenatal care is to get the patient to drink water. Selling water to women, incidentally, is one of the most difficult jobs you ever tried. I feel that if a woman developed pyelonephritis, responded to the usual treatment, and then on a good water intake developed it again, the important thing would be urologic diagnosis. Then the condition would be getting out of the field of the ordinary pyelonephritis of pregnancy, and we should look for such things as stones, aberrant artery, and the like.

Dr. Moore: Dr. Mengert, do you know of any reason why the pregnant patient should not have the ureters catheterized in such cases?

Dr. Mengert: We used to do it repeatedly, and not only that; I have seen a pregnant woman go for a week with bilateral indwelling ureteral catheters.

Dr. Moore. What effect would the knee-chest position or postural drainage have on pyelonephritis?

Dr. Mengert: As a general rule, it is not so efficacious in pyelonephritis in pregnancy as it is in the pyelonephritis that sometimes occurs immediately puerperal. The ureter does not only dilate during pregnancy, it also elongates, but to compensate for this to some small extent the uterus in a pregnant woman pushes the kidney up about the size of one whole vertebra. You can see that repeatedly on your intravenous pyelograms. However, it should be remembered that if the patient does not respond in other ways, then it is worth while to put her to bed with her feet high in the air; but, as I say, I have seen that work better with immediate puerperal pyelonephritis than I have with the antepartum.

Dr. Moore: Dr. Dippel, the question has been raised as to what you mean by small doses of sulfonamides.

Dr. Dippel: We use sulfadiazine, and we give .5 Gm. five times daily for five days out of each month for the prophylactic treatment against pyelitis in the patient who has had pyelitis or pyelonephritis previous to that pregnancy, even though she has no symptoms during the current pregnancy.

POLIOMYELITIS

Dr. S. Foster Moore, Jr., San Antonio: There is a question here concerning poliomyelitis. Is there an increased incidence of poliomyelitis during pregnancy? Also, would therapeutic abortion ever be considered following acute poliomyelitis in early pregnancy in which there was considerable paralysis of the lower extremities? Dr. McDonald, would you comment on that, please?

Dr. R. P. McDonald, Fort Worth: In the first part

of your question concerning increased incidence of poliomyelitis in pregnancy, or rather susceptibility to poliomyelitis in pregnancy, I would like to state that Bowers and Danforth[2] at Northwestern University summed up all the reported cases in the country in a recent comprehensive article and they concluded that the incidence of poliomyelitis does not increase with pregnancy. In other words, pregnant women are not more susceptible. However, a series of cases was reported at Wayne University in Detroit during an epidemic in 1949 and 1950;[5] the workers concluded that there, according to the public health figures, the incidence of poliomyelitis increased three times during pregnancy.

In reply to the second question, I do not feel that therapeutic abortion is indicated in poliomyelitis. You are just adding other hazards to a bad situation. The pregnancy itself has little effect on the poliomyelitis, and I think vice versa.

Dr. Moore: Dr. Mengert, I know that this is a subject in which you have been interested. Would you care to comment on that?

Dr. William F. Mengert, Dallas: Of course, if a pregnant woman develops poliomyelitis, I think that the only thing to do is to treat her for poliomyelitis and completely ignore the pregnancy. But the question was asked, as I got it, about the woman who has had poliomyelitis and now has residual paralysis of her legs and becomes pregnant after the poliomyelitis is over. Is that the way of the question?

Dr. Moore: I think that the question is: Following acute poliomyelitis in the early pregnancy in which there was considerable residual paralysis of the lower extremities, would you consider interrupting the pregnancy?

Dr. Mengert: No, I would not abort.

Dr. Moore: What about the necessity of delivering a patient in a respirator? Are there any special procedures that should be followed in such instances? Dr. Taylor, have you had that experience?

Dr. E. Stewart Taylor, Denver: No, I have not. We have delivered women just after they have been in a respirator or when they have had to go in one a few days later. I think that if you follow the dictum about treating the disease and letting the pregnancy take care of itself, you will not make things any worse. There is, I believe, no indication for any type of interference in any of the acute or chronic conditions which arise from poliomyelitis.

Dr. Moore: Would you say that the same thing applied in the case of bulbar poliomyelitis in a patient at or near term, for instance in a patient in whom you anticipate immediate delivery will be necessary?

Dr. Taylor: Absolutely; the same thing applies. That whole question has arisen, and curiously enough, it is the internists who get after us most often and want us to deliver by cesarean section a woman who has acute bulbar poliomyelitis. I see no purpose in it. It is largely based upon a misconception. Here is a woman in respiratory embarrassment. The idea is that if you relieve her of the pregnancy, you relieve her of her respiratory embarrassment. This is based on a misconception that pregnancy causes respiratory embarrassment. As a matter of fact, it does not. All the physiologic work that has been done shows that not to be the case; and it is far better, if the woman has respiratory embarrassment, to do a tracheotomy, to feed her oxygen, to keep her in a respirator, and to ignore her pregnancy.

OTHER INFECTIOUS DISEASES

Dr. S. Foster Moore, Jr., San Antonio: Should acute infections in general be treated differently in pregnancy than when the patient is not pregnant? If so, what additional precautions should be used during pregnancy? Dr. Mengert, would you comment on that?

Dr. William F. Mengert, Dallas: I do not think they should be treated any differently. Again, I come back to the dictum, "Treat the disease and ignore the pregnancy," because the pregnancy lasts longer than any acute infectious disease with the possible exception of tuberculosis. Even here, I feel that it is far better to treat the disease and not worry too much about the pregnancy. There are two ideas to consider. How does an acute infectious disease affect the pregnancy, and how does the pregnancy affect the disease? Actually, only a few infectious diseases affect the pregnancy. Fever has been thought to affect the pregnancy. As a matter of fact, it does not. Women have been given artificial fever to untold heights and yet have gone to term and produced live, healthy children. With some acute infectious disease, the toxin crosses the placental barrier and kills the child. I do not know what good could be done by doing away with the pregnancy or by treating the acute infectious disease in any other way. Again, I wind up with the dictum, "Treat the disease and ignore the pregnancy."

Dr. Moore: Dr. Dippel, would you comment on that?

Dr. A. Louis Dippel, Houston: Well, I certainly agree with what has been said and can think of only rare instances in which one might want to deviate from that. For example, in the case of malaria in

pregnancy, one of course would want to avoid the use of quinine because of its toxicity to embryotic tissue; but today we probably are not using quinine as much but other drugs which would not have the same effect on the embryo. In general, that dictum certainly is true—treat the disease, pregnant or not pregnant.

Dr. Moore: Dr. McDonald, do you have anything to say in summing up on this subject?

Dr. McDonald: No, I agree with the others. We know, of course, that both penicillin and streptomycin can be found in comparable concentration in the fetal blood and apparently are not harmful at all. And in malaria, as mentioned, we feel that cases of malaria in the newborn occur in the process of birth —on separation of the placenta rather than filtered through the placenta during pregnancy. I feel just as the others do on that subject.

Dr. Moore: How about you, Dr. Taylor? Would you like to comment?

Dr. Taylor: I would like to bring up the question of vaginitis during pregnancy. There is a feeling among some physicians that one should not treat actively such infections during pregnancy for fear of interfering with the pregnancy. I know in my part of the country we constantly run into the situation of a patient suffering with one of the more common vaginal infections which is easily treated in the nonpregnant woman. The physician in charge of the patient becomes conservative. I think that is a mistake; the vaginitis should be treated.

Audience member: What is presently considered to be adequate treatment of tertiary syphilis discovered during pregnancy?

Dr. Dippel: I do not think it makes much difference what the stage of syphilis is so far as treatment during the pregnancy is concerned. The standard recognized amount of therapy required to protect the fetus against development of congenital syphilis is in the neighborhood of 4.8 million units of penicillin.

Dr. Mengert: I might comment that there is a general rule that the effect of syphilis on the baby in utero depends upon when the woman got her syphilis. If she acquired her syphilis and got pregnant at the same time, the baby almost certainly is going to be involved. However, as the syphilis becomes older and more chronic, in other words as a period of years elapse, the effect on the child is less and less pronounced. At one time, it was said the number of pregnancies would take care of that. I think it is not so much the number of pregnancies as it is the length of time, and the longer the time between the initial acquisition of syphilis and the conception or the pregnancy, the less likely the child is to be involved. So with tertiary syphilis, I think that we can more or less automatically figure that the child is not so likely to be involved, but definitely the woman should be treated.

SUMMARY

Dr. S. Foster Moore, Jr., San Antonio: Time has run short as it always does in the course of a discussion which stimulates as much interest as this has done. However, there are a few minutes left in which to summarize.

I think it may be concluded that certain acute infections occurring in the pregnant woman may have an undesirable effect upon the fetus. Chief among these seems to be rubella and, to a lesser extent, some of the other acute infectious diseases. This problem in general does not seem to be as grave as was thought a few years ago, and the occurrence of rubella in the pregnant woman rarely, if ever, justifies the interruption of pregnancy.

On the other hand, certain acute infections occurring during pregnancy may have a harmful effect upon the mother and thereby have an indirect influence on the fetus. I am thinking particularly about pyelitis and pyelonephritis, which were discussed at some length.

Generally speaking (and this I believe is a good statement with which to conclude), during pregnancy any acute infection should be treated in the most effective manner without regard for the pregnancy.

I would like to take this opportunity to thank the various members of the panel who, I think, have contributed significantly to our knowledge of this subject. I am particularly pleased with the splendid response which we have had from the floor.

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Texas Adoption Laws That Affect Doctors

JOHN BEN SHEPPERD,* LL. B., Austin, Texas

TEXAS doctors of medicine, especially general practitioners, obstetricians, and pediatricians, need a working knowledge of the provisions of the Texas Adoption Law. This law is the culmination of years of evolution and at present offers a humanitarian protection for adopted children and adoptive parents alike.

The practice of adoption goes back to the early days of the Greeks and Romans and received considerable attention from Emperor Justinian. The Anglo Saxons, however, did not recognize adoption in any form, and it was unknown in the common law of England. At present all of the law relating to adoption may be found in the statutes and in their interpretation by the courts. The statutes of this state completely cover the subject of adoption, and their provisions offer the protection of the law to the practice of adoption.

The first adoption laws in Texas were contained in an act of 1850, which merely provided the right of adoption and the right of an adopted child to inherit from adoptive parents. No provision was made in this early law for the method of transferring parental custody or for the welfare of an adopted child.

Successive amendments, however, did fully provide the steps of adoption, and the last amendment in 1947 gave full consideration to the rights of the adopted child. Under the Texas law, an adult person may be adopted; however, most often adoption concerns children and usually babies.

Texas doctors may be asked by childless couples for advice on how they can obtain an adopted child. Doctors are peculiarly qualified, as a result of their knowledge of the physical, mental and economic condition of the prospective parents, to know if the couple will be suitable for an adopted child. Doctors also are frequently confronted with the pregnancy of unmarried women and in this respect need to be familiar with the laws of adoption.

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STEPS IN ADOPTION

When it is possible for a suitable couple to adopt a child, the first step is the employment of a dependable lawyer who has the interest of all parties at heart. His first action will be to draw up the transfer of parental authority and to petition the appropriate court for the adoption of the child.

The petition of the prospective foster parents must set out certain specified information, such as sex, race, birth place and birth date of the person to be adopted, the date he was placed in the home of the petitioners, consent from the natural parent or parents, and other kindred matters.

After the petition for adoption is filed, the district clerk mails a certified copy of it to the State Department of Public Welfare and notes on his docket the date of mailing. In the ordinary case, the judge appoints an investigator to make a complete study of the child and adoptive home and to give a report of such investigation to the judge. The executive director of the Department of Public Welfare may make an independent report if he sees fit.

A hearing is held before the judge, at which the husband and wife who are petitioning must appear and the child to be adopted must be present if he is 14 years old or older. A younger child need not attend unless ordered to do so by the judge. After the hearing, the judge may authorize or refuse to authorize the adoption.

One important point should be kept in mind by anyone concerned with adoption. It is that no child may be adopted without the consent of its natural living parents unless those parents have abandoned and deserted such child for a period of two years, turned over the care and custody to other persons, or failed to contribute to the child's support during the period of two years. In such cases no parental consent is necessary from the natural parents.

If more than 14 years of age, a child may also express his consent to adoption in open court for consideration by the court.

The age of an unwed mother is not material in giving the required consent.

If the natural parents place a child in a child placing agency licensed by the State Department of Public Welfare, the agency may give the consent ordinarily required of the natural parents. Such consent must be in writing.

The consent given by natural parents for the adoption of their child always must be in writing, after the birth of the child, and fully acknowledged with the needed information and facts contained in such consent.

If the simple steps just set out and contained in the adoption statute are followed, all of the legal relationships, rights, and duties between the child and its natural parents cease and thereafter the child is considered to have all of the rights of children born to its adoptive parents in lawful wedlock. After a proper adoption, the new parents also are entitled to all the rights and privileges of natural parents.

The natural parents of an adopted child and their kin cannot inherit from and through such child, but an adopted child may inherit from its natural parents. Of course, an adopted child may be excluded by specific words in a will, a deed, or other instrument.

In this state a Negro may not be adopted by a white person and no white person may be adopted by a Negro.

Considerable comment has been caused in recent years by the occasional discovery of the sale of a baby—the so-called black market in babies. Texas laws have gone far toward prohibiting any such practice, and the ethical doctors of this state have been in the forefront of the fight against this practice.

The Texas adoption statutes are farsighted, inclusive, and effective and provide protection and justice for all persons involved in an adoption. The physicians of the state can be of great assistance in assuring that these laws will be properly carried out.

NURSING NEEDS IN TEXAS

Viewpoint of the Medical Profession

A. C. SCOTT, JR., M. D., Temple, Texas

I AM particularly pleased to be a member of this Texas Joint Commission for Improvement of Care of the Patient, primarily because its main objectives are centered on the patient and are not limited to such subjects as nurse shortages, doctor shortages, or hospital deficiencies.

Although temporarily acting in the capacity of a hospital administrator, my views are, ipso facto, those of a doctor. To me, good personal care of each individual patient by the doctor and the nurse is paramount above all hospital rules, regulations, needs, or aspirations; above the laudable desire for specialized training of doctors and nurses; above the justifiable wish on the part of any doctor or nurse to better his professional standing or financial status; above every other consideration in our daily contacts and care of patients.

I believe I can safely say that I represent the general medical profession's viewpoint with respect to nurses when I state that the doctor's greatest desire today is that we obtain for our patients better personalized bedside nursing care.

I had rather have one well-trained nurse, giving excellent personal and sympathetic care to four patients, than to have the same four patients nursed by twelve nurses who consider themselves specialists, know all theories, and meticulously follow all the rules and the clock. I shall have more to say subsequently about group nursing.

From the medical profession's viewpoint, the nursing needs of the state are twofold—related to quantity and quality of nursing care. Each of these is also probably affected or modified by two other factors, namely, (1) the views of those doctors who largely conduct their practice in hospitals and (2) the views of those doctors whose principal practice is in the home and office.

QUANTITY OF NURSES

Regardless of how or where they practice, doctors are well agreed that we do not have enough nurses to go around for all our needs, and I believe the vast majority would agree that the quality of good nursing care has diminished in the past two decades.

For the last dozen years, many of us in this state—doctors, hospital administrators, nursing educators, and representatives of the nursing profession at large—have been concerned with these problems of nursing care; studying them intensely; proposing methods

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of alleviating the shortage of nurses; conducting drives to interest more young women to go into the nursing field; devising new methods of training—in short, expending tremendous energy on many fronts to try to solve the problem of increasing the number of nurses of all classes available for patient care.

In spite of this tremendous amount of thought and energy expended, not too much has been accomplished, and we are still faced with shortages in some areas. Much more has been accomplished in our state than in many others, since we provided for training and licensure of vocational nurses; and the hue and cry from the doctors for more nurses is not as great now as it was three years ago. Nevertheless, the question arises as to whether we have not been expending too much of our energy in one direction.

In most of the conferences we have had during the past ten years, and in most of our drives, our efforts have been centered on the dearth of nursing care and how to overcome this shortage. In practically every conference I have attended (and I have attended many of them), all parties have agreed that there is a shortage, and that in order to overcome it, we must interest more young women in nursing. Beyond that, there has been division, and two central themes have stood out in our discussions.

Representatives of the nursing profession have maintained that in order to interest more young women in nursing, we must raise the standards ever higher and higher. The standards must be raised to meet the present rigid requirements for certification and licensure, and to make nurses eligible for more responsible positions and more lucrative compensation.

The doctors have repeatedly expressed a different view, namely, that we need more intensive training in personalized bedside care for student nurses and fewer scientific educational requirements.

Hospital administrators, by and large, have taken a middle view, that we need both things; but they have expressed great concern at the exorbitant cost of highly specialized training.

Controversial subjects such as these cannot be solved by dodging them or by dodging the issues involved. To solve any problem, one must face all of the facts and issues head on, laying all the views and cards, and the truth, out on the table. Then, and then only, can we use sound judgment in resolving the problems. I shall do that very thing in expressing the medical profession's viewpoint of our nursing needs in Texas. Come the time when this commission will discuss doctor needs in Texas—all of you should do exactly the same thing, and I shall join you.

With respect to the quantity of nursing care, that is, the shortage of nurses, I have only one brief comment to make at this time. In many hospitals, luxury nursing is as prevalent today as it was ten or fifteen years ago. The continuation of this practice is reprehensible in view of our shortage of nurses and indicates utter, pure selfishness on the part of doctors, nurses, and patients. We have not done a good job of informing the public that available nurses must be used where they are most needed. We simply must teach the rich Mrs. Joneses who are eight to ten days convalescent that they are not entitled to keep a full quota of single-duty nurses when there are two, three, or five critically ill patients who need those nurses badly.

Not only is this luxury type of nursing still being practiced, but group nursing has never been utilized to its fullest extent. It can be done successfully. We have had it in full and successful operation in our own hospital since the war years. Only the most critically ill patients and those who have had a very extensive or dangerous operation ever have single-duty nurses, and these patients are put on group nursing service as soon as they are out of danger. The universal use of group nursing in the hospitals of this state would at once alleviate some of our shortage.

QUALITY OF NURSES

Now, let us consider the quality of nursing care in more detail. To begin with, doctors think the Art of Nursing is rapidly being lost. Many doctors likewise agree with me that the Art of Medicine is fast becoming a dead art. The factors producing this rapid and unfortunate disintegration of the Arts of Medicine and Nursing are almost identical and threefold: (1) superscientific educational requirements; (2) over-specialization; both of which lead to (3) a lack of close personal contact with and understanding of the patient.

Perhaps it is true that the medical profession's desire for better, more personalized bedside nursing care for patients harks back to the dark ages of twenty, thirty, or forty years ago, when we did not have nursing station red tape, unions, eight-hour shifts, overtime, or specialists in metabolic, psychiatric, diabetic, urologic, orthopedic, pediatric, geriatric, and rocking-chair nursing care, and we simply had to be satisfied with personalized bedside nursing. But, oddly enough, we find the public, represented by individual patients all over the United States, desiring exactly the same thing as the medical profession.

The crux of most of the troubles of both the nursing and the medical professions today is that we have just about specialized ourselves out of business. The public is sick of it. Patients want one thing pri-

marily, *personal attention from the doctor or the nurse.* In our zeal ever to raise our educational standards higher and higher, which leads to greater and more intensified specialization, our minds have become so concentrated on the procedures and rules for attaining those ends that we have forgotten the humanics of patient care. The patient has become the means to our goal rather than the object of our training, attention, and care.

The time has come when we must reevaluate our ideas and objectives. It is not simply a matter of how do we get more nurses to train and super-educate into specialists, and how do we get more nurses to work in hospitals? The real problem is how can we satisfy the public's desire for personal nursing attention?

The medical profession, as represented by the officers and members of the House of Delegates of the American Medical Association, became concerned a few years ago about the seriousness of this problem in the practice of medicine. Medical practitioners began to recognize that extensive specialization, with ever increasing standards for recognition and certification in the various specialties, was doing two things: (1) creating among doctors an ever growing interest in research and science, with a corresponding breakdown in the former intimate and personal doctor-patient relationship, and (2) increasing the feeling among patients that they could no longer get close, personal attention from doctors. A special committee of the American Medical Association, of which Dr. F. J. L. Blasingame and I happen to be members, has been at work for the past three years, studying this problem and the possible means of overcoming it.

I am convinced that the nursing profession is faced with exactly the same problem but does not fully recognize its significance. The minds and endeavors of those of us who have worked in the nursing field have been so centered on the shortage of nurses, we have completely overlooked this more critical problem, namely, improving the quality of personal bedside nursing care—a thing the patients and doctors intensely desire.

Incidentally, and I think significantly, this decrease in the quality of good personal patient care has been a definite, silent factor in our shortage of nurses. Its effect on the public has probably kept many families from encouraging their daughters to enter nurse training.

TRAINING FOR QUALITY

The keystones of the Art of Nursing and the Art of Medicine are the fundamental urges of women and men to minister to and alleviate the pains and ills of fellow human beings. Actually, the urge is much greater in women than in men. My best guess is that 95 to 97 per cent of young women enter the nursing field because of this primordial urge, and 85 to 90 per cent of the young men entering medicine do so because of this urge to help patients.

The 3 to 5 per cent of women and the 10 to 15 per cent of men who do not have this urge enter the profession for financial or commercial reasons. But, for the time being, let us forget them. They are not worth remembering anyway. Let us consider the vast majority who enter these portals of training because of their fundamental humanitarian urge to help patients.

In the nursing field, these young women enter training school, thinking they will see patients and be with patients more or less constantly as they learn how to treat and care for them. They soon become disillusioned and find they were wrong in this belief. However, despite the fact that in their training period they seldom have an opportunity nowadays to be with, treat, or care for patients, the flame of this fundamental, humanitarian urge is so intense in a few of these students, thank God, that it burns on through all of their formative educational years of training and lights their path of practice clear on throughout life.

Unfortunately, the vast majority who started out with this fine, fundamental humanitarian urge lose it along the wayside in the complexities, profundities, and multiplicities of our scientific educational requirements, which more and ever more take nursing students out of close personal contact with patients.

Whereas in years gone by student nurses spent nine-tenths of their working time with and around patients, today I doubt if more than one-tenth of their time is actually spent with patients except in the very smallest hospitals.

It has oft been said that "absence makes the heart grow fonder," and this is true up to a certain point; but even in so fundamental a thing as love, it is a proven fact that too long, continued absence dulls desire and love is often lost. The things we remember best are those things with which we come in contact most often. Even to maintain an interest in and for a thing requires close contact with it.

Let us illustrate this in another way. A student of physics or chemistry can learn the theory, memorize the books, and pass an examination with a high grade; but when he gets through, he will have only a theoretical, smattering knowledge of either subject, virtually no knowledge of the practical application, and certainly very little interest in its practical application. Consequently, modern educators require and provide in collegiate training that the student shall spend only one hour in the lecture room as compared with four to six hours devoted exclusively to labora-

tory training, actually coming in close personal contact with the subject. "Experience is the best teacher" for intimate knowledge of and continuing interest in any subject.

Certain it is that the emphasis which has been placed on educational and scientific attainment in the last thirty years has paid off well in the form of new discoveries and many important, worth-while changes in both the medical and nursing fields, to the benefit of the public at large. Most certainly, we must continue to have many good specialists in both fields. But the emphasis has been so great on educational and scientific attainment in recent years that the pendulum has swung too far—just as it always does in all great, new, advancing movements. In this instance, it has been at the expense of the Art of Nursing and the Art of Medicine.

It is a hundred times more important that we reverse this trend back to a sensible middle ground than that we furnish hospitals double or treble the present number of nurses.

> Next to a good mother and a good mate,
> God's greatest gift to mankind is a good nurse.

Many good nurses are highly educated—nurse educators, nursing directors, administrators of hospitals, specialists in limited fields, department supervisors, or private duty nurses—but the best ones are those who in their early training had much close, frequent contact and personal experience with individual patients.

Doctors today want more good nurses, whose training experience with patients taught them to give excellent personalized bedside nursing care.

Our greatest nursing need today is a renaissance of the Art of Nursing.

Scott and White Memorial Hospitals.

Pediatric Tuberculosis in Texas

JOHN S. CHAPMAN, M. D., Dallas, Texas

In the years between 1950 and 1954, 376 children died of tuberculosis in Texas. All of these children were under the age of 4 years. The total deaths from this disease amounted to almost as many as died during the same period and in the same age group from poliomyelitis, heart disease, and renal disease combined. The important difference is that, whereas there are no specific treatments for these other conditions and whereas the deaths were probably unavoidable, in tuberculosis there are specific antimicrobial drugs available and it seems highly probable that many of these children could have been saved. Of course it is true that the amount of tuberculosis in the pediatric age group is dependent upon the amount of tuberculosis in the adult population. But it is inhumane to leave children whose lives might be saved to die while one is trying to start a control program among adults.

Facilities for children in the age group under 6 are not furnished at this time by the State of Texas. Children above that age are hospitalized in the regular tuberculosis sanatoriums. The highest death rate by far, however, is in the younger age group and in fact is highest in the first 24 months of life.

Although up to this point discussion has revolved around the death rate, the fact to be faced is that for everyone that has died there must have been possibly two or three others who had serious disease but happened spontaneously to overcome it. But that these children who obtained spontaneous arrests may have suffered severe visceral damage seems to be reasonable and almost certain. That they may even have been spreaders of the disease during their early illness seems to be a definite possibility, since children of this age group commonly have positive cultures from their bronchial washings.

At this time there are hospitals which accept children in the earliest age ranges in Dallas, Corpus Christi, Beaumont, Amarillo, and Houston. Possibly a very few are accepted in some of the other cities of the state. Because these various hospitals which accept tuberculous children are locally supported, the burden upon them of treating children from the rest of the state is great and in fact in some places becomes insupportable.

In all of these places, largely because they are for the most part required to confine their admissions to county residents, there are considerable numbers of empty beds. At present, as well as can be judged from information available, it appears that in the hospitals in the cities mentioned there may be enough vacant beds to permit hospitalization of every seriously sick tuberculous child in the state.

From the University of Texas Southwestern Medical School Department of Medicine, Ivor O'Connor Morgan Memorial Hospital for Tuberculous Children, and William Buchanan Laboratory.

SUGGESTED SOLUTION

Since there are available beds in institutions already set up to provide pediatric care, but beds that cannot be used on account of local restrictions in regard to admission, it would seem reasonable that the state as a unit of government might well contract with these local hospitals to care for tuberculous infants and young children. There is plenty of precedent in other states for this type of arrangement as between locally owned hospitals and the state, which is generally considered to be responsible for the care of tuberculosis. There is even in the past history of the tuberculosis situation in Texas some precedent for such an action, in that during the depression the state government leased beds from private sanatoriums for the care of adult patients.

According to the information available from one of the hospital administrators, a per diem of $7 would be adequate to provide completely satisfactory care for children in the age range of from birth to 6 years. Furthermore in the various cities named there is already an adequate staff set up to deal with the problem as it occurs in the youngest age group.

As a protection both to the state and to the patients involved it would be understood that these hospitals would be regularly inspected and approved by a representative of the State Board for Hospitals and Special Schools, but that the administration would be in the hands of a local administrator and the medical care in charge of the local staff. There would be no remuneration from the state for the local medical staffs.

The routine and regular inspection should adequately protect the interests of the state as well as of the patients and prevent the development of any conscienceless efforts to capitalize on the illness of these children.

ADVANTAGES

The advantages of the proposed plan are multiple:

1. This solution of the problem would result in the earliest possible activation of a plan to care for tuberculous children. The buildings are already erected and the beds are standing. The medical staff has been assembled and needs only to be supplemented by the addition of a few nurses or aides.

2. In terms of economy there is every argument in favor of this solution. The State of Texas and the Board for Hospitals and Special Schools would not be under the necessity of any large investment in land or buildings. If the fortunate time shall ever arrive when children do not develop tuberculosis, these buildings can be used for other pediatric services and the state would suffer no loss in consequence.

3. The State Board for Hospitals and Special Schools would be spared the extreme difficulty of attempting to assemble a superior pediatric staff at the sites of their present state sanatoriums. Such a problem would in fact be almost insuperable, particularly since in addition to the pediatric staff itself there should be available extensive consultation with other specialty services such as orthopedics, neurosurgery, and thoracic surgery.

4. This plan is equitable in that it distributes the cost of the care of tuberculous children throughout the state and places the burden of their care not on a single small unit but on the citizenry as a whole. The plan, moreover, is subject to revision and reconsideration in the event it proves to be unsatisfactory either from the standpoint of the local hospitals or from the standpoint of the State Board for Hospitals and Special Schools.

5. This plan has the further advantage that it distributes centers for the care of tuberculous children over the greater part of the state so that the geographic separation of the child from his parents is minimized.

Histamine Useful in Blood Vessel Disease

Histamine can bring relief from disabling leg pains caused by diseases of the peripheral blood vessels, Dr. Isidor Mufson of New York reports in *The Journal of the American Medical Association* for August 28. Infusions of histamine may help inadequate circulation by expanding nearby vessels and may bring about permanent structural changes which prolong the successful effect of the treatment. Histamine is too strong to be injected into the veins in concentrated form, Dr. Mufson says, but when infused it is safe and powerful.

Of 150 patients with foot and leg pain, 36 per cent were able to walk up to seven blocks after treatment with histamine, the article states. Fifty-two per cent could walk from seven blocks to an unlimited distance. Of this last group, 40 per cent remained improved for as long as two to seven years after treatment. In another group of 41 patients treated and reported by other physicians, 70 per cent walked better after histamine infusions.

Dr. Mufson indicates that 23 patients so disabled that amputation was being considered returned to normal routines. Only 6 patients required amputation. Many of this whole group had gangrene, which was cleared with the help of the histamine infusions and antibiotics.

TV Scripts Prepared by AMA

A script which can be narrated by a local physician and accompanying film to illustrate the script has been prepared by the Bureau of Health Education of the American Medical Association to help societies which want to use television but have a limited budget. The first of a series of two tells how vaccines are prepared, laboratory tested, and given. The second, "Jimmy's Noise Box," shows how to teach a deaf child to use a hearing aid.

PHYSIOLOGIC AND THERAPEUTIC ASPECTS OF HEPATIC INSUFFICIENCY

R. D. HAINES,* M. D., and J. A. COLEMAN, M. D., Temple, Texas

HEPATIC insufficiency, regardless of its cause, has a myriad of interesting manifestations, and many factors determine the patient's hope for recovery. These factors include (1) the functional state of the liver at the time of injury, (2) the nature and extent of the insult, and (3) the promptness of adequate therapy. As treatment of any disease is accomplished best if there is understanding of the abnormal physiochemistry, we present the various phases of the abnormal physiology of hepatic insufficiency as a basis for suggested therapy.

DIET

In the treatment of hepatic insufficiency, a highly nutritious diet, rich in protein and supplemented with vitamin B concentrate, has been advocated for a number of years by Patek and his co-workers.[1] This diet contains protein, 140 Gm.; carbohydrate, 365 Gm.; and fat, 175 Gm. It has been demonstrated by animal experimentation that in the absence of adequate protein and carbohydrate, fat is productive of cirrhosis and increases the injurious effects of toxins;[2] a moderate amount of fat is not harmful but is beneficial in that it adds palatability to the diet; and fat increases the caloric intake. Some[3] have allowed small amounts of alcohol to stimulate appetite; however, as alcohol is not a complete food and it is so frequently a cause of the patient's previous inadequate diet, it perhaps should be avoided entirely.

Those patients who are too ill to take anything by mouth must be supported by parenteral means until some improvement occurs. With the more liberal use of glucose given intravenously, the mortality rate of acute hepatic insufficiency has decreased. It has been demonstrated that by raising the blood sugar level with intravenous glucose, the damaged liver can be stimulated to store glycogen.[3] Insulin, under these circumstances, actually defeats the purpose, for it causes an increased storage of muscle glycogen which lowers the blood sugar level and stimulates the liver to pour out more sugar. Protein may be supplied in the form of protein hydrolysate since the cirrhotic liver can utilize amino acids.[4]

Patients maintained on parenteral therapy should have substantial vitamin supplements. These should amount to at least 500 mg. of thiamine hydrochloride, 1,000 mg. of nicotinamide, and 300 mg. of riboflavin daily. With the possible exception of vitamin D, there seems to be an increased need for practically all vitamins in patients with hepatic insufficiency. As they are fat soluble vitamins, the absorption of vitamins A, D, K, and E tends to be deficient when the bile content of the intestine is lowered. A defective vitamin A storage in the liver may increase the need for additional vitamin A. Added to the decreased intestinal absorption of vitamin K is the liver's decreased ability to utilize vitamin K in the synthesis of prothrombin. These deficiencies necessitate the administration of fairly substantial amounts of vitamin A (50,000 to 100,000 units daily) and vitamin K, preferably natural vitamin K (20 mg. daily). The absorption of water soluble vitamins is not affected by hepatic disease except in instances of a complicating gastrointestinal disorder. Their metabolism after absorption may be altered. That vitamin B complex is important in the treatment of hepatic insufficiency seems well documented.[1, 5, 6]

Lipotrophic substances, including choline,[7] methionine,[8] inositol,[9] liver extract,[10] and vitamin B_{12},[11] are of value in treating experimental hepatic insufficiency and human hepatic cirrhosis. It has been demonstrated that fatty infiltration precedes fibrosis[12] and, indeed, that fatty infiltration may cause hepatic insufficiency without fibrosis. It is thought that compression in the peripheral portion of the hepatic lobule by fat-swollen cells causes periportal atrophy and fibrosis.[13] Treatment of hepatic insufficiency, to be most effective, should begin as early as possible, preferably in the stage of fatty infiltration. While some physicians believe that lipotrophic agents are of benefit only in cases of inadequate protein consumption, there is some difference of opinion as to their value in the presence of adequate dietary intake. To be effective, choline should be given in a dosage of 4 to 6 Gm. daily; methionine, 3 to 6 Gm. daily. Cystine combined with choline has lipotrophic properties, but alone it may increase liver damage. For this reason, it always should be combined with choline. Liver extract has been used for many years in the treatment of hepatic insufficiency. We recommend crude liver extract in the dosage of 3 cc. three times weekly.

Read before Section A (Medical), Texas Medical Association, Annual Session, San Antonio, May 4, 1954.
From the Department of Internal Medicine, Scott and White Clinic.
**From the Section on Gastroenterology.*

HEMATOLOGIC ASPECTS

Patients with chronic hepatic insufficiency frequently exhibit varying degrees of anemia. This is usually of the macrocytic type. Wintrobe[14] found that, except when hemorrhage or infection was present, anemia was normocytic or macrocytic. He believed that it was similar, if not identical, to pernicious anemia and that it showed spontaneous remissions and responded to liver extract.

Bateman, Shorr, and Elgvin,[15] in their studies, found a marked increase in total blood volume with relatively greater increase in plasma than in red cells. They thought that the hypervolemia with normal red cell mass at least partially explained the poor response in their patients to antianemic agents. Schiff, Rich, and Simon[16] were able to recover antipernicious anemia substances from the livers of cirrhotic patients with macrocytic anemia, and they suggested that the defect was one of utilization rather than of storage. Jarrold and Vilter[17] found the bone marrow of cirrhotic patients with macrocytic anemia to be normally cellular or moderately hypocellular. These authors concluded that the macrocytic anemia of chronic liver disease is produced by a metabolic defect entirely different from that present in pernicious anemia and related macrocytic anemias.

The evidence seems to indicate that the disturbed physiology responsible for the anemia of chronic hepatic disease is (1) hypervolemia with greater increase in plasma than in red cells and (2) a metabolic defect in the utilization of antianemic factors. From a therapeutic standpoint, iron deficiency anemia, as seen in patients with chronic hepatic insufficiency, responds in most instances to ferrous sulfate therapy.[15]

In rare instances, hemolytic factors may be responsible for anemia in hepatic disease. Morlock and Hall[18] found thrombocytopenia in 14 of 80 patients with hepatic cirrhosis. This fact, added to the frequent finding of a lowered prothrombin level, accounts for the severe bleeding tendencies seen in patients with severe hepatic insufficiency.

ALTERED HORMONAL EXCRETION

Evidence of endocrine imbalance is frequently encountered in the patient with cirrhosis and is manifested in the male by gynecomastia, impotence, testicular atrophy, and pectoral alopecia; in the female by menstrual disturbances (menorrhagia, amenorrhea), breast changes (cystic changes), and breast symptoms (pain); and in both sexes by palmar erythema, spider angiomas, and acne.

The original theory that the liver normally inactivates or detoxifies estrogens has been elaborated. Several authors found increased urinary estrogens and decreased 17-ketosteroid and gonadotrophin excretion during the phase of severe liver disease.[19] Cantarow and his co-workers[20] showed that estrogens are removed from the blood by the hepatic cells and are excreted in the bile in an active form. Later, as in the case of bile acids, they progress through an "enterohepatic circulation." In addition to the free forms of estrogen being excreted in the bile, metabolism of this hormone is also by conjugation,[21] as well as by transference to compounds of lesser biologic activity. The observed increase in urinary estrogen excretion doubtfully is related to increased production of estrogen, but more likely to a combination of decreased production and decreased biliary excretion.

It also has been demonstrated that diets deficient in vitamin B complex decrease the liver's ability to inactivate either endogenous or exogenous estrogens,[22] whereas yeast[23] and methionine[24] could correct this defect experimentally. Some investigators have found no correlation of hypoadrenal or hyperadrenal cortical activity as 17-ketosteroids were normal in 6 patients and low in 2 patients.[25] Engstrom and his associates[26] administered testosterone to patients with liver disease and found this group converted the same amount of 17-ketosteroids as did normal persons.

The actual relationship of liver disease and adrenal gland function is not clear; however, Topperman[27] has suggested that since the normal hepatic function of esterifying cholesterol is diminished, the esterified cholesterol may be absent as a precursor of the cortical steroid hormone. Also, the direct effect of suppression of adrenal function by increased estrogen may be a factor, as demonstrated by Hamblen.[28]

Smith and Smith[29] have shown that the luteinizing hormone increases after administration of diethylstilbestrol, as well as that this release of luteinizing hormone is augmented by the metabolic products of estrogen. One might theorize that the adrenotrophic hormone is released by the same stimulus as the luteinizing hormone. With these facts as the basis, Lloyd[30] has proposed a rational theory to explain the "endocrine" changes seen in cirrhosis. It can be summarized as follows: With the decrease in liver function, free estrogen accumulates in the blood and urine, which inhibits the release of follicular stimulating hormone, secondarily resulting in suppression of spermatogenesis and follicular maturation as well as estrogen stimulation of target organs. The decrease in the inactive oxidative products of estrogen leads to decrease in luteinizing hormone and, perhaps, adrenotrophic hormone. These will reflect themselves in menstrual irregularities, decreased Leydig cell activity, decreased adrenal function, loss of axillary hair, and decrease in 17-ketosteroid excretion.

Pathologic substantiation is available, as Bennett and others[31] found from a study of patients dying with

cirrhosis that definite microscopic changes occurred in the testes, breasts, and prostate. These facts suggest the need for male hormone in the male and the disadvantage of estrogen in the female with a history of jaundice. In addition, testosterone has a protein sparing effect, and this is an added advantage as liver disease is often associated with negative nitrogen balance and hypoproteinemia. One of its controversial drawbacks is its possible effect upon salt and water retention.

ASCITES AND EDEMA FORMATION

As more information is accumulated, it is apparent that production of ascites and edema is a subtle disturbance involving several different physiologic mechanisms. These five major factors deserve some emphasis.[32, 33, 34]

Alterations in Portal Venous System Pressures.[32]—Normal portal vein pressure is approximately 80 to 120 mm. of water; in patients with cirrhosis of the liver, the tension rises from 300 to 600 mm. of water. The increased pressure no doubt is conducive to ascites formation.

The syndrome of increased portal tension, splenomegaly, ascites, and increased venous collaterals was first explained on the basis of increased connective tissue within the liver, with subsequent contraction of the hepatic vascular space. Recently, evidence has appeared to substantiate another factor, and to quote Kelty and others, "the growth of the regenerative nodule is more important in the production of a distorted, narrowed, and obliterated vascular tree than the increased fibrous connective tissue."[32]

As early as 1933, McMichael and Smirk[35] noted correlation of portal vein obstruction and diminished rate of absorption of water from the gastrointestinal tract, as well as delayed diuresis. Bradley[36] showed that increase in intra-abdominal pressure produced by ascites decreases hepatic blood flow tremendously. In addition, blood flow from other organs—including kidney, cardiac, pulmonary, and gastrointestinal systems—is adversely affected.

Thorington and Schmidt[37] showed that intra-abdominal pressure up to 30 mm. in dogs is consistently followed by anuria. It is suggested that the anuria is related to secondary effects on renal circulation comparable to partial occlusion of renal veins. In man, Bradley and Halperin[38] have demonstrated correlation of intra-abdominal pressure and reduction in renal blood flow as well as cessation of urine formation in certain proportions of nephrons. These observations suggest that portal congestion causes delayed absorption of water from the gastrointestinal tract and that when intra-abdominal pressure exceeds certain limits, it adversely affects urine output.

Renal function in relation to patients with cirrhosis has been studied extensively. Leslie and his associates[39] studied this problem, measuring renal function by several means, and they found that the glomerular filtration rate, effective renal plasma flow, and maximum tubular excretory capacity for para-aminohippuric acid (Tm_{PAH}) are reduced during the phase of ascitic accumulation and normal when ascites has disappeared. These data suggest that it is important to establish normal renal function. Paracentesis, therefore, should not be used as a last resort measure, but early, considering the fact that loss of protein accompanies paracentesis as the lesser of the two evils.

Changes in Oncotic Pressure of Serum.—The effective osmotic forces are four in number; they are (1) capillary blood pressure, (2) ascitic hydrostatic pressure, (3) plasma colloid osmotic pressure, and (4) ascitic colloid osmotic pressure. The average colloid osmotic pressure ranges from 200 to 350 mm. of water, and colloid osmotic pressure of ascitic fluid ranges from 25 to 175 mm. of water. Effective serum osmotic pressure above a certain critical level differs in various patients and prevents ascites formation,[40] and below this level ascites reaccumulates. There has been debate as to whether the low serum albumin level seen in patients with cirrhosis is due to altered protein synthesis, low intake, poor assimilation, or persistent loss. It must follow that a variable depletion of tissue protein also exists; and perhaps plasma albumin values can be restored only after tissue protein depletion has been erased.[41]

There has been variable enthusiasm for the use of salt-free serum albumin in the treatment of ascites. Encouraging results were obtained by Kunkel;[42] however, others[43, 44, 45] have observed only conservative response. As reported by Kunkel and his associates,[46] its greatest value may lie in the treatment of two groups of persons, those patients with low plasma albumin levels and severe liver damage following infectious hepatitis and those patients of alcoholic and nutritional cirrhosis with short-lived ascites. Its cost may be prohibitive to some. One disadvantage should be mentioned, that is, the possibility of increasing total blood volume and therefore increasing the burden of esophageal varices and the likelihood of bleeding or the increased possibility of pulmonary edema.

Since there is clinical evidence that prognosis of life is increasingly grave as levels of serum albumin decrease[47] (levels of total protein and globulin are of no prognostic value), the use of human salt-free albumin should not be abandoned, nor should it be used as the sole measure of treatment, but rather it should be added to the therapeutic program of all patients with severe hepatic insufficiency. The avail-

ability of serum albumin as human salt-free albumin is not limited. The amount necessary for favorable response varies from a few to many units given, if no untoward reactions occur, once or twice daily depending upon results. The combined use of mercurial diuretics[48] and salt-free albumin has been recorded to give synergistic beneficial results and should be further investigated.

Alterations in Hepatic Lymph Flow.—Volwiler and his associates,[33] by constricting the thoracic segment of the inferior vena cava, have produced, experimentally, ascites which has protein content similar to hepatic lymph. It was their conclusion "that ascitic fluid associated with hepatovenous congestion is in reality hepatic lymph."

Changes in Permeability of Abdominal Venous Channels.[34]—As postulated by Karl and his co-workers,[34] the possibility exists that a factor tending to accumulate ascites resides within the endothelial cells lining the mesenteric vascular bed. It is closely connected with the tissue and cellular protein metabolism. In those persons with a decreased tissue protein there exists a factor within the individual endothelial cell which favors increase in permeability and, therefore, increased ascites.

Changes in Salt and Water Metabolism.—It has been demonstrated repeatedly in cirrhotic patients with ascites that there is an increased retention of sodium[49] as well as a diminished urinary sodium excretion.[50] There is debate as to whether there is impaired renal excretion of sodium[51, 52] or increased tubular reabsorption of sodium.[52] Epstein and others[53] found normal glomerular filtration rate and renal plasma flow values in 11 patients accumulating ascites; also, they added evidence that retention of sodium is due to increased tubular reabsorption. On the other hand, Leslie and his associates[39] noted reduction in filtration rate, effective renal plasma flow, and Tm_{PAH} during the phase of rapid accumulation of ascitic fluid. They considered renal alterations to be functional and reversible since insulin and PAH clearance returned to normal after therapy.

In any respect, regardless of the route administered, practically all ingested sodium appears in the ascitic fluid and little appears in the urine.[52, 53, 54]

In cirrhotic patients with ascites, another interesting observation relative to sodium excretion has been the finding of a reversal of the diurnal excretion rhythm of sodium and chloride.[55] Simultaneous with this was a noted increase in the nocturnal glomerular filtration rate and effective renal plasma flow.[56]

The subnormal concentration of sodium in the thermal sweat and saliva[57] of cirrhotic patients with ascites has suggested a generalized mechanism at fault, such as a hormonal imbalance. Leaf[58] and Faloon[54] have suggested that this abnormal sodium retention is probably related and regulated by the adrenal cortex. In a direct approach, Bongiovanni[59] attempted to demonstrate increased renal excretion of adrenal salt active hormones and did find slight elevation of reducing "cortin" excretion in cirrhotic patients with ascites. Blahd and others[60] demonstrated that in far advanced cirrhosis, DOCA, cortisone, and ACTH accelerated the development of ascites and edema whereas patients with less far advanced disease manifested only transient salt and water retention. With the discontinuance of DOCA, cortisone, and ACTH, withdrawal diuresis was pronounced, especially in less far advanced cases, and in certain instances all edema and ascites disappeared. Thorn[61] and Eliel[62] suggested that this "withdrawal diuresis" may be a state of temporary relative adrenal cortical insufficiency.

The volume of ascitic fluid in females with cirrhosis has been observed to increase during the premenstrual period, evidence that progesterone also has a salt and water retaining effect.

Closely related to sodium excretion is water metabolism itself. The clinical feature of oliguria in advanced hepatic insufficiency is well known. The presence of an antidiuretic factor has been demonstrated in the urine of cirrhotic patients with ascites and not present in those without ascites.[63] Ralli[64] and Dochios[65] found increased amounts of antidiuretic substances in the urine of cirrhotic patients with ascites as compared with normal persons.

Likewise, Perry and Fyles[66] measured an antidiuretic substance in serums of normal persons and patients with liver damage. They also demonstrated in normal males greater quantities of this antidiuretic substance when the patient was dehydrated. These investigators also correlated quantities of antidiuretic substances in patients with liver disease and in normal persons and found no significant variation. Therefore, they questioned the exact similarity of these antidiuretic substances found in urine and serum and doubted the cause and effect relationship of the serum antidiuretic substance and the production of ascites. Contrary to this, Dochios and Dreifus[65] established the presence of increased antidiuretic hormone titers in the urine of 2 patients with cirrhosis and also have shown that urinary levels of this factor have a correlation with degree of clinical edema.

Assuming, as is the consensus, that there is an increased antidiuretic substance present, one raises the question of whether this represents increased production or decreased inactivation. If commercial Pitressin can be compared with the antidiuretic hormone produced in vivo, the theory of decreased inactivation would not appear to be true as it has been reported[67]

that cirrhotic patients can inactivate injected Pitressin as rapidly as normal persons. Therefore, one must consider the prospects of increased antidiuretic hormone as the likely hypothesis.

Verney[68] postulated pressure "osmoreceptors," which in response to serum solute concentration regulate the pituitary antidiuretic level. With slight increases in total solute concentration of the serum, stimulation through osmoreceptors produces increase in antidiuretic hormone and subsequent increase in reabsorption of water from glomerular filtrate and resultant conservation of body water and dilution or serum solute concentrate to normal. The opposite effect also occurs.

Various authors[69, 70] have demonstrated that water diuresis was inhibited in patients who were in sitting position more than in those in recumbent position and that this water diuresis could be increased by increasing the cerebral venous pressure by means of a pressure cuff about the neck. This information suggests also a "volume receptor" which in response to decreased volume of cerebral blood and extracellular fluid stimulates antidiuretic activity in the presence of dilute extracellular fluid. Perhaps one can speculate that osmoreceptors and volume receptors reside within the pituitary gland and independently respond to specific stimuli.

Mazur and Shorr[71] have reported that the hepatic vasodepressor principle in experimental animals is profoundly antidiuretic by inducing an increase in tubular reabsorption of water. It is suggestive, therefore, that sodium metabolism may be under the influence of adrenal corticoids while water metabolism is under the influence of antidiuretic substance.

Other electrolytes, however, such as potassium, calcium, and phosphorus, have been recorded below normal value in severely decompensated portal cirrhosis, questionably due to dietary deficiency.

Kunkel[72] reported that in 13 patients the urinary excretion of sodium chloride ranged from .012 to .13 Gm. per day while the patients ingested 7 to 9 Gm. of sodium chloride per day.

It seems rational, therefore, that a diet low in sodium should be and is ideal for patients with ascites and edema. It has been our policy in patients with severely decompensated hepatic insufficiency to use a diet containing .2 Gm. of sodium per day. This restricted sodium diet has its advantages as evaluated by Lowe.[73] Since under ordinary conditions 150 mg. of sodium are lost in stool and sweat per day, only the remaining 50 mg. would be available for urinary excretion or retention, and since a liter of extracellular fluid contains 140 milliequivalents of sodium, even if 50 mg. of sodium (2.2 milliequivalents) were retained a day, it would take sixty-four days for 1 liter of ascitic fluid to accumulate.

This restricted sodium regimen is not without hazard, particularly in patients with chronic renal disease, as manifestations of "low salt syndrome" may occur as a result of diuresis and failure of the kidney to reabsorb sodium. Accompanying this low level of serum sodium (less than 130 milliequivalents of sodium per liter) are the findings of an increased blood urea level and a depression of the carbon dioxide combining power of the plasma. Various alterations in serum potassium have been found.

Because of the unpalatability of the low sodium regimen, "cation exchange resins" would seem to be advantageous, permitting some salt in the food. Although these substances themselves have inherent disadvantages, they often suffice to tide the patient over critical periods. However, with the use of hydrogen cation exchange resins, hypokalemia has been produced in persons with renal insufficiency.[74] This hazard has been overcome with the newer resins which have incorporated potassium with the substance thereby providing this anion for absorption.

On the other hand, paracentesis has been a common therapeutic practice; and in patients who previously followed a low sodium regimen and who were subjected to frequent paracentesis, hyponatremia and the "low salt syndrome" have been reported. It is not necessary for this latter group of patients to have renal disease as body sodium is depleted by removal of electrolytes in the ascitic fluid.

Mercurial diuretics also have been used to aid in eliminating ascites and edema and may have some value. Their beneficial effects seem to decrease with repeated use. It should be mentioned that these measures (paracentesis, exchange resins, and mercurial diuretics) should not all be used simultaneously as they would hasten the potentiality of inducing the "low salt syndrome."

As stated previously, even though paracentesis may deplete the body of electrolytes and proteins, its use should be encouraged as satisfactory diuresis is often seen immediately thereafter, perhaps on the basis of increased renal blood flow. To substantiate this, experimental evidence in dogs shows that increase in intra-abdominal pressure is followed by oliguria.[75]

The ingenious idea of reinfusing ascitic fluid[76] has two disadvantages, in that the reinfusion produces anaphylactoid reactions and increases the amount of an already excessive antidiuretic material.

Before instituting the previously mentioned procedures renal function should be assayed, and during treatment observations of the electrolyte response should be noted.

SUMMARY AND CONCLUSIONS

The therapy of hepatic insufficiency is not stereotyped; however, there are certain basic therapeutic aspects appropriate for all patients. Rest is fundamental. A high caloric diet, with emphasis on adequate protein and carbohydrate consumption, supplemented with necessary vitamins, is essential. The avoidance of sodium has been stressed. Adequate lipotrophic substances and liver extract are important.

During acute infectious episodes antibiotics are valuable. Value of paracentesis should be weighed in the light of anticipated loss of protein against possible increase in renal function and likelihood of diuresis. Transfusions to combat anemia, whatever its origin, are imperative.

Exchange resins may be a valuable adjunct to treatment despite their shortcomings—unpalatability, possibility of hypokalemia, and production of symptoms mimicking hepatic coma. Human salt-free albumin may be a means of increasing plasma levels, restoring depleted associated stores, and potentially improving vascular permeability. Plasma extenders may be of momentary value during shock. The use of balloon esophageal compression may be a life-saving measure during bleeding until other specific surgical measures, such as a local injection, can be undertaken. Mercurial diuretics may yield transient beneficial diuresis, and they may be administered simultaneously with human salt-free albumin with synergistic efficacy. Testosterone may be indicated in certain male patients. The use of intravenous glutamic acid in coma reveals therapeutic promise.

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CHOLESTEROL METABOLISM

Evaluation of Polysorbate 80-Choline-Inositol Complex (Monichol) for the Management of Hypercholesteremia

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ALTHOUGH great strides have been achieved in recent years toward the understanding of the possible underlying causes in the pathogenesis of atherosclerosis, the internist still is faced with the problem of treating this disease and its complications.

In a recent review, Moses[1] pointed out the two factors from a practical view which are of prime importance in the development of arteriosclerosis. They are the cholesterol in the circulating blood and the stress and strain on the arteries carrying cholesterol. This same author[2] has stressed that the emphasis should be placed not only upon the quantity of the circulating cholesterol but also on the physical form in which this cholesterol is carried and presented to the liver for degradation.

Pollack[4] stated that stabilization of cholesterol in the serum emulsion would help reduce the incidence of atherosclerosis. Sherber and Levites[6] also have demonstrated the importance of the physical state of serum cholesterol, especially for its utilization by the adrenal cortex, during their study of a new physiochemical complex (Monichol) containing polysorbate 80, choline, and inositol. Schaff,[5] in his review of cardiovascular diseases, stated that hypercholesteremia with predisposition to atherosclerosis is considered an inborn error of lipid metabolism. He was doubtful whether the ultracentrifugal lipoprotein patterns are any more accurate an index of atherosclerotic tendencies than the total serum cholesterol determinations.

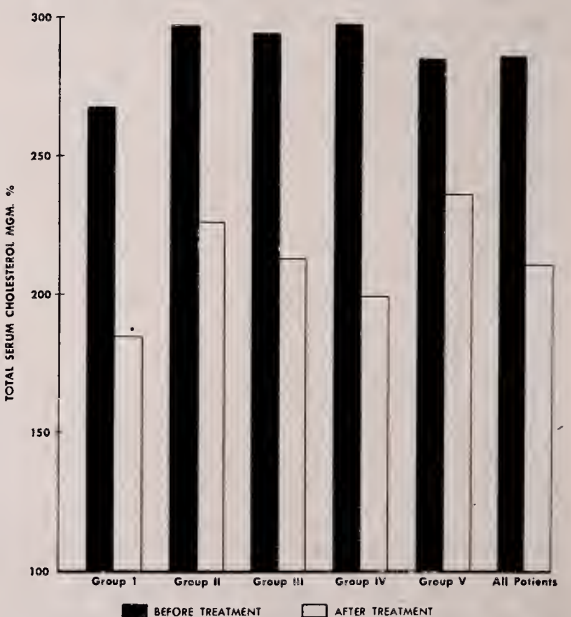

FIG. 1. A graph showing the mean serum cholesterol levels of five groups of patients before and after treatment with polysorbate 80–choline–inositol complex.

Over the years, many therapeutic methods and agents have been employed to lower elevated serum cholesterol levels. Among the agents suggested are potassium iodide, thyroid substance, pancreatic and brain extracts, lipotropic substances, plant sterols, heparin, estrogens, and low fat, low cholesterol, and low caloric diets.

It is not our intent to review the possible merits and limitations of any of the mentioned agents which may be antiatherogenic. Page,[3] in a recent article, summarized the present views concerning these methods and agents. He concluded that whereas no treatment exists for atherosclerosis, there may be ways of slowing its development and possibly aiding to reverse the existing pathologic process. Also, because the conditions under which experimental atherogenesis in animals is induced are of such an abnormal nature that its inhibition may result in producing an equally abnormal state, no practical means of a prophylactic or therapeutic nature can be judged from animal experimentation.

Since we believe that hypercholesteremia exists in a large number of average patients seen by the internist in private practice and that it may occur in the younger as well as the older age group, the problem of practical treatment for these patients becomes paramount. In our clinic we have used low fat, low cholesterol, and low caloric diets for the management of hypercholesteremia. This regimen has proved unsatisfactory as patients generally do not accept it after a period of a few months. We also have tried lipotropic mixtures and have found no significant change in the elevated serum cholesterol levels post-treatment as compared to pretreatment, confirming what already has been published to date concerning the use of lipotropic agents. Since Sherber and Levites published their results with the solution of polysorbate 80–choline–inositol, we decided to undertake an evaluation of this drug (Monichol*) in private practice patients rather than in hospital patients.

The expressed views that disturbances in lipid metabolism are an important factor in the pathogenesis of coronary artery disease and occlusion and the fact that patients with a family history of gallbladder dysfunction with gallstone formation and patients who are obese, diabetic, and hypothyroid all exhibit some degree of abnormal lipid metabolism led us to study the effects of the new polysorbate 80–choline–inositol complex, both therapeutically and prophylactically. The investigation we pursued had a twofold purpose. It was our intent to determine whether the polysorbate 80–choline–inositol complex would reduce the elevated serum cholesterol levels as well as whether it would improve the subjective symptoms of the patients studied.

METHODS AND MATERIAL

Cholesterol determinations were made on approximately 200 patients, and findings were considered normal if they were between 150 and 200 mg. of

**Supplied by Ives-Cameron Company.*

TABLE 1.—*Effect of Polysorbate 80–Choline–Inositol Complex on Serum Cholesterol Level of Patients with Biliary Tract Disease with Hypercholesteremia.*

Patient	Age (yr.)	Sex	History & Diagnosis	Initial Cholesterol (mg./100 cc.)		Remarks	Last Cholesterol (mg./100 cc.)		Subjective Findings
1	56	F	Hypertensive & cardiovascular disease; gallstones, colic, bloating	229	Feb. 17, 1954	Medication reduced cholesterol to 156 mg. per 100 cc.; discontinued for cholecystectomy April 18, 1954; cholesterol rose to 277 mg.	265	May 12, 1954; medication not yet resumed	Feels better; no bloating
2	61	F	Postoperative biliary dyskinesia; cholecystectomy in 1939 for gallstones; hypertensive heart disease	234	June 30, 1953		226	May 28, 1954	Improved; no bloating
3	59	F	Cholecystectomy for stones in duct and bladder in 1941; postoperative biliary dyskinesia	307	Sept. 12, 1953	Liver function tests normal	192	May 4, 1954	Improved
4	67	F	Cholecystectomy for stones Dec. 3, 1953; postoperative biliary dyskinesia	318	March 10, 1954	Liver function tests showed some liver damage before surgery	218	May 10, 1954	Bloating, indigestion, pain in right upper quadrant and right subscapular region subsided
5	60	M	Cholecystectomy for stones and cholecystitis in 1951; old myocardial infarction; coronary artery disease; anginal syndrome; postoperative biliary dyskinesia	256	Feb. 19, 1954		130	April 27, 1954	Significant improvement; no bloating; few anginal attacks

TABLE 2.—*Effect of Polysorbate 80–Choline–Inositol Complex on Serum Cholesterol Level of Diabetic Patients with Hypercholesteremia.*

Patient	Age (yr.)	Sex	Diagnosis	Initial Cholesterol (mg./100 cc.)		Last Cholesterol (mg./100 cc.)	
6	55	M	Diabetes mellitus	272	April 19, 1954	233	May 10, 1954
7	53	F	Diabetes mellitus	380	April 24, 1954	286	May 22, 1954
8	54	M	Diabetes mellitus	238	Feb. 20, 1954	165	March 27, 1954

cholesterol per 100 cc. of serum using Bloor's method. Liver function was tested, electrocardiograms were made, and basal metabolic rates were determined along with the cholesterol studies.

After screening these 200 patients, the 25 with hypercholesteremia were placed into one of five diagnostic categories: (1) hepatic and biliary tract disease, (2) diabetes mellitus, (3) cardiovascular disease, (4) idiopathic hypercholesteremia associated with obesity, and (5) hypothyroidism.

Monichol is a brand of polysorbate 80, with choline and inositol in a base consisting of water, glycerine, and flavoring agents. Each 5 cc. contains polysorbate 80, 500 mg.; choline dehydrogen citrate, 500 mg.; and inositol, 250 mg. The average dose was two teaspoons twice daily. However, occasionally when the fall in cholesterol was not restored to nearly normal with the average dose, two tablespoons were given twice daily.

FINDINGS

Group 1 represents patients who had a cholecystectomy performed because of a history of gallstones. In these cases surgery had been performed anywhere from one month to fourteen years prior to this study. Postoperatively, the patients complained of bloating, indigestion, and discomfort in the right upper quadrant with some pain in the subscapular region. The average serum cholesterol level of this group prior to instituting treatment with the polysorbate 80–choline –inositol complex was 269 mg. per 100 cc. After treatment the average serum cholesterol level was 184 mg. per 100 cc. (fig. 1). All of the patients subjectively improved, bloating subsided, indigestion ceased, and discomfort and pain subsided (table 1).

Group 2 consists of diabetic patients who were controlled with insulin prior to being included in the study. The average serum cholesterol level improved from 297 mg. per 100 cc. pretreatment to 228 mg. per 100 cc. post therapy (fig. 1). Individual results are noted in table 2.

Group 3 consists of cardiovascular patients, representing also the largest group of patients in the older age limits. Most patients in this group had anginal syndrome. Treatment with the polysorbate 80–cho-

TABLE 3.—*Effect of Polysorbate 80–Choline–Inositol Complex on Serum Cholesterol Level of Patients with Cardiovascular Disease with Hypercholesteremia.*

Patient	Age (yr.)	Sex	History & Diagnosis	Initial Cholesterol (mg./100 cc.)		Remarks	Last Cholesterol (mg./100 cc.)		Subjective Findings
9	62	F	Hypertensive & cardiovascular disease; blood pressure 210/100; nonfunctioning gallbladder; refused surgery; bloating, indigestion	460	Oct. 10, 1953	Liver function tests normal	378	May 22, 1954	Does not have as much bloating & indigestion
10	70	M	Arteriosclerotic heart disease with angina	240	April 27, 1954	EKG shows chronic coronary insufficiency	186	May 28, 1954	Feels better; anginal pains subsided
11	57	M	Subthalamic damage (vascular)	212	April 5, 1954		190	June 8, 1954	Feels better
12	66	F	Arteriosclerotic heart disease with anginal syndrome	380	April 6, 1954	EKG shows chronic coronary insufficiency	212	May 6, 1954	Feels better; no anginal symptoms
13	76	F	Arteriosclerotic heart disease with angina	271	March 20, 1954	EKG shows heart strain on left side & coronary insufficiency	198	May 28, 1954	Improved; fewer anginal pains
14	44	M	Anginal syndrome	233	May 8, 1954		212	June 9, 1954	Improved
15	65	M	Anginal syndrome; arteriosclerotic heart disease	264	May 15, 1954	EKG shows coronary insufficiency	160	June 5, 1954	Improved; no anginal pains
16	72	F	Anginal syndrome; arteriosclerotic heart disease	367	Dec. 29, 1953	EKG shows coronary insufficiency	180	April 27, 1954	Improved; few anginal pains
17	59	M	Hypertensive & arteriosclerotic heart disease; anginal syndrome; had coronary occlusion, age 58	227	March 24, 1954	EKG shows myocardial damage due to old coronary occlusion	202	May 8, 1954	Anginal pains relieved

TABLE 4.—*Effect of Polysorbate 80–Choline–Inositol Complex on Serum Cholesterol Level of Patients with Idiopathic Hypercholesteremia.*

Patient	Age (yr.)	Sex	History & Diagnosis	Initial Cholesterol (mg./100 cc.)	Remarks	Last Cholesterol (mg./100 cc.)	Subjective Findings
18	53	F	Obesity; menopausal syndrome	233 Sept. 29, 1953	On 1,200 calorie diet	155 May 15, 1954	Feels better; sense of euphoria
19	58	F	Obesity	248 March 22, 1954	On 1,200 calorie diet	205 May 6, 1954	Sense of euphoria
20	50	F	Menopausal syndrome; hypertension	353 Jan. 8, 1954	On medication only; no dietary restrictions	192 April 3, 1954	Feels better; sense of euphoria
21	38	M	Obesity	318 March 6, 1954	On 1,200 calorie diet	254 May 1, 1954	Feels better; sense of euphoria
22	33	F	Obesity	338 April 10, 1954	On 1,200 calorie diet	198 May 15, 1954	Feels better

line–inositol complex not only reduced the average serum cholesterol level from 295 to 213 mg. per 100 cc. but also gave these patients relief from anginal pain (fig. 1 and table 3).

Group 4 represents obese patients with idiopathic hypercholesteremia. This group, though small in number, presents some interesting data. Unlike the previous groups in which the patients were mostly in the fifth, sixth, and seventh decades of life, the average age of this group is 46 years and includes 1 man 38 years and 1 woman 33 years of age. The younger patients' serum cholesterol levels fell in like manner as the older patients. In six to eight weeks the levels went from 318 mg. per 100 cc. to 254 mg. and from 338 mg. per 100 cc. to 198 mg. respectively (table 4).

Four of the 5 patients studied in this group were maintained on diets consisting of 1,200 calories. One patient (patient 20), however, was maintained on a regular ad libitum regimen with no restrictions during the course of treatment with the complex. The result was just as striking in this patient (from 353 mg. of cholesterol to 192 mg. per 100 cc.) as in the patients on concomitant dietary control. The average cholesterol level following treatment fell from 298 mg. to 201 mg. per 100 cc. (fig. 1).

Group 5 represents 3 hypothyroid patients. On a diet consisting of 1,200 calories plus treatment with the complex, 2 of the 3 patients showed significant drops in their serum cholesterol levels. One patient maintained on a regular diet without restrictions experienced only a slight reduction in serum cholesterol. No thyroid therapy was instituted in any of the patients (table 5). The average cholesterol level for this small group fell from 288 mg. per 100 cc. to 238 mg. (fig. 1).

COMMENT

In this study lowering elevated serum cholesterol values helped the patients objectively as well as improved them subjectively. For hypercholesteremic patients, particularly those with cardiovascular disease and angina and those with postoperative biliary dyskinesia, there may be opened a new avenue of therapeutic approach. It is also important to mention that when treatment with the polysorbate 80–choline–inositol complex was stopped, the serum cholesterol levels rose to their pretreatment high. Upon resumption of therapy, the serum cholesterol levels were noted to fall again. While on treatment all patients reported a sense of euphoria. The complex possibly may possess a clearing, antichylomicronic property. Because of the small number of patients studied and for a relatively short period of time, it is impossible to draw definite conclusions. Some patients, however, have been on continuous therapy for almost one year and are in favorable condition.

A long range study with a larger group of patients undoubtedly would give further insight into the complexity of cholesterol metabolism and its physiologic significance. Prophylaxis of hypercholesteremia in obese, hypothyroid, and cardiovascular patients and in

TABLE 5.—*Effect of Polysorbate 80–Choline–Inositol Complex on Serum Cholesterol Level of Patients with Hypothyroidism and Hypercholesteremia.*

Patient	Age (yr.)	Sex	History & Diagnosis	Initial Cholesterol (mg./100 cc.)	Remarks	Last Cholesterol (mg./100 cc.)	Subjective Findings
23	44	M	Obesity; hypothyroidism	248 April 8, 1954	On 1,200 calorie diet	189 May 13, 1954	Sense of euphoria
24	36	M	Obesity; sluggish gallbladder; bloating; pain in right scapular region; hypothyroidism	248 March 13, 1954	Liver function tests normal	236 June 3, 1954	Losing weight
25	53	F	Menopausal syndrome; obesity; hypothyroidism	367 April 1, 1954	On 1,200 calorie diet	288 May 17, 1954	Feels better; losing weight; sense of euphoria

patients with a personal or family history of gallstones or even those with hypercholesteremia of unknown origin would be the ideal approach to this problem.

SUMMARY

The polysorbate 80–choline–inositol complex used was found to lower significantly elevated serum cholesterol levels in the patients studied. Patients studied with anginal syndrome and postoperative biliary dyskinesia with hypercholesteremia were improved subjectively and symptomatically. Diabetic, obese, and hypothyroid patients with hypercholesteremia likewise were improved objectively and subjectively.

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Potassium Depletion in the Treatment of Essential Hypertension

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A NEW method of treatment of hypertension needs no excuse even though, like all past methods, it explains little as to basic causes and is nonspecific in character. Psychotherapy, depressants like phenobarbital, or derivatives of Rauwolfia serpentina lower the blood pressure only slightly.

Potassium thiocyanate is a more definite hypotensive drug[6] but often must be increased to dangerously toxic levels. At such levels, the serum potassium on occasion has been found to be noticeably decreased—a parallel to the results to be presented. The median drops in blood pressure during therapy with thiocyanate were 20 mm. systolic and 10 mm. diastolic.

Drastic sodium depletion,[5, 8] accomplished in our Hypertensive Clinic by a 200 mg. sodium diet plus mercurial diuresis, lowered the blood pressure more markedly, that is, 25 mm. systolic and 15 mm. diastolic. The addition of preparations of Veratrum viride,* alone mildly hypotensive, aided this effect of sodium depletion without serious side reactions.

Powerful new sympathetic depressant agents, the methonium compounds, for example hexamethonium and hydralazine, alone or in combination, enjoy greater popularity than efficacy and safety. Even with the patient on rigid hospital control sudden marked drops in blood pressure from hexamethonium have been fatal. Increased dosage requirements and the development of a partial lupus erythematosus syndrome have plagued the administration of hydralazine.

Medical, if not surgical, sympathectomy has its place, however, in treatment of rapidly advancing malignant hypertension. Various combinations of the regimens just mentioned are also useful in the management of difficult cases of hypertension, and to these can now be added moderate potassium depletion.

In 1950 and 1951 a low potassium intake was found to lower the blood pressure of hypertensive as well as normal rats.[1] Various workers have demonstrated the lowering of potassium concentrations in serum, skeletal muscle, and possibly cardiovascular tissue on this regimen. As in human cases,[4] the blood pressure elevating effect of desoxycorticosterone was blocked in these rats, and the peripheral vessels became less reactive to various agents, that is, less spastic. The claim that potassium restriction was hypotensive only on a high, and not a low, sodium intake has not been confirmed (see below).

For the past two years my associates and I have been studying 22 patients with uncomplicated essential hypertension on various regimens involving potassium depletion. The low potassium diet[9] included diced meats and fish cooked for two hours in parchment paper, dairy products, cereals except bran and rye, certain vegetables, and canned fruits. Totally excluded were soups and gravies; dried fruits and most fruit juices; potatoes, spinach, dried vegetables, nuts, cocoa, chocolate, spices, catsup, mustard, and tartrate baking powders. Milk (1 glass), eggs (1), bread (3 slices), rice, and coffee (1 cup) were restricted; fats,

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**Vertavis or Unitensen, Irwin, Neisler & Company.*

ginger ale, and sugar were unrestricted. The potassium of this diet was reduced to less than 20 milliequivalents (800 mg.) per day instead of the normal 70 to 100. To increase the potassium loss from the body further an ammonium type of carboxylic exchange resin* without potassium was administered in divided doses of 60 to 120 Gm. daily and generally was well tolerated. Unlike sodium, potassium is not greatly reabsorbed from the bowel and hence is largely excreted when absorbed by the resin. When the combined regimen failed to lower the serum potassium concentration and/or the blood pressure, occasional mercurial diuresis (for example, using Mercaptomerin, 2 cc. weekly) was added. This was necessary in only 5 cases.

For at least three week periods each the patients were observed on a regular diet and on the potassium depletion regimen just described. Blood pressures were checked in the early morning hours in triplicate at least twice weekly by the same observers. All the systolic and diastolic readings in each period were compared statistically as in our previous studies[5, 6, 8] to evaluate the drops obtained by potassium depletion. The efficacy of the regimen was also checked by weekly determination of serum potassium (and sodium) levels (flame photometry).

The results (table 1) indicate that the systolic pressure fell in most cases 30 mm. of mercury or more and the diastolic pressure 20 to 29 mm. from the control readings. The average falls were 29 mm. systolic and 17 mm. diastolic. At the same time there was a significant reduction in serum potassium, often to levels of 2.5 to 3.0 milliequivalents per liter (average fall of 1.3 milliequivalents per liter). The serum sodium did not change appreciably (average drop of 0.6 milliequivalents per liter).

TABLE 1.—*Blood Pressure Changes on the Potassium Depletion Regimen from the Control Values.*

Extent of Change (mm. of Hg.)	No. Patients Showing Change	
	Systolic	Diastolic
+ 10 to — 9	2	4
— 10 to — 19	2	6
— 20 to — 29	6	9
> — 30	12	3

Muscular weakness and dizziness were the most frequent complaints and were associated with an average weight loss of 11.8 pounds (7.4 per cent of body weight). Occasional nausea, vomiting, and loose bowels could be blamed on the resin, and not the low potassium diet. In many cases, on the other hand, headache, palpitation, insomnia, nocturia, and other hypertensive symptoms subsided rapidly with potassium depletion. The electrocardiograms and ballistocardiograms did not change significantly, presumably because the serum potassium level never fell below 2.5 milliequivalents per liter.

**Win-3000, supplied by Winthrop-Stearns Co.*

DISCUSSION

The results indicate that hypotensive effects could be produced in cases of essential hypertension by moderate potassium depletion. No severe toxic effects were noted beyond muscular weakness, precisely because the hypokalemia obtained was moderate in degree. The effects were comparable to those of drastic sodium depletion that we had used previously.[5, 8] Perera[3] also has noted significant but less marked lowering of blood pressure on a low potassium intake alone.

In Grollman's[2] animal experiments and in our work[7] in human subjects the use of a simultaneous low (or high) sodium regimen together with potassium depletion did not affect the hypotensive effects of the latter. This controverts the experimental findings in rats of Freed and Friedman[1] that potassium depletion is hypotensive only if the sodium intake is high, just as desoxycorticosterone depletes the body of potassium only if an adequate salt intake is provided.

The desoxycorticosterone type of potassium depletion (and sodium repletion), of course, may actually raise the blood pressure in hypertensive patients—a Cushing syndrome–like picture. Nor does hyperkalemia (with hyponatremia), prevent arterial hypotension, as witness clinical adrenocortical insufficiency. The type of hypopotassemia produced by us was associated with insignificant changes in serum sodium concentration. This is also true of the hypopotassemia (and hypotension) resulting from insulin administration. Hence, the low serum and presumably tissue potassium concentrations present in our cases must in some way relax the arterioles. Whether they do so directly or by interfering with acetylcholine synthesis and neuromuscular (sympathetic) transmission cannot be answered at this time.

SUMMARY

Dietary deprivation of potassium and its further depletion by means of the pure ammonium type of carboxylic exchange resin lowers the blood pressure markedly in hypertensive patients. The resulting hypokalemia, weight loss, and muscular weakness are moderate in degree and emphasize the method's safety and special usefulness in obese patients. Thus, these effects are comparable to those of drastic sodium depletion. If gastrointestinal symptoms due to the resin administration are persistent, the replacement of the resin by mercurial diuresis is generally adequate in sustaining the hypokalemia and the hypotension. Salt supplements are unnecessary except when mercurials are used in excess, since hypotension due to potas-

sium depletion occurs or persists whether the sodium intake is high or low.

The mechanism of the hypotensive effect of potassium depletion is unknown.

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CASE REPORTS

FATALITY FROM PARENTERAL PROTEIN ADMINISTRATION

Case Report

J. C. GEORGE, M. D., Brownsville, Texas

IN SEPTEMBER, 1949, Coppinger and Goldner[1] reported that a review of literature revealed 4 deaths due to an injection of a protein hydrolysate and added a case of their own. These deaths were all reported following the use of Amigen. Two of these cases were not suggestive of allergic shock, 1 reported insufficient details to be evaluated, and 2 seemed to be sufficiently described to attribute death to anaphylactic shock.

Levey and others[4] have shown that the free glutamic acid levels in these solutions of amino acid have been responsible for the occurrence of nausea and vomiting, and measures have been successfully taken to remove this substance from the commercial products.

Hopps and Campbell[3] have expressed the opinion that severely damaged livers are unable to conjugate amino acids at sufficiently rapid rates to escape acidosis and that this may be a mechanism causing death.

The following is a case report which falls into the category of fatal anaphylactic shock following the administration of several cubic centimeters of protein hydrolysate made from bovine plasma (Travamin).

CASE REPORT

E. W., a 56 year old white man, was admitted to Mercy Hospital on July 20, 1953, with the complaint of flatulence and back pain and the desire to avoid alcohol. The admitting diagnosis was Laennec's cirrhosis of the liver and alcoholism.

The past history revealed that the patient had been hospitalized with vague abdominal complaints and backache eight months previously, at which time a diagnosis of cirrhosis of the liver had been made. At that time laboratory examinations revealed the hemoglobin, erythrocytes, and leukocytes to be within normal limits. The prothrombin time was forty seconds or 31 per cent of normal; the cephalin-cholesterol flocculation result was 2 plus in forty-eight hours.

The patient had been hospitalized three weeks prior to this admission at his own request to avoid alcohol and to aid in a postalcoholic neuritis. The laboratory tests at that time revealed normal erythrocytes, leukocytes, and hemoglobin. Bromsulphalein tests was reported as 20 per cent retention in thirty minutes, total proteins within normal limits, as was the albumin-globulin ratio. Blood cholesterol was 314 mg. per 100 cc.; van den Bergh's test showed 1.2 mg. of bilirubin per 100 cc. of serum; and cephalin-cholesterol flocculation was determined as 1 plus in forty-eight hours. Prothrombin time was 40 per cent of normal.

No definite food allergy or idiosyncrasy was known about. However, the patient had had two episodes of urticaria about the face and hands, which was thought to have occurred after he had eaten mushrooms. One episode had been within the past year. There had been no history of previous administration of plasma, blood, or protein digests.

Physical examination revealed a well developed, well nourished, slightly obese white man in no acute distress. The patient had a slightly increased psychomotor activity and a moderate tremor. His blood pressure was 140/90, pulse rate 90, and temperature 98.4 F. The abdomen was somewhat rotund and the liver edge was found to be somewhat smooth and rounded when palpated approximately three finger breadths below the right costal margin in the midclavicular line. There was absence of pulsation of the dorsalis pedis artery on the left.

Laboratory tests at this time showed hemoglobin 97 per cent; erythrocytes 4.86 million; leukocytes 9,000, with 62 per cent polymorphonuclear leukocytes, 6 per cent stabs, and 6 per cent young forms.

On admission to the hospital the patient was given 100 mg. of Demerol Hydrochloride and 30 grains of chloral hydrate. He was placed on a regimen of a high carbohydrate diet, high vitamin concentrate, 1 cc. daily of adrenal cortex extract, and 1,000 cc. of 10 per cent invert sugar with soluble vitamins B and C and 2 cc. of adrenal cortex extract in the solution. Subsequently he was given .5 ounce of paraldehyde, every three hours as necessitated for nervousness. He was given vitamin K daily.

The patient was relatively restless but had a satisfactory course for forty-eight hours, after which 1,000 cc. of plasma hydrolysate (Travamin) was ordered. The infusion was begun with a venipuncture in the antecubital fossa on the right in the median cubital vein using a 20 gauge needle, care being taken to avoid any administration of air. The solution was begun at a full drip with no obstruction in the tubing. The nurse who administered the solution left the room immediately, and a vocational nurse was left to observe the patient. After the nurse's departure, the vocational nurse noted that the patient was beginning to gag. At this point his false teeth were removed. The patient began to scratch his genitals, asked for a urinal, and began urinating. Subsequently he asked for a drink of water and was given a sip of water. After this he complained of difficulty in breathing. At this point the nurse was summoned, and the flow in the intravenous medication was decreased. He then began to complain of shortness of breath, and administration of oxygen was started immediately. He took a deep breath and then profuse diaphoresis and cyanosis began, and his eyes opened wide with the sclera showing marked hyperemia. He took a deep breath and collapsed. The intravenous medication was discontinued, and from observation of the solution, it appeared that the patient had received considerably less than 50 cc. Medication was then begun with 1 cc. of Coramine intravenously, 2 cc. of Benadryl intravenously, and subsequently 1 cc. of epinephrine hydrochloride in saline solution intracardially; however, no audible or palpable pulsations returned.

The patient made slow and feeble attempts at respiration and then was given artificial respiration for fifteen minutes with no results. He died approximately five to seven minutes after the administration of the fluid was begun.

An autopsy was obtained with the following pertinent findings being noted:

The sections from the heart showed fibrils which appeared slightly hypertrophied. Extensive cloudy swelling and transverse fragmentation was noted in some of the fibrils. Considerable interstitial hemorrhage of the petechial type was seen. All vessels showed marked engorgement.

The sections from the liver showed an increase in the amount of fibrous tissue in the portal spaces, with some round cell infiltration in these areas. All liver cells showed extensive cloudy swelling; some showed fatty degeneration. The deposition of bile pigment also was noted in several liver cells. All sinuses were engorged with blood, many being distended.

The sections from the lungs showed extensive engorgement of the smaller vessels. Marked emphysema of some of the alveoli was seen. Some of the alveoli were collapsed, while others showed rupture of their walls with the production of emphysematous areas. The smaller bronchioles showed narrowing of their lumens with stenosis, as though they had been spastic. A considerable number of eosinophils were seen in the lung and liver sections.

As the examiner noted, the histopathologic findings were compatible with the diagnosis of anaphylactic shock. The dilation of sinuses in the liver, the stenosis of the bronchioles in the lungs, collapse of some of the alveoli, rupture of the walls of other alveoli with the formation of emphysematous areas, and the peculiarity of the inflammatory cell infiltrations with the presence of neutrophils, all would support the diagnosis in this case as an anaphylactic type of death.

COMMENT

The Prausnitz-Küstner passive transfer test was not done; it would have been helpful in further establishing anaphylaxis. This is a test done by injecting 1 cc. of the patient's serum intracutaneously in the forearm of a normal person. Later intracutaneous injection of the hydrolysate in the area produces swelling and itching if the test is positive. This is thought to be a reliable test for hypersensitivity to a specific allergen.

Anaphylactic reactions to parenteral protein therapy such as in the case cited must be infrequent, but increasing reports of fatalities lead to the conclusion that these substances cannot be used with complete impunity. It seems more judicious not to use this method of administration for persons able to take protein therapy orally or in those cases in which withholding protein for a few days would not seem to cause undue hazard to eventual recovery.

SUMMARY

A case of fatal anaphylactic shock following administration of plasma hydrolysate (Travamin) is reported. It is suggested that a more judicious selection of patients for parenteral protein therapy be used and that testing for sensitivity of patients receiving protein digest would be a worth-while procedure.

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757 East St. Charles Street.

Immunization Against Stress Needed

The emphasis in the mental health movement has shifted from the lowering of hazards to the raising of immunity, Sir Geoffrey Vickers, one of Britain's public health leaders pointed out at the Fifth International Mental Health Congress held in Toronto recently. "By all means let us reduce the occasions for stress," he declared, "but stress will remain a characteristic of human life."—*Alabama Mental Health,* October, 1954.

NEWS

COMING MEETINGS AND CLINICS

Texas Medical Association, Fort Worth, April 24-27, 1955. Dr. F. J. L. Blasingame, Pres.; Mr. C. Lincoln Williston, 1801 North Lamar Blvd., Austin, Executive Secy.

American Medical Association, Miami, Fla., Nov. 30-Dec. 3, 1954. Dr. Walter B. Martin, Norfolk, Va., Pres.; Dr. George F. Lull, 535 North Dearborn St., Chicago 10, Secy.

NATIONAL AND REGIONAL

American Academy of Allergy, New York, Feb. 7-9, 1955. Dr. John M. Sheldon, Ann Arbor, Pres.; Dr. Frances C. Lowell, 65 E. Newton St., Boston, Secy.

American Academy of Dermatology and Syphilology, Chicago, Dec. 4-9, 1954. Dr. Fred D. Weidman, Philadelphia, Pres.; Dr. John E. Rauschkolb, P. O. Box 6565, Cleveland 1, Secy.

American Academy of General Practice, Los Angeles, March 28-31, 1955. Dr. W. B. Hildebrand, Menasha, Wis., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology, Chicago, Dec. 14, 1954. Dr. Bayard Carter, Durham, N. C., Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 9-14, 1955. Dr. Walter H. Theobald, Chicago, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, Chicago, Oct. 3-6, 1955. Dr. A. Crawford Bost, San Francisco, Calif., Pres.; Dr. E. H. Christopherson, 610 Church St., Evanston, Ill., Secy.

American Association for Thoracic Surgery, Atlantic City, N. J., April 24-26, 1955. Dr. Edward S. Welles, Saranac Lake, N. Y., Pres.; Dr. Paul C. Samson, 3959 Happy Valley Rd., Lafayette, Calif., Secy.

American Association of Genito-Urinary Surgeons, Monterey, Calif., May 22-25, 1955. Dr. Fletcher H. Colby, Boston, Pres.; Dr. John A. Taylor, 2 E. 45th St., New York 22, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 8-10, 1955. Dr. Thaddeus L. Montgomery, Philadelphia, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver St., New York, Executive Vice-Pres.

American College of Allergists, Chicago, April 25-30, 1955. Dr. Homer Prince, Houston, Pres.; Dr. Fred W. Wittich, 401 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, Atlantic City, N. J., June 2-5, 1955. Dr. William A. Hudson, Detroit, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut St., Chicago 11, Executive Secy.

American College of Physicians, Philadelphia, April 25-29, 1955. Dr. C. C. Sturgis, Ann Arbor, Mich., Pres.; Mr. E. R. Loveland, 4200 Pine St., Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 11-12, 1955. Dr. Howard P. Doub, Detroit, Pres.; Mr. W. C. Stronach, 20 N. Wacker Drive, Chicago 6, Executive Secy.

American College of Surgeons. Dr. Frank Glenn, New York City, Pres.; Dr. Michael L. Mason, 40 E. Erie St., Chicago 11, Secy.

American Congress on Obstetrics and Gynecology, Chicago, Dec. 13-17, 1954. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chairman.

American Congress of Physical Medicine and Rehabilitation, Detroit, Aug. 28-Sept. 2, 1955. Dr. William D. Paul, Iowa City, Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Belleair, Fla., April 17-21, 1955. Dr. Richard S. Weiss, St. Louis, Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, Atlantic City, N. J., June 4-5, 1955. Dr. Dwight L. Wilbur, San Francisco, Pres.; Dr. H. Marvin Pollard, University Hosp., Ann Arbor, Mich., Secy.

American Gynecological Society, Quebec, Canada, May 23-25, 1955. Dr. Philip F. Williams, Philadelphia, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association, New Orleans, Oct. 26-30, 1955. Dr. E. Cowles Andrus, Baltimore, Pres.; Mr. Irving Hexter, 44 E. 23rd St., New York 10, Secy.

American Hospital Association, Atlantic City, N. J., Sept. 19-22, 1955. Dr. Frank R. Bradley, St. Louis, Pres.; Dr. Edwin L. Crosby, 18 E. Division St., Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Hollywood, Fla., March 15-17, 1955. Dr. Kenneth M. Day, Pittsburgh, Pres.; Dr. C. S. Nash, 277 Alexander St., Rochester 7, N. Y., Secy.

American Neurological Association, Chicago, June 13-15, 1955. Dr. Percival Bailey, Chicago, Pres.; Dr. H. Houston Merritt, 710 W. 168th St., New York 32, Secy.

American Ophthalmological Society, W. Sulphur Springs, W. Va., June 2-4, 1955. Dr. Everett L. Goar, Houston, Tex., Pres.; Dr. M. C. Wheeler, 30 W. 59th St., New York 19, Secy.

American Orthopedic Association, W. Sulphur Springs, W. Va., June 19-22, 1955. Dr. J. Warren White, Honolulu, Hawaii, Pres.; Dr. George O. Eaton, 4 E. Madison St., Baltimore 2, Secy.

American Pediatric Society, Quebec, Canada, June 13-17, 1955. Dr. Alfred H. Washburn, Denver, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, New York, June 1-4, 1955. Dr. A. W. Martin Marino, Brooklyn, N. Y., Pres.; Dr. Karl Zimmerman, 3500 Fifth Ave., Pittsburgh 13, Secy.

American Psychiatric Association, Atlantic City, N. J., May 9-13, 1955. Dr. Alfred P. Noyes, Norristown, Pa., Pres.; Dr. William Malamud, 80 E. Concord St., Boston 18, Secy.

American Public Health Association. Dr. Hugh R. Leavell, Boston, Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists. Dr. Ralph T. Knight, Minneapolis, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph St., Chicago, Secy.

American Society of Clinical Pathologists. Dr. John R. Schenken, Omaha, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan St., Indianapolis 6, Secy.

American Surgical Association, Philadelphia, April 27-29, 1955. Dr. John H. Gibbon, Jr., Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, Los Angeles, May 16-19, 1955. Dr. W. Joseph McMartin, Omaha, Neb., Pres.; Dr. C. H. deT. Shivers, 121 S. Illinois Ave., Atlantic City, N. J., Secy.

Association of American Physicians and Surgeons, Pittsburgh, Pa., April 14-16, 1955. Dr. Thomas G. Goldsmith, Greenville, S. C., Pres.; Mr. Harry E. Northam, 185 N. Wabash Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter. Dr. William R. Lovelace, Albuquerque, N. M., Pres.; Dr. Karl Meyer, 1516 Lake Shore Drive. Chicago, Secy.

National Tuberculosis Association, Milwaukee, May 23-27, 1955. Dr. John H. Skavlem, Cincinnati, Pres.; Mrs. Morrell DeReign, 1790 Broadway, New York 19, Secy.

Radiological Society of North America, Los Angeles, Dec. 5-10, 1954. Dr. Eugene P. Pendergrass, Philadelphia, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2. N. Y., Secy.

Southern Medical Association, Houston, Texas. Dr. Robert L. Sanders, Memphis, Tenn., Pres.; Mr. C. P. Loranz, 1020 Empire Bldg., Birmingham 3, Ala., Secy.

Southern Psychiatric Association. Dr. John D. Trawick, Louisville, Ky., Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association, Hollywood, Fla., Dec. 7-9, 1954. Dr. John C. Burch, Nashville, Pres.; Dr. George Finney, 2947 St. Paul St., Baltimore, Secy.

Southwest Allergy Forum. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise St., New Orleans, Secy.

Southwest Regional Cancer Conference, Fort Worth. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association. Dr. Willard W. Schuessler, El Paso, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Kansas City, Mo., Sept. 12-14, 1955. Dr. Lawrence P. Engel, Kansas City, Mo., Pres.; Dr. C. M. O'Leary, 207 Plaza Court Bldg., Oklahoma City, Secy.

Tri-State Medical Society, Texarkana, September, 1955. Dr. William B. Harrell, Texarkana, Pres.; Dr. Karlton Kemp, 408 Hazel, Texarkana, Ark., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

STATE

Private Clinics and Hospitals Association of Texas, Corpus Christi, Dec. 4-5, 1954. Dr. W. R. Swanson, Taylor, Pres.; Dr. John Dupree, Levelland, Secy.

Texas Academy of General Practice. Dr. L. Bonham Jones, San Antonio, Pres.; Dr. Woodson W. Harris, 308 W. 15th St., Austin, Secy.

Texas Academy of Internal Medicine, Galveston, Dec. 11-12, 1954. Dr. Martin S. Buehler, Dallas, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association. Dr. J. S. Minnett, Dallas, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks, Abilene, Dec. 3-4, 1954. Dr. C. T. Ashworth, Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Houston, February, 1955. Dr. G. F. Goff, Dallas, Pres.; Dr. Carey Hiett, 815 Fifth Ave., Fort Worth, Secy.

Texas Chapter, American College of Chest Physicians, Fort Worth, April 24, 1955. Dr. Howard E. Smith, Austin, Pres.; Dr. John Wiggins, 1707 Medical Arts Bldg., Fort Worth, Secy.

Texas Club of Internists. Victor E. Schulze, San Angelo, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society, Fort Worth, April 24, 1955. Dr. Paul H. Power, Waco, Pres., Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, Fort Worth, April 24, 1955. Dr. George M. Jones, Dallas, Pres.; Dr. Hugo Engelhardt, P. O. Box 2180, Houston, Secy

Texas Division, American Cancer Society, San Antonio, Jan. 28-29, 1955. Mr. Travis Wallace, Dallas, Pres.; Mr. J. Louis Neff, 1609 Colorado, Austin, Executive Director.

Texas Geriatric Society. Dr. Henry H. Niehuss, Longview, Pres.; Dr. Frank V Mondrik, 214 Bramlette Bldg., Longview, Secy.

Texas Heart Association, Fort Worth, April 25, 1955. Dr. George R. Herrmann, Galveston, Pres.; Mr. Edgar M. Brown, 404 Jesse H. Jones Library Bldg., Texas Medical Center, Houston 25, Executive Director.

Texas Hospital Association, Houston, April 12-14, 1955. Mr. W. U. Paul, El Paso, Pres.; Mrs. Ruth Barnhart, 2210 Main St., Dallas, Secy.

Texas Neuropsychiatric Association. Dr. Edgar S. Ezell, Fort Worth, Pres.; Dr. Bruce H. Beard, 1519 Pennsylvania, Fort Worth, Secy.

Texas Orthopedic Association, Fort Worth, April 25, 1955. Dr. Brandon Carrell, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount St., Dallas, Secy.

Texas Pediatric Society, Galveston, October, 1955. Dr. M. C. Carlisle, Waco, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society. Dr. Jack Kerr, Dallas, Pres.; Dr. John McGivney, 2202 Avenue L, Galveston, Secy.

Texas Public Health Association, Galveston, Feb. 13-16, 1955. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Houston, Jan. 21-22, 1955. Dr. E. F. Lyon, Jr., San Antonio, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, Fort Worth, April 25, 1955. Dr. Raleigh White, Temple, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Alfred W. Harris, Dallas, Pres.; Dr. Charles H. Cornwell, Marlin, Secy.

Texas Society for Mental Health, Mineral Wells, 1955. Dr. Charles N. Burrows, San Antonio, Pres.; Mrs. Elizabeth F. Gardner, 2504 Jarratt Ave., Austin 3, Executive Secy.

Texas Society of Anesthesiologists, Fort Worth, April 24, 1955. Dr. Frank O. Barrett, El Paso, Pres.; Dr. Milton M. Rosenzweig, 200 Wildwood Dr. E., San Antonio, Secy.

Texas Society of Gastroenterologists and Proctologists, Fort Worth, April 25, 1955. Dr. Charles Hardwicke, Austin, Pres.; Dr. W. T. Arnold, 1402 Hermann Prof. Bldg., Houston, Secy.

Texas Society of Ophthalmology and Otolaryngology, San Antonio, Dec. 3-4, 1954. Dr. John L. Matthews, San Antonio, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists, Dallas, Jan. 30, 1955. Dr. John J. Andujar, Fort Worth, Pres.; Dr. Lloyd R. Hershberger, Shannon Memorial Hospital, San Angelo, Secy.

Texas Surgical Society. Dr. Dudley Jackson, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro St., San Antonio 5, Secy.

Texas Tuberculosis Association, Galveston, April 15-16, 1955. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 2406 Manor Rd., Austin, Executive Secy.

Texas Urological Society, Corpus Christi, Feb. 27-28, 1955. Dr. S. J. R. Murchison, Fort Worth, Pres.; Dr. A. J. Ashmore, 255 Medical Dental Bldg., Corpus Christi, Secy.

West Texas Surgical Society, Dec. 8, 1954. Dr. J. A. Shapira, Midland, Pres.; Dr. Milton J. Loring, 304 North N St., Midland, Secy.

DISTRICT

First District Society, Pecos, 1955. Dr. John W. O'Donnell, Alpine, Pres.; Dr. H. D. Garrett, First National Bldg., El Paso, Secy.

Second District Society. Dr. John R. Mast, Midland, Pres.; Dr. M. J. Loring, 304 North N St., Midland, Secy.

Third District Society, Borger, April, 1955. Dr. M. C. Overton, Jr., Pampa, Pres.; Dr. William Klingensmith, 215 Fisk Bldg., Amarillo, Secy.

Fourth District Society, Brownwood, October, 1955. Dr. James N. White, San Angelo, Pres.; Dr. Joe B. Stephens, Bangs, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 7-9, 1955. Dr. John J. Sloan, Corpus Christi, Pres.; Dr. E. Jackson Giles, Medical Center, Suite 42, Corpus Christi, Secy.

Seventh District Society, Austin, Feb. 17, 1955. Dr. William McLean, Austin, Pres.; Dr. John Rainey, 1709 San Antonio, Austin, Secy.

Eighth District Society, Galveston, 1955. Dr. George E. Glover, Jr., Victoria, Pres.; Dr. York Lancaster, Port Lavaca, Secy.

Ninth District Society, Houston, Marcb 17, 1955. Dr. Thomas H. Giddings, Brenham, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Medical Society. Dr. J. C. Klein, Lufkin, Pres.; Dr. Rider Stockdale, Jasper, Secy.

Eleventh District Society, Dr. Porter Bailes, Tyler, Pres.; Dr. Hugh F. Rives, Jacksonville, Secy.

Twelfth District Society, Marlin, Jan. 11, 1955. Dr. Neil Buie, Marlin, Pres.; Dr. Paul H. Mitchell, Corsicana, Secy.

Thirteenth District Society, Abilene, March 2, 1955. Dr. Mal Rumph, Fort Worth, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society. Dr. J. David Thomas, Denton, Pres.; Dr. L. W. Johnston, 502 W. College St., Terrell, Secy.

Fifteenth District Society, Mount Pleasant, 1955. Dr. R. L. Johnson, Mount Pleasant, Pres.; Dr. R. L. Hardman, Mount Pleasant, Secy.

CLINICS

Dallas Southern Clinical Society, Dallas, March 14-17, 1955. Dr. Lawrence B. Sheldon, Dallas, Pres.; Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

Central Texas Spring Clinic, Waco, March 2, 1955. Dr. Ross Shipp, Waco, Pres.; Dr. Milton Spark, 121 Dallas St., Waco, Secy.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 24-26, 1955. Dr. John M. Smith, Jr., 205 Camden St., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, March 7-10, 1955. Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy..

North Texas-Southern Oklahoma Fall Clinical Conference. Dr. L. N. Simmons, 1518 Tenth St., Wichita Falls, Chairman.

Oklahoma City Clinical Society Conference, Oklahoma City. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas. Dr. Edward T. Smith, 906 Hermann Professional Bldg., Houston, Secy.

State Tumor Conference, Wichita Falls, April, 1955. Dr. Bailey R. Collins, 925½ Scott Street, Wichita Falls, Director.

BOARD EXAMINATIONS

Texas State Board of Examiners in Basic Sciences, Austin. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners, Fort Worth, Dec. 2-4, 1954. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

UNIVERSITY OF TEXAS MEDICAL BRANCH

The University of Texas Medical Branch, Galveston, has been given a $10,000 grant for the maintenance of a loan fund for medical students by the T. J. Brown and C. A. Lupton Foundation, Inc., Fort Worth. A $5,000 grant has been given by the M. D. Anderson Foundation, Houston, for the establishment of a youth development center, which will be under the direction of Dr. Eugene C. McDanald and Dr. Brooks W. Mullen, both of the Neuropsychiatric Department.

Dr. André Lwoff, of the Pasteur Institute, Paris, spoke on "Nutritional and Virus Diseases of Bacteria" at the Medical Branch on December 10.

Sir Lionel Whitby, vice-chancellor of the University of Cambridge, gave a series of conferences and seminars on blood disorders on December 13. He also was scheduled to speak on aspects of medical education in different parts of the world while he was in Galveston.

Dr. Bingt Yohanson, Sweden, is visiting the Medical Branch for surveying methods in use in the treatment of severe burns; and *Dr. Pierre Grabar,* Pasteur Institute, Paris, is a senior fellow in the James W. McLaughlin Fellowship program in Infectious Diseases and Immunity at the Medical Branch. He will work in association with *Charles M. Pomerat, Ph. D.,* and *W. W. Nowinski, Ph. D.*

The Texas Medical Association Memorial Library needs your constant support. Have you used its facilities during the past year?

TEXAS NURSING SITUATION AIRED

Ten physicians, twenty-five hospital administrators, and seventy-six registered nurses (directors of schools and nursing services) were present for a two day conference on nursing sponsored by the Texas Joint Commission for the Improvement of the Care of the Patient at the Texas Medical Association headquarters building in Austin, November 5 and 6. The commission, organized early in 1954, is comprised of representatives from the Medical Association, Texas Hospital Association, Texas Graduate Nurses' Association, and Texas League for Nursing. Serving as delegates of the medical profession are Drs. Truman G. Blocker, Jr., Galveston; G. E. Brereton, Dallas; A. C. Scott, Jr., Temple; and Joseph F. McVeigh, Fort Worth, with the President and executive secretary as ex officio delegates.

Dr. Blocker, first regularly elected and current chairman of the commission, presided at the conference; Mrs. Ruth Barnhart, Dallas, executive secretary of the Texas Hospital Association and commission secretary, acted as secretary.

The conference was held to discuss all aspects of nursing education and recruitment in Texas and led to six specific recommendations which those in attendance believe will be effective in helping to alleviate the shortage of nursing personnel.

Program

Following a discussion of the objectives of the commission and of major problems in relation to nursing by Dr. Blocker, the presidents of the organizations constituting the commission spoke briefly. Tol Terrell, San Angelo, hospital administrator; Dr. A. C. Scott, Jr., Temple, physician; and Mrs. Ruth Yankauer, R. N., Fort Worth, director of nursing service, then expressed the viewpoints of their professions toward "What Are Our Nursing Needs in Texas?"*

The purpose of all educational programs in nursing in Texas were defined in a series of presentations. Programs covered were inservice training for aides, vocational nurse programs, modified diploma program, three-year diploma program, collegiate program, and two-year experimental diploma program. Also included was a review of the responsibilities of the Board of Nurse Examiners.

Dr. Brereton presided over a session in which nurse recruitment programs in Texas were outlined. Admissions to schools of nursing, fall-out rates in schools of nursing, recruitment on a local level, and the nurse recruitment program of the Woman's Auxiliary to the Texas Medical Association, the latter by Mrs. William D. Nicholson, Freeport, were discussed.

Finally, the entire conference, together with recommendations drawn up by the Joint Commission between sessions of the conference, was summarized by Miss Faye Pannell, R. N., Dallas, program committee chairman. The material which follows is drawn from her report.

Summary of Conference

The stage for the conference was set, Miss Pannell began, when the chairman reminded that problems cannot be solved by one group alone, but that they must be approached through an exchange of ideas and mutual cooperation of all concerned. It became apparent, as the president of each of the participating organizations spoke, that the primary objective of each group is the improvement of patient care. It also became apparent that everyone present favored the opportunity for doctors, nurses, and hospital administrators to think through together some of the ways by which each group may contribute toward "doing something" about nursing to improve care of the patient.

It was agreed that hospitals still are experiencing, and will continue to experience in the foreseeable future, an acute shortage of registered nurses. A few isolated hospitals report that they have adequate numbers of nurses but that other problems are encountered because of the fast turnover among registered nurses.

Texas hospitals have a high ratio of people in nursing services for taking care of patients as compared with numbers of beds, but the ratio of professional personnel to nonprofessional personnel is not high. There continues to be a number of completely constructed hospital beds in Texas that cannot be occupied because there are not adequate numbers of personnel for the hospitals.

Conference members were told that much talking is done about numbers of nursing personnel, but that equal concern should be exhibited about the quality of the preparation of the people who are going to give nursing care. For optimum production from nursing service staffs, the best utilization must be made of all the skills in each of the categories of nursing personnel.

The medical members who participated in the conference, as did the others, pleaded for a return of more personalized nursing care for their patients. Nursing service personnel determine what needs to be done for the patient and who can best do the job. They also should decide what qualifications are essential to do the job. The nursing educators likewise need to concentrate on preparing all levels of personnel in the nursing services.

It was recognized that one of the great needs in this state is for adequately prepared head nurses and supervisors and for qualified nursing school faculty personnel. Also needed are management skills in the people who will supervise and direct the activities of many other workers and, in instructional personnel, the ability to give the student who has intellectual curiosity a high motivation for carrying on her own education after she has completed the basic program.

The discussions of the objectives of the various nursing education programs in Texas indicated that there are six different programs for preparing all levels of nursing personnel, Miss Pannell reported.

The nurse aide is trained on the job through an inservice program. It is the responsibility of nursing service administration not only to carry on the educational program for these personnel, but also to conduct inservice training for other personnel in the nursing service.

Great strides have been made in the last few years in vocational nurse training programs in the state, and there now are seventy-one approved vocational nurse training schools with several more ready to apply for approval at the next meeting of the State Board of Vocational Nurse Examiners. The ratio of professional nursing personnel to nonprofessional nursing personnel probably will not be markedly altered in the near future, and it will be necessary to continue to depend upon licensed vocational nurses to take on many responsibilities. Efforts should be continued to strengthen and improve their training programs and recruit students for them as they should be for all other nurse education programs.

Members of the conference heard of the efforts of the Board of Vocational Nurse Examiners to assist the people responsible for vocational nurse education through workshops and conferences conducted in cooperation with the state vocational education department. They also learned that it is now possible in Texas for those who have been graduated from approved schools of vocational nursing to take a six months' postgraduate course in specific clinical areas to be more effective workers in the technical fields of their choice.

*Dr. Scott's address appears in full in the Original Articles section of this JOURNAL.

A report was made on the recently approved modified registered nurse education program. This program, an effort to help meet the nurse-shortage situation by providing more adequate numbers of prepared people to do nursing, is a departure from tradition, but there is a possibility that the end results will help solve the problem. One of the limitations in this program is that it will meet licensure requirements only in Texas and a limited number of other states. There are both limitations and advantages in each of the nurse education programs being offered, and all the affected allied professional groups have the responsibility of interpreting each of the different programs to those interested in a nursing education.

In the discussion of the objectives of the typical three-year nurse diploma program, which prepares the general practitioner nurse, it was agreed that the graduates should be ready for development into good bedside nurses, that they require supervision, that they have need of an opportunity for more maturity, and that they need good direction from people who have had more experience and additional educational preparation.

Also discussed were the objectives of collegiate nurse education programs, which prepare more highly educated young men and women to give comprehensive nursing care to all types of patients, in hospitals or in homes. Because of the additional maturity as well as the educational opportunities of these graduates greater stability can be expected in this group of nurses than in the others. They will have had a broad basic preparation and will meet qualifications essential for additional study on higher degree levels, and, after additional preparation and experience, will progress more rapidly to positions of greater leadership and responsibilities.

It was reported that the two-year experimental diploma program, started this fall, is expected to meet the objectives of the traditionally longer program in a shorter period, twenty-five months. During the last eleven months of the program, the student will be employed by the nursing service of the hospital, during which time she will participate in a continuous inservice educational program while completing the requirements for state licensure. She will thereby serve as a general staff nurse in a junior staff capacity, with a salary of three-fourths of that of the registered nurse.

Conference members learned that the Board of Nurse Examiners, which has responsibility for the accreditation of four of the six nurse educational programs in Texas, is interested in assisting in the development of each program because it is believed that each has a contribution to make toward helping to meet nursing needs in this state.

In all the discussions, Miss Pannell commented, there appeared to be an attitude on the part of program participants and audience of open mindedness, cooperation, and interest in alleviating the present critical situation. No one seemed to feel that only one approach or only one program will suffice.

From the report on the admissions of students to Texas schools of nursing, it was noted that there has been a continued increase in number of admissions, particularly in the last three years. If a similar increase continues, Texas schools of nursing can hope to admit 7 per cent of eligible high school graduates as is true on the national level, rather than the present 4.3 per cent.

All the facilities in schools of nursing are not being used; there still are vacancies in collegiate, diploma, and vocational nurse training programs. It was agreed that recruitment efforts should be for all types of educational programs, helping the student to fit into the program that most nearly meets her needs.

It also was shown that the rising trend in numbers of admissions is not apparent in the numbers of graduates from schools of nursing, but the increased admissions should be reflected in the numbers of graduates in the next three years.

Persons attending the November conference were made aware of the contribution that the Woman's Auxiliary to the Texas Medical Association is making over the entire state in its efforts to tell high school students of the opportunities in nursing as a career. In its campaign the Auxiliary is making scholarships and loans available to nursing students and is organizing Future Nurses Clubs in high schools.

A report of a survey of fall-out rates in schools of nursing made evident a need for careful evaluation of the schools' selection procedures and of established student qualifications. It was shown that 49 per cent of all nursing students who did not complete their education did so for reasons associated with these causes. Another important fact in the survey was that of all those who withdrew from the schools of nursing, 70 per cent showed continued interest in nursing.

A report was made on how one community in the state made student nurse recruitment "everybody's business" with excellent results for the local school of nursing. It was shown that there is a role for each person in the community to fill in nurse recruitment and that the particular role for hospital administrators, nursing administrators, and doctors is in interpreting to future nursing school applicants the opportunities that are available to them.

Recommendations

Miss Pannell concluded her summary of the conference on nursing with the six recommendations brought before the conference by the Texas Joint Commission for the Improvement of the Care of the Patient:

1. That every hospital in Texas set up a commission for itself, similar in organizational arrangement to the Texas Commission, with appointed representatives from hospital administration, nursing education and service, and medical staff, for study of mutual problems and exchange of ideas toward solving these problems, with their chief aim to be improvement of the care of the patient.

2. That all hospitals in Texas conduct detailed job analyses for all hospital personnel contributing toward patient care, with a view toward clarifying the duties of these personnel in their job descriptions and toward clarifying existing confusion in descriptions of jobs in the hospitals.

3. That the Board of Nurse Examiners for the State of Texas be requested to undertake a detailed and long-range statewide study of the curricula of the three-year schools of nursing with a view toward clarifying the aims of these schools in their education of practitioners of nursing.

4. That the Texas Hospital Association be requested to undertake a detailed study of salaries of all levels of nursing personnel in Texas hospitals.

5. That all component organizations of the commission and their members—doctors, nurses, and hospital administrators—make every possible effort to keep luxury nursing at the lowest possible minimum in hospitals and that they be encouraged to make use of group nursing whenever possible.

6. That the Woman's Auxiliary to the Texas Medical Association be commended by the commission and encouraged to continue its plans to arrange for a state-level meeting for members of Future Nurses Clubs in Texas, being assured of the cooperation and assistance of the commission in this endeavor, and that local-level organizations of hospital administrators, doctors, and nurses be encouraged to promote the organization of Future Nurses Clubs where they do not exist and to underwrite the expenses of selected representatives from their Future Nurses Clubs to attend the state-level meeting now being planned.

WORLD MEDICAL ASSOCIATION

The eighth annual general assembly of the World Medical Association was held September 26 to October 2 in Rome, Italy. More members from the United States were present than from any other nation; among them was Dr. F. J. L. Blasingame, Wharton, delegate of the American Medical Association.

Dr. Blasingame stated that the scientific program, conducted by Italian physicians, composed one afternoon session; the remainder of the program was devoted to socio-economic matters. The assembly meetings were conducted in four languages simultaneously. Interpreters spoke from booths into a system connected to headphones which could be tuned into any one of the four channels, English, Spanish, French, or Italian.

"In general," Dr. Blasingame said, "it was apparent that physicians the world around are very similar, that medical ethics are almost the same in all countries, and that an atmosphere of mutual respect and understanding exists on fundamental issues when physicians of the world are brought together. Naturally, training, cultural background, local economic circumstances, and other items may make for minor differences."

Plans were discussed at the meeting for a second World Conference on Medical Education to be held in North America in 1959. The first such conference was held in London in 1953. Also, the WMA considered sponsoring a World Conference on Occupational Health in the next few years.

Of major interest was a discussion of social security. As Dr. Walter B. Martin, Norfolk, Va., President of the AMA, wrote in a recent President's Page (J.A.M.A., November 27, 1954): "I believe it is of vital importance to American medicine that we be kept fully informed as to the social security activities on the international level. Proposals that are being 'whispered in the bed chamber' of the social security in Washington are being 'shouted from the housetops' by the International Social Security Association. The voice and the arm of the World Medical Association needs to be powerfully strengthened so it can adequately meet the sustained pressure from international groups and their American allies." The WMA, explained Dr. Blasingame, is a professional association of national medical groups representing the profession at the international level. Unlike the World Health Organization, which represents branches of government at the international level, the World Medical Association is free of governmental regulation and control, he added.

Another item of grave importance to the assembly was the financial condition of the WMA. Since the growth of the Association threatens to outrun the financial sources, more funds are needed urgently. Annual dues of the United States Committee of the WMA are $10, which includes subscription to the *World Medical Journal*. At present only about 4,600 Americans are members.

Some other subjects discussed at the meeting were supply and distribution of physicians, human experimentation, world population as related to nutrition and health, and the cost of medical care.

The ninth general assembly will be held in Vienna, Austria, in 1955.

Arizona Cancer Seminar

The third annual Cancer Seminar presented by the Arizona Division of the American Cancer Society in association with the Arizona Medical Association will be given in Phoenix, January 13-15, 1955. Nine out-of-state speakers will participate on the program.

TUBERCULOSIS CHRISTMAS SEAL SALE

For the first time since the beginning of the Tuberculosis Christmas Seal sales, a double seal is being offered this year. The sale, which was originally begun in 1907 in Wilmington, Del., began in Texas in 1909. Last year it brought $789,272.98 from the people of Texas toward the fighting of tuberculosis. Of that amount, 82 per cent remained in the counties where it was contributed, 12 per cent financed the statewide program, and the remaining 6 per cent went to the National Tuberculosis Association.

There are approximately three thousand local tuberculosis associations throughout the United States, Alaska, Hawaii, the Canal Zone, Guam, and Puerto Rico. Ninety-nine counties in Texas were served by their own local associations in

1953-1954. These counties represent almost 70 per cent of the Texas population, and, during that time, within their borders more than 80 per cent of the known cases of tuberculosis and tuberculosis deaths were concentrated.

It is estimated that the average cost of a case of tuberculosis now is $15,000; and the estimated cost of tuberculosis control in the United States in 1953 was six hundred million dollars. Even though the death rate from this disease has been cut 90 per cent since the organized fight against tuberculosis began fifty years ago in the United States, death from tuberculosis still strikes every five minutes somewhere in the country.

In 1907 several Wilmington doctors ran out of money while trying to cure 8 charity patients sick with tuberculosis. Miss Emily Bissell, a cousin of one of the doctors, had heard of the sale of stamps in Denmark three years earlier to help some sick children, so she decided to try it in the United States. She raised $3,000 that first year, and there has been a Christmas Seal sale each year since.

INDUSTRIAL HEALTH MEETING

In Houston September 23-25, the seventh annual Industrial Health Conference was held. Out-of-state doctors for the three day session included Drs. William C. Menninger, Topeka, Kan.; Dr. Elmer Hess, Erie, Pa.; Dr. G. H. Gehrmann, Wilmington, Del.; Dr. James H. Sterner, Rochester, N. Y.; Dr. George Manov, Washington, D. C.; and Dr. W. D. Norwood, Richland, Wash.

Citations for outstanding contributions to industrial health were awarded to Dr. Sterner, medical director of Eastman Kodak Company, and to the Atomic Energy Commission. Dr. John C. Bugher, director of the atomic energy medical division, accepted the plaque for that organization.

HOSPITAL DISTRICT AMENDMENT PASSED

Texans voted in the November 2 election to amend the state Constitution to permit the establishment of hospital districts in counties with a population of more than 190,000 and in Galveston County. This amendment went into effect on November 19 along with ten others which voters in the state approved. The hospital districts, instead of cities and counties, could assume the function of financing and operating hospitals, provided that the local voters first approved.

San Antonio Assembly to Meet January 24-26

The International Medical Assembly of Southwest Texas will be held in San Antonio January 24-26. The following guests will participate in the three day meeting:

DR. WILLIAM B. DEAN, State University of Iowa College of Medicine, Iowa City.

DR. EDWARD F. BROOKS, University of Toronto, Ontario, Canada.

DR. GARFIELD G. DUNCAN, Jefferson Medical College, Philadelphia.

DR. ROBERT A. KIMBROUGH, JR., University of Pennsylvania Graduate School of Medicine, Philadelphia.

DR. HAROLD G. SCHEIE, University of Pennsylvania Graduate School of Medicine, Philadelphia.

DR. LESTER A. BROWN, Emory University School of Medicine, Emory University, Ga.

DR. JAMES B. MCNAUGHT, University of Colorado School of Medicine, Denver.

DR. STEWART H. CLIFFORD, Boston Lying-In Hospital, Boston.

DR. EARL E. BARTH, Northwestern University Medical School, Chicago.

DR. GEORGE CRILE, JR., The Cleveland Clinic, Cleveland, Ohio.

DR. FRANK GLENN, Cornell University Medical College, New York.

DR. R. K. GHORMLEY, Mayo Foundation Graduate School of Medicine, Rochester, Minn.

DR. GEORGE F. CAHILL, New York Presbyterian Hospital, New York.

DR. WARNER BOWERS, Brooke Army Hospital, San Antonio.

After a general scientific meeting on Monday morning, January 24, sectional luncheons will be held at noon, with programs in the following sections being presented: general practice; surgery; medicine; pediatrics and gynecology; radiology and urology; and eye, ear, nose, and throat.

That afternoon there will be two medical panels, "Diabetic Problems" and "Diseases of the Thyroid," plus a meeting of the eye, ear, nose, and throat section and a surgical clinical-pathologic conference.

On Tuesday there will be a general scientific meeting in the morning; a buffet luncheon; and two surgical panels, a medical clinical-pathologic conference, and a meeting of the obstetrics and pediatrics section in the afternoon. Wednesday morning after the general scientific meeting, there will be sectional luncheons for the sections on medicine and surgery.

There will be a cocktail party Tuesday evening for all doctors and exhibitors and their wives, and following the adjournment Wednesday afternoon, a golfing tournament will be held at the Oak Hills Country Club.

Details of the assembly program, which is open to physicians who are members of their county medical societies, may be obtained from James C. Anderson, Executive Secretary, P. O. Box 2445, San Antonio 6. The registration fee of $20, which covers all aspects of the meeting, is also being accepted in advance at that address.

Television Shows on Medicine Increasing

Network television shows which hold special interest to medicine are increasing in number with eleven on the subject scheduled for presentation between the middle of November and the last of December.

A twenty-six week series of fifteen-minute medical news programs is being sponsored by Ciba in cooperation with the American Medical Association over the ABC television network. The inaugural telecast of the series, December 12, was on the subject of tuberculosis.

Texas doctors and a Texas patient were in the spotlight on the December 5 March of Medicine Show when the operation on an East Texas oil field worker which was developed by Dr. Michael E. DeBakey, Houston, and his associates, Dr. Denton A. Cooley and Dr. Oscar Creech, Jr., Houston, was described. The telecast showed George Chisum, the patient who underwent the operation, going to his general practitioner, Dr. Robert Ryan, Sour Lake, and then to the Texas Medical Center, where Dr. DeBakey and Dr. Cooley were able to use a human aortic graft to replace the patient's diseased tissue high in the chest near the heart. Dr. Creech reported on the use of the freeze-dry technique in preserving arteries from donors; Dr. Robert Hettig, Houston, explained the tests made on Mr. Chisum to determine his ability to withstand surgery; and Dr. DeBakey and Dr. Cooley showed the details of the operative procedure. The show was presented by Smith, Kline and French Laboratories with the AMA cooperating.

Medic, which is produced under the technical supervision of the Los Angeles County Medical Association and sponsored by the Dow Chemical Company, scheduled programs for November 22 and 29 and December 6, 20, and 27 over the NBC television network.

"The Search," a CBS public service show, scheduled a telecast to report on work at the John Hopkins University School of Medicine, "New Hope for the Deaf," on December 19. "Night Call," the December 7 Cavalcade of America telecast, starred Dean Jagger as Dr. Ben Collins and humanized the small town general practitioner.

PERSONALS

Dr. Donald W. Seldin, Dallas, participated in a symposium on electrolyte disturbances at the fifty-fifth annual meeting of the American Therapeutic Society, St. Louis, November 4-7.

Dr. T. G. Blocker, Jr., Galveston, spoke at the annual conference of the Kansas City Southwest Clinical Society, Missouri, the first week in October.

Dr. J. B. McKnight, San Angelo, and *Dr. Z. T. Scott,* Austin, were among four awarded medallions commemorating the fiftieth anniversary of the voluntary movement for tuberculosis control at the meeting of the board of directors of the Texas Tuberculosis Association, October 24, in Austin. Dr. McKnight, unable to attend the meeting, received his award at a Tom Green County Tuberculosis Association meeting.

A memorial library has been established at Southton, Bexar County Sanatorium, in honor of the late *Dr. R. G. McCorkle,* San Antonio, through efforts of a special committee of the Bexar County Tuberculosis Association.

Dr. Warren M. Jacobs, Houston, was named faculty doctor of the year by the students of Baylor University College of Medicine at opening exercises in September.

Dr. Ernest W. Grumbles, Atlanta, is new district chairman of the Sulphur District of Boy Scouts of America.

Dr. Franklin Yeager, Corpus Christi, a district governor of Rotary International, spoke to the Three Rivers Rotary Club on November 2.

Dr. Joe L. Stevens, Bonham, recently presented an outstanding registered Angus bull to the East Texas State Teachers College herd.

Dr. Thel Williams, Bonham, and Miss Nickie Farris, Jacksonville, were married in Jacksonville on August 20.

Dr. Woolworth Russell, Amarillo, and Miss Jane Doris Bobbitt of that city were married on October 23.

The *Alumni Bulletin,* The University of Texas Medical Branch, Galveston, lists new parents of boys as *Dr. Marjorie F. Roper and Leonard B. Roper,* Bullard, whose son was born September 5; *Dr. and Mrs. Edward A. Blackburn, Jr.,* Houston, July 1; *Dr. and Mrs. Ralph Lane,* Lubbock, September 8. The *Bulletin* lists *Dr. Miles Sedberry and Dr. Margaret Sedberry,* Austin, as parents of a girl, born September 27.

The Stethoscope, bulletin of the Woman's Auxiliary to Tarrant County Medical Society, announces the birth of a boy to *Dr. and Mrs. Tilden L. Childs, Jr.,* Fort Worth.

Ninth AAPS Essay Contest

The Woman's Auxiliary to the Texas Medical Association in cooperation with the Association will sponsor in Texas the Association of American Physicians and Surgeons' 1955 essay contest on "The Advantages of Private Medical Care." Prizes will be given to high school students in public, parochial, and private schools who contribute the best papers on the national, state, and local levels. Mrs. Perry J. C. Byars, San Angelo, is the Auxiliary's state chairman. Texans serving on the national committee for the 1955 contest are Dr. Mal Rumph, Fort Worth, chairman, and Dr. Charles D. Reece and Dr. Hampton C. Robinson, Houston.

A project of the AAPS Freedom Programs, this ninth annual contest will have six national prizes as follows: $1,000 for first place, $500 for second, $100 for third, and $25 each for the fourth, fifth, and sixth place winners. Certificates of meritorious achievement will be awarded to all contestants whose essays reach the finals. The Texas Medical Association has allocated $500 for state prizes, $250 of which will be given the first place winner, $100 to the second, $75 to the third, $50 to the fourth, and $25 to the fifth.

Two of the six national winners in 1954 were from Texas. David Curry of El Paso won $100 as the third prize, and $25 was given to Kate Wood of El Campo for the sixth best paper. In the 1953 contest two Texans also were among the national winners, taking second and third places.

Writing competition is expected to begin about January 1 so county judging can be completed and the three best papers submitted for state judging by March 15. National deadline is April 1.

Additional details are available from Mrs. Byars, 109 Churchill Boulevard, San Angelo.

Texas and Mexican Neuropsychiatrists Meet

The Texas Neuropsychiatric Association and the Mexican Neuropsychiatric Society held a joint meeting in Galveston, October 24-25, and tentative plans were made for a joint meeting next October in Acapulco.

Texas doctors participating on the program were Drs. Don P. Morris and Frank T. Harrington, Dallas; W. B. Cline, Jr., Corpus Christi; R. M. Finney, Pedro Caram Caram, George Ehni, James Greenwood, Jr., and Charles M. Gaitz, Houston; Neville Murray, Kerrville; E. Ivan Bruce, S. R. Snodgrass, Ira J. Jackson, George T. Hoffman, Hamilton Ford, Grace Jameson, Irvin M. Cohen, John D. Archer, and Kenneth Earle, Galveston; Howard C. Reid, Amarillo; C. M. Covington, Orange; Melbourne J. Cooper, Jean Head Cooper, James R. Blair, Jr., and Hector Jaso, San Antonio; and Robert P. Jeub and Henry A. Brandt, Lackland Air Force Base.

Invited guests were Dr. Howard D. Fabing, Cincinnati, Ohio; and Dr. John R. Green, Phoenix, Ariz.

Mexican physicians who opened the discussion after each paper were the following from Mexico, D. F.: Drs. Edmundo Buentello, Luis Saenz Arroyo, Guillermo Calderon, Joaquin Mendizabel, Manuel Falcon, Mario Fuentes, Miguel Ramos Murguia, Juan Cardenas, Augustin Caso, Hernando Guzman West, Dionisio Nieto, Pedro Ortiz, Frederico Pascual Del Roncal, and Jose Gonzalez Varela. Others were Drs. Mario Sanmiguel, Monterrey; Angel Ortiz Escudero, San Pedro; and Lorenzo Gallardo, Zapopan, Jal.

Entertainment for the session included a cocktail party and buffet supper at the home of Dr. and Mrs. M. L. Towler, Galveston, and a cocktail party and smorgasbord at the Jack Tar Hotel. Special tours were arranged for the wives.

Allied Health Professions

An interim committee has been formed since the September 3 meeting of persons interested in establishing an interprofessional health organization in Texas, and another meeting of the group is soon to be scheduled. Dr. F. J. L. Blasingame, Wharton, representing the Texas Medical Association, is chairman. He has appointed Dr. L. P. Walter, Austin, representing the State Department of Health, to head a subcommittee which will determine the most important items for inclusion in the agenda and dates and places for meetings. Serving with Dr. Walter are Miss Stella McCullough, Austin, Texas League for Nursing, and C. J. M. Roesch, Austin, Texas Pharmaceutical Association.

Dr. Paul B. Blunt, San Antonio, representing the Texas Veterinary Medical Association, was named head of a subcommittee to formulate a constitution and by-laws for the group. On his committee are Dr. Kenneth W. Thomas, San Antonio, Texas Dental Association, and Mrs. Sadie J. Brown, San Antonio, Texas Graduate Nurses' Association.

Also participating in the activities designed to foster closer cooperation between members of the health professions of the state are the Chiropody Society of Texas, Inc., with Dr. George Y. McMahan, Fort Worth, as its representative; Group Hospital Service, Ralph E. Webb, Dallas; and the Texas Hospital Association, John Dudley, Houston. Two who are cooperating but have not named delegates to the interim committee are the Texas Joint Commission for the Improvement of the Care of the Patient and the Texas Public Health Association.

Texas Pediatric Society

The Texas Pediatric Society met October 22-23 in Fort Worth and elected the following officers: Dr. Russell J. Blattner, Houston, president-elect; Dr. James N. Walker, Fort Worth, secretary; Dr. Jack M. Woodall, Big Spring, treasurer; Dr. A. O. Manske, Waco, counselor of District 4; and Dr. Frank H. Lancaster, Houston, historian. Dr. M. C. Carlisle, Waco, assumed the office of president.

There were 273 members present to hear the guest speakers, Dr. Douglas Buchanan, Chicago; Dr. Henry L. Barnett, New York; Dr. Wilburt C. Davison, Durham, N. C.; Dr. Russell J. Blattner, Houston; Dr. John Chapman, Dallas; and Dr. Harriet M. Felton, Galveston.

On the program the first day were "Tuberculosis in Infants and Children," by Dr. Chapman; "Hepatitis and its Risks from Blood and Plasma Transfusions," Dr. Davison; "Brain Tumors in Childhood," Dr. Buchanan; "Kidney Diseases in Children," Dr. Barnett; "Advances in Pertussis Immunization," Dr. Felton; and "Congenital Malformations," Dr. Blattner. The second morning, members heard "Common Problems Encountered in a Pediatric Metabolism Clinic," by Dr. Barnett; "Degenerative Nervous Disorders of Childhood," Dr. Buchanan; and "Evaluation of Infant Feeding and the Advantages and Disadvantages of Sour Milk Mixtures," Dr. Davison.

Members and wives were entertained during the two day session with a cocktail party and a breakfast. Wives were given a luncheon and city sight-seeing trips from a helicopter.

Pan-American Academy of General Practice

The Pan-American Academy of General Practice will hold its sixth congress meeting in Lima, Peru, February 11-25, 1955. Post convention visits to Quito, Ecuador, Cali, Colombia, and Panama have been scheduled. The meeting is combined with the Pan-American Association of Medical Specialties and the Latin-American Congress of Physical Medicine.

GERIATRICS SEMINAR JANUARY 9

The Texas Geriatrics Society and the Southwestern Medical School of the University of Texas are sponsoring a seminar on the problems of geriatrics on January 9 at Parkland Memorial Hospital, Dallas. In addition to lecture by faculty members of Southwestern, guests will be Dr. Edward Henderson, Montclair, N. J., editor of the Journal of the American Geriatrics Society; Dr. Stewart Wolf, Oklahoma City; and Dr. R. Hejtmancik, Galveston.

Dr. Hejtmancik's subject will be "Refractory Congestive Heart Failure," and Dr. Wolf will speak on "Psychosomatic Problems of Aging." A short business session will be held January 8, at 3 p. m. Additional information may be obtained from Dr. Martin S. Buehler, 3225 Turtle Creek, Dallas.

POSTGRADUATE COURSE IN HOUSTON

The University of Texas Postgraduate School of Medicine, Houston Division, will give a six weeks course in endocrinology to be held two hours each Tuesday and Thursday evening, January 11 through February 17. Dr. Mavis P. Kelsey, Houston, will be in charge of the course, which is to be at the Auditorium of the M. D. Anderson Hospital and Tumor Institute, from 7:30 until 9:30 p. m. The course offers twenty-four credit hours, and the tuition fee is $30.

Surgery Postgraduate Course

The University of Texas Southwestern Medical School in association with the Dallas Southern Clinical Society gave a course in Recent Advances in Special Surgery, December 2-4, in Dallas. On the faculty for the course were Drs. Morris J. Fogelman, Jerry A. Stirman, Grant L. Boland, Albert P. D'Errico, Willard C. Sellman, Jr., James T. Mills, Robert R. Shaw, Warner Duckett, Donald L. Paulson, W. L. Bush, Jack G. Kerr, Billie L. Aronoff, Louis E. Adin, Marvin P. Knight, T. M. Anderson, and Carroll W. Browning, all of Dallas.

LIBRARY SECTION

DERMATOLOGY

Dermatology, like other branches of medicine, had a small beginning. Its origin is found in the early times of Egypt, Persia, India, and the Hebrew nation.

In the historical writings of Egypt there are mentioned the "Nile boil," leg ulcers, and leprosy. Elephantiasis of the lower extremities is recognized in the statute of Pharoah Menthuhotp (2,000 B. C.). Among diseases of the scalp were "tumors, alopecia, and eruptions." Sunburn, freckles, wrinkles, roughness, and blotches were discussed under facial diseases. Pustules, prurigo, swellings, tumors, leprosy, eczema, scabies, itching, cankers, boils, and carbuncles were known and discussed in the famous Papyrus Ebers. There were remedies for baldness consisting of equal parts of fat of the lion, hippopotamus, crocodile, goose, snake, and ibis.

It seems that specialism had its origin in Egypt, as Herodotus says: "The art of medicine is divided among them. Each physician applies himself to one disease only, and not more. All places abound in physicians; some for the eyes, others for the teeth, others for the belly, and others for the internal disorders."

Cosmetics were in vogue in early Egypt, and it is recorded that Cleopatra wrote a treatise on the subject.

The Hebrews had no special books devoted to medicine, and their source of information was the Bible and the Talmud.

The Hindus used arsenic for leprosy; mixture of mercury and sulfur for pediculosis; hot applications, hot baths, oils, and fumigation for ulcers and skin diseases; and the cautery.

About 460 B. C. Hippocrates separated medicine from religious superstitions and philosophical sophistries. He endeavored to prove that diseases arose from natural causes rather than from the anger of the gods.

In the works of Cornelius Celsus forty diseases of the skin are mentioned. Many remedies are listed for various conditions, among them the great truth that "no remedy whatever can prevent the heads of some people from becoming bald with age" and that it is "almost folly" to attempt to cure freckles.

The first treatise on dermatology was prepared by Hieronymus Mercurialia of Venice in 1572, "De Morbis Cutaneis et de Omnibus Corporis Excrementis," a compilation of the ancient writers.

Historically, dermatology is covered in three periods, the ancient; the second period, which includes the works of Mercurialis, Daniel Turner, Torrey, and von Plenck; and the modern period of Willan, Alibert, Rayer, Wilson, Tilbury Fox, Hebra, Kaposi, and their contemporaries.

A recent book, "Classics in Clinical Dermatology" by Dr. Walter B. Shelley and Dr. John T. Cressey, is worth-while reading material for anyone interested in the history of medicine.

The following items on dermatology are available in the Texas Medical Association Memorial Library:

Books

Andrews, George Clinton: *Diseases of the Skin,* ed. 4, Philadelphia, W. B. Saunders, 1954.

Behrman, Howard T.: *The Scalp in Health and Disease,* St. Louis, C. V. Mosby, 1952.

Conant, Norman Francis: *Manual of Clinical Mycology,* ed. 2, Philadelphia, W. B. Saunders, 1954.

Frazier, Chester N., and Blank, Irvin H.: *A Formulary for External Therapy of the Skin,* Springfield, Ill., Charles C Thomas, 1954.

Holmquist, Ivar: *Occupational Arsenical Dermatitis,* Acta Dermato-Venereologica, Supp. 26, 1951.

Lerner, Marguerite Rush: *Dermatologic Medications,* Chicago, Year Book Publishers, 1954.

Lewis, George Morris: *Practical Dermatology for Medical Students and General Practitioners,* W. B. Saunders, 1952.

MacKenna, Robert Merttins Bird: *Modern Trends in Dermatology,* New York, Paul B. Hoeber, 1948.

Moss, Emma Sadler, and McQuown, Albert Louis: *Atlas of Medical Mycology,* Baltimore, Williams and Wilkins, 1953.

Polano, M. K.: *Skin Therapeutics, Prescription and Preparation* (materia medica dermatologica), with Introduction by Clarence S. Livingood, Houston, Elsevier Publishing Company, 1952.

Shelley, Walter B., and Crissey, John T.: *Classics in Clinical Dermatology,* with Introduction by John H. Stokes, Springfield, Ill., Charles C Thomas, 1952.

Simons, R. D. G. Ph.: *Handbook of Tropical Dermatology and Medical Mycology,* Amsterdam-New York, Elsevier Publishing Company, 1952, 2 volumes.

Skinner, Charles E.; Emmons, Chester W.; and Tsuchiya, Henry M.: *Henrici's Molds, Yeasts and Actinomycetes,* ed. 2, New York, Wiley and Sons, 1947.

Sulzberger, Marion B., and Wolf, Jack: *Dermatology, Essentials of Diagnosis and Treatment,* Chicago, Year Book Publishers, 1952.

Swartz, Jacob Hyams: *Dermatology in General Practice,* foreword by C. Guy Lane, Baltimore, Williams and Wilkins, 1953.

Waldbott, George L.: *Contact Dermatitis,* Springfield, Ill., Charles C Thomas, 1953.

Wittkower, Eric, and Russell, Brian: *Emotional Factors in Skin Diseases,* New York, Paul B. Hoeber, 1953.

Yearbook of Dermatology and Syphilology, Chicago, Year Book Publishers, 1953.

Articles

Fox, Howard: Dermatology of the Ancients, J.A.M.A. *65:*469-474 (Aug. 7) 1915.

King, J. M.: Historical Review of Early Dermatology, South. M. J. *20:*402-415 (May) 1927.

Journals

Acta Dermato-Venereologica.

Acta Pathologica et Microbiologica Scandinavica.

American Journal of Syphilis, Gonorrhea and Venereal Disease.

American Journal of Tropical Medicine.

Annals of Tropical Medicine and Parasitology.

Archives of Dermatology and Syphilology.

Bacteriological Review.

British Journal of Dermatology.

Dermopapiloscopia Clinica.

Excerpta Medica, Section on Dermatology and Venereology.

Journal of Bacteriology.

Journal of Investigative Dermatology.

Journal of Parasitology.

Journal of Venereal Disease Information.

Parasitology.

Urologic and Cutaneous Review.

BOOKS RECEIVED IN NOVEMBER

Adriani, John: *Nerve Blocks—A Manual of Regional Anesthesia for Practitioners of Medicine,* Springfield, Ill., Charles C Thomas, 1954.

Akl, F. M. A.: *Surgical Technigrams,* New York, McGraw-Hill, 1954.

Association for Research in Nervous and Mental Disease: *Metabolic and Toxic Diseases of the Nervous System,* Baltimore, Williams and Wilkins, 1953.

Bauer, Julius: *Differential Diagnosis of Internal Diseases,* New York, Grune and Stratton, 1950.

Burrows, Harold, and Horning, Eric S.: *Oestrogens and Neoplasia,* Springfield, Ill., Charles C Thomas, 1952.

Ciba Foundation Symposium: *The Spinal Cord,* Boston, Little, Brown and Company, 1953.

Drinker, Cecil K.: *The Clinical Physiology of the Lungs,* Springfield, Ill., Charles C Thomas, 1954.

Jones, Georgeanna Seegar: *The Management of Endocrine Disorders of Menstruation and Fertility,* Springfield, Ill., Charles C Thomas, 1954.

Lassek, A. M.: *The Pyramidal Tract, Its Status in Medicine,* Springfield, Ill., Charles C Thomas, 1954.

Lown, Bernard, and Levine, Samuel A.: *Current Concepts in Digitalis Therapy,* Boston, Little, Brown and Company, 1954.

Major, Ralph H.: *A History of Medicine,* Springfield, Ill., Charles C Thomas, 1954.

Markowitz, Jacob: *Experimental Surgery,* ed. 3, Baltimore, Williams and Wilkins, 1954.

Moore, Daniel C.: *Stellate Ganglion Block,* Springfield, Ill., Charles C Thomas, 1954.

Morgan, Willard D., and Lester, Henry M.: *Graphic Graflex Photography,* New York, Morgan and Lester, 1947.

Najjar, Victor A., Chairman: *Report of the Eleventh M & R Pediatric Research Conference,* Columbus, Ohio, M & R Laboratories.

Pitkin, George P.: *Conduction Anesthesia,* ed. 2, Philadelphia, J. B. Lippincott, 1953.

Rydberg, Erik: *Mechanism of Labour,* Springfield, Ill., Charles C Thomas, 1954.

Saunders, Lyle: *Cultural Difference and Medical Care, The Case of the Spanish-Speaking People of the Southwest,* New York, Russell Sage Foundation, 1954.

Selman, Joseph: *The Fundamentals of X-Ray and Radium Physics,* Springfield, Ill., Charles C Thomas, 1954.

Spencer, William A.: *Treatment of Acute Poliomyelitis,* ed. 2, Springfield, Ill., Charles C Thomas, 1954.

Stallard, H. B., ed.: *Modern Practice in Ophthalmology,* New York, Paul B. Hoeber, 1949.

Thorek, Philip: *Diseases of the Esophagus,* Philadelphia, J. B. Lippincott, 1952.

Watson, E. H., and Lowrey, G. H.: *Growth and Development of Children,* ed. 2, Chicago, Year Book Publishers, 1954.

Welch, Henry, ed.: *Antibiotics Annual, 1953-54, Proceedings of the Symposium on Antibiotics,* New York, Medical Encyclopedia, 1953.

Wolstenholme, G. E. W., ed.: *Chemical Structure of Proteins,* Ciba Foundation Symposium, Boston, Little, Brown and Company, 1954.

Wolstenholme, G. E. W., ed.: *Mammalian Germ Cells,* Ciba Foundation Symposium, Boston, Little, Brown and Company, 1953.

Wolstenholme, G. E. W., ed.: *Preservation and Transplantation of Normal Tissue,* Ciba Foundation Symposium, Boston, Little, Brown and Company, 1954.

CONTRIBUTIONS TO LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library for the following recent gifts:

Ciba Foundation, Summit, N. J., 4 books.

Dr. Wylie F. Creel, Austin, 108 unbound journals, 11 bound volumes.

Dr. P. R. Fayle, Baytown, $10.

Dr. J. O. S. Holt, Jr., Dallas, 3 journals.

Dr. J. Edward Johnson, Austin, 83 journals, 1 book.

Dr. Karl J. Karnaky, Houston, 250 reprints.

Dr. Sam N. Key, Jr., Austin, 13 books.

Dr. James E. Kreisle, Austin, 15 books, 25 reprints.

Dr. Georgia Legett, Austin, 3 journals.

Dr. N. L. Schiller, Austin, 5 journals, 25 reprints.

Dr. S. P. Todaro, Austin, complete set of "Obstetric and Gynecological Survey," consisting of 15 bound volumes.

Dr. Milton E. Turner, Austin, 7 journals.

Dr. David R. Womack, Austin, 47 journals, 1 book, 1 case of antique surgical instruments.

MOTION PICTURES FOR LOAN

Molly Grows Up

16 mm., sound, 16 minutes.

This film on the subject of menstruation was designed especially for girls of junior high school age. It is up to date in its educational approach and presentation. It shows Molly, a school girl, growing into a healthy knowledge and attitude about womanhood. Without being shocking, the film deals directly with all the problems and information which girls want discussed. Everything in the film is handled naturally, and girls easily identify with Molly, the 13

year old who, in the film, experiences her first menstrual period.

Both teachers and children like the way the information they want is "gotten across." The film is excellent not only for girls but also for parents. It is recommended that the film be used only in an organized, educational setting and that a competent person be on hand to conduct discussion.

Artificial Respiration, Back Pressure–Arm Lift Method

16 mm., sound, 21 minutes.

In addition to giving an excellent demonstration of the back pressure–arm lift method of artificial respiration, this film also presents a number of other methods and illustrates the circumstances in which they should be used. This is an excellent film for all lay groups and also can be utilized in nursing classes.

Operation Herbert

16 mm., sound, 27 minutes.

This excellent public relations film on the cost of medical care shows Herbert, under the watchful eye of his penny-pinching Aunt Agatha, going to the hospital for an appendectomy. To win an argument with Aunt Agatha, Herbert, with the aid of his attractive nurse, demonstrates that it costs less to have an appendectomy now than it did in 1937.

Done in an amusing and entertaining style, this film will be useful to physicians and Woman's Auxiliary members who are planning programs for the public.

BOOK NOTICES

The Physics of Radiation Therapy

HAROLD ELFORD JOHNS, M. D., Ph. D., F.R.C.C., *Professor of Physics, University of Saskatchewan; Physicist, Saskatchewan Cancer Commission, Saskatoon, Saskatchewan, Canada. 287 pages. $8.50. Springfield, Ill., Charles C Thomas, 1953.*

The purpose of this monograph is to explain to students and physicians the physical principles basic to an understanding of radiotherapy.

The first chapter on the nature of matter and of radiation is followed by six, explaining roentgen rays, energy absorption, and radium, and high energy devices such as the betatron. Emphasis is placed on the therapeutic use of materials like radioactive cobalt that emit gamma rays. There are splendid tables, diagrams and illustrations. It is recommended for students and specialists using radiation therapy.

[1]Cancer—Diagnosis, Treatment, and Prognosis

LAUREN V. ACKERMAN, M. D., *Professor of Surgical Pathology and Pathology, Washington University School of Medicine, St. Louis, Mo.; Surgical Pathologist, Barnes Hospital and Affiliated Hospitals, St. Louis, Mo.; and* JUAN A. DEL REGATO, M. D., *Director, Penrose Cancer Hospital, Colorado Springs, Colo.; Associate Professor of Radiology, University of Colorado Medical School, Denver, Colo. Second edition. 702 text illustrations and 23 color reproductions. 1,201 pages. $22.50. St. Louis, C. V. Mosby Company, 1954.*

This book is well organized as to discussion of anatomy, incidence, etiology, clinical presentation or characteristics, gross and microscopic pathology, clinical evaluation, differential diagnosis, treatment, complications, and prognosis of cancer.

The bibliography at the end of each chapter for those who are scholarly inclined is excellent, comprehensive, and apparently covers the important contributions to each subject discussed. The sketches, photographs, line drawings, radiographs, and color reproductions are all sharp and clear and represent the best in publication workmanship.

This book is a handy reference work with answers to many questions; it is recommended to all who have to deal with neoplastic lesions.

[2]Surgery of the Biliary Tract, Pancreas and Spleen—A Handbook of Operative Surgery

CHARLES B. PUESTOW, M. D., Ph. D., (Surg.), *Clinical Professor of Surgery, College of Medicine and Graduate College, University of Illinois; Chief Surgical Service, Veterans Administration Hospital, Hines, Ill.; Chief Surgeon, Henrotin Hospital, Chicago. Illustrated by* JESSIE W. PHILLIPS. *370 pages. $9. Chicago, The Year Book Publishers, Inc., 1953.*

This is one of a series of books on operative surgery published by the Year Book Publishers and, like its predecessors, is an excellent addition to a surgeon's library. This book is a guide for surgical residents and trained surgeons but would be inadequate for the physician inexperienced in the surgical procedures.

The book is divided into four sections: the liver, the extrahepatic biliary system, the pancreas, and the spleen. Each section is then considered under the subdivisions of anatomy and physiology, surgical diseases, and surgical procedures. The subjects are briefly but adequately covered in the space allotted. For more detailed investigation of any particular subject, further fundamental literature should be consulted. However, for a concise review of operative procedures successful in the experience of the author, the book is highly recommended to those doing surgery.

Fifty Years of Medicine

T. J. H. HORDER, G.C.V.O., M. D., F.R.C.P. *70 pages. $2.50. New York, Philosophical Library, 1954.*

The three lectures published here were presented in condensed form by Lord Horder as the Barben Lectures and delivered at the Royal Institute of Public Health and Hygiene in 1952. They are divided into the "Birth of Scientific Medicine," "Medicine Enlarges Its Boundaries," and "The Present and the Future."

Lord Horder states his reasons for advocating birth control and reviews the story of the Noise Abatement League and his support of the Cremation Society. The lectures are of great historical interest.

Carcinoma of the Colon

LELAND S. MCKITTRICK, M. D., F.A.C.S., *Clinical Professor of Surgery, Harvard Medical School, and Surgeon-in-Chief, New England Deaconess Hospital; and* FRANK C. WHEELOCK, JR., M. D., F.A.C.S., *Assistant in Surgery, Massachusetts General Hospital, and Assistant in Surgery, Harvard Medical School, Boston. 94 pages. $3.25. Springfield, Ill., Charles C Thomas, 1954.*

This is one of the most comprehensive texts written on the colon; all the important facts are included in the 94 pages. The essential points in the diagnosis and treatment of lesions of the large bowel and rectum are well presented. The sigmoidoscope and its importance in the diagnosis of lesions of the colon, showing how the general practitioner can use it effectively, are included. For a surgeon doing colon surgery, this book is highly recommended, and other physicians may find it a competent reference.

[1]*Joe C. Rude, M. D., Austin.*

[2]*Mitchell S. Madison, M. D., Austin.*

ORGANIZATION SECTION

TEXAS MEDICAL ASSOCIATION

Annual Session Hotel Reservations

Reservations for the period of the Texas Medical Association's 1955 annual session are being accepted now by Fort Worth hotels. Requests should be sent directly to the hotel of choice. If necessary, requests which cannot be filled are being forwarded to the chairman of the Association's Hotels Committee, Dr. Ray V. Brasher of Fort Worth, who expects to be able to obtain comfortable accommodations for all wishing to attend the meeting April 24-27.

Applications for reservations should include the type and number of accommodations desired, the date and hour of arrival and departure, the relation to the Association or Auxiliary of the person sending the application, and the names and addresses of all persons who will occupy the rooms requested. No deposit is being required, but it is expected that all persons who later find it impossible to attend the annual session will cancel their reservations promptly.

Blocks of rooms have been promised for those requiring special priority as follows: Hotel Texas, Association officials and members of the House of Delegates; Hilton Hotel, guest speakers and Woman's Auxiliary officials; Worth Hotel, technical exhibitors. It has been recommended that persons fitting these categories apply to the hotel suggested at their earliest opportunity so that rooms not needed for these purposes can be released to other members of the Association and Auxiliary.

Among the Fort Worth hotels and motor courts which are cooperating to assure adequate accommodations are the following:

Century Motel, 3434 E. Lancaster.
Coates Hotel Apts., 611 W. 4th.
Fayette Hotel, 615 W. 3rd.
Fortune Arms, 200 Burnet.
Hickman Hotel, 515 W. 5th.
Hilton Hotel, 601 Main.
Ivanhoe Hotel, 709 W. 3rd.
Loring Hotel, 3101 Camp Bowie.
Park Plaza Motel, 1815 E. Lancaster.
Texas Hotel, 815 Main.
Town and Country Motel, 3520 Camp Bowie.
Town House, 600 W. 3rd.
Westbrook Hotel, 408 Main.
Western Hills Hotel, 6451 Camp Bowie.
Westmoor Courts, 5800 Camp Bowie.
Worth Hotel, 310 W. 7th.

It is anticipated that a number of committee meetings will be held in Fort Worth on Saturday, April 23. The House of Delegates will convene first Sunday morning, April 24, and some of the specialty societies will meet that day. The Executive Board of the Woman's Auxiliary will meet for a luncheon Sunday, and joint memorial services will be held in the afternoon. A special program of scientific motion pictures is being planned for Sunday evening. Refresher courses, registration for which will be in advance by mail, will be held each morning Monday through Wednesday, with general meetings later each morning. Scientific sections will meet Monday and Tuesday afternoons. Specialty societies not meeting Sunday will have programs Monday. Alumni banquets Monday night, fraternity parties and the President's entertainment Tuesday night, and a general luncheon Wednesday noon are on the docket. The Auxiliary, which will join the Association for the entertainment features just mentioned, will continue its activities through Wednesday morning.

Final plans for the scientific program will be reviewed by the Council on Scientific Work on January 16. Anyone interested in submitting a paper for the program should act promptly, Dr. May Owen, Fort Worth, chairman of the council points out.

County Society Officials to Meet

The program for the Conference of County Medical Society Officials, which will be held at the headquarters building of the Texas Medical Association, Austin, January 22, has been announced. Formerly the County Medical Society Presidents' and Secretaries' Meeting, this year it has been broadened to include delegates and public relations and legislative committee chairmen. Members of all councils and committees of the Texas Medical Association also have been invited to attend the day long conference which precedes the January 23 Executive Council meeting.

Guests participating in the county officials program are Dr. George F. Lull, Chicago, secretary and general manager, American Medical Association; Frank G. Dickinson, Ph. D., Chicago, director of the Bureau of Medical Economics Research, AMA; and Edwin J. Faulkner, Lincoln, Neb., president of the Woodmen Accident Company. Mr. Faulkner is also a trustee of the Bryan Memorial Hospital in Lincoln, being chairman of the finance committee, and served in 1950-1951 as president of both the Health and Accident Underwriters Conference and the Insurance Federation of Nebraska. These men plus officers and staff members of the Association will speak to physicians attending the meeting about topics on which they are especially informed.

The complete program of the Saturday meeting of county society officials appears in this same section.

Many of the committees of the Association will meet Friday and Saturday, January 21 and 22. Meetings scheduled at press time included the following on Friday: 7:30 p. m., Committee on Liaison with Workmen's Compensation Insurance Companies; 7:30 p. m., Board of Trustees; 8 p. m., Committee on Public Relations. On Saturday: 1 p. m., Committee on Blood Banks; 2 p. m., Board of Councilors; 2 p. m., Committee on Negro Medical Facilities; 2 p. m., Council on Medical Education and Hospitals; 3 p. m., Committee on Tuberculosis; 3 p. m., Council on Medical Economics; 4 p. m., Committee on Maternal Mortality; 4 p. m., Committee on Nursing Care; 4 p. m., Committee on Mental Health; 4:30 p. m., Committee on Public Health; 5 p. m., Council on Medical Jurisprudence; 5 p. m., Committee on Rural Health and Doctor Distribution; 5 p. m., Committee on Revision of the Constitution and By-Laws; 7:30 p. m., Advisory Committee to the President; 7:30 p. m., State Committee for American Medical Education Foundation; hour to be designated, State Council on National Emergency Medical Service.

All members of the Association present for earlier meetings are invited to attend the Executive Council session on Sunday morning, January 23, when reports will be given.

January Visitations

Visitations scheduled for January to county medical societies by officers and members of the central office staff of the Texas Medical Association are as follows: Smith County Medical Society, January 11; Dallas County Medical Society, January 13; Cameron-Willacy Counties Medical Society, January 17; Victoria-Calhoun-Goliad Counties Medical Society, January 27; Tarrant County Medical Society, January 4.

Conference of County Medical Society Officials

January 22, 1955, 9:00 a. m.–4:15 p. m.

9:00—*Registration.*

9:30—*Organized Medicine: Its Importance to Each Physician.*
DR. F. J. L. BLASINGAME, Wharton, President, Texas Medical Association.

9:45—*Internal Problems Confronting Medicine: Activities of Texas Delegates in the House of Delegates of the American Medical Association.*
DR. MILFORD O. ROUSE, Dallas, Delegate, American Medical Association.

10:00—*Issues Pending Before the House of Delegates of the Texas Medical Association at Fort Worth in April, 1955.*
DR. HOBART O. DEATON, Fort Worth, Speaker, House of Delegates.

10:10—*An Accounting of Stewardship: What Happens to Your $50 Dues?*
DR. ROBERT W. KIMBRO, Cleburne, Chairman, Board of Trustees.

10:20—*Obligations of Members to Organized Medicine and Medical Ethics.*
DR. R. G. BAKER, Fort Worth, Chairman, Board of Councilors.

10:30—*Services of the Texas Medical Association: Improving Liaison with County Medical Societies.*
C. LINCOLN WILLISTON, Austin, Executive Secretary, Texas Medical Association.

10:40—*The 1955 Annual Session at Fort Worth.*

The Scientific Program.
DR. MAY OWEN, Fort Worth, Chairman, Council on Scientific Work.

Welcome to Fort Worth.
DR. C. S. E. TOUZEL, Fort Worth, President, Tarrant County Medical Society.

11:00—*Medical Economics and Public Relations.*
DR. HARVEY RENGER, Hallettsville, Chairman, Council on Medical Economics, Presiding.

The Cost of Medical Care.
FRANK G. DICKINSON, PH. D., Chicago, Ill., Director, Bureau of Medical Research, American Medical Association.

The Present Role of Voluntary Health Insurance.
EDWIN J. FAULKNER, Lincoln, Neb., President, Woodmen Accident Company.

Combating Criticism Through Public Relations.
DR. WILLIAM M. CRAWFORD, Fort Worth, Chairman, Committee on Public Relations.

12:30—*Buffet Luncheon.*

1:30—*The American Medical Association: What You Should Know About It.*
DR. GEORGE F. LULL, Chicago, Ill., Secretary and General Manager, American Medical Association.

2:00—*Medical and Health Legislation Anticipated in Washington and in Austin.*
DR. JOSEPH B. COPELAND, San Antonio, Chairman, Council on Medical Jurisprudence, Presiding.
Why Reinsurance Won't Work.
MR. FAULKNER.
The Physician and Social Security.
DR. DICKINSON.
Malpractice Insurance and Other Legislative Problems in Texas.
PHILIP R. OVERTON, Austin, General Counsel, Texas Medical Association.

3:30—*Implementing the Legislative Program in County Societies.*
County Societies with 5-50 Members.
DR. J. W. RAINER, Odessa, Moderator; DR. HERBERT DONNELL, Waxahachie; DR. CARLOS E. FUSTE, Alvin; DR. RALPH E. GRAY, Lake Jackson; DR. C. E. OSWALT, Fort Stockton.
County Societies with More Than 50 Members.
DR. J. R. DONALDSON, Pampa, Moderator; DR. E. E. ANTHONY, Fort Worth; DR. DELPHIN VON BRIESEN, El Paso; DR. JAY WADDELL, Dallas; DR. FORD WOLF, Temple.

AMERICAN MEDICAL ASSOCIATION

TV Visual Aids Available for Societies

The American Medical Association Bureau of Health Education now has a lending library of television-tested visual aids to lend without charge to medical societies for demonstration purposes. These include anatomical charts, three-dimensional relief models, and films.

The filmed television programs which are available include the "What to Do" series of a dozen five-minute shows; "Sally's Little Noise Box," a script with accompanying ten-minute film; and "Double Take," a script with accompanying ten-minute film about smallpox vaccination.

Three dimensional models including skin, heart, brain, head, eye, and obstetrical models are also available. In addition to twenty-six anatomical charts in full color, there are many black and white diagrams and line drawings. A list of these AMA Televisuals can be obtained from the Bureau of Health Education of the AMA, 535 North Dearborn Street, Chicago 10.

COUNTY SOCIETIES

Bell County Medical Society

October 6, 1954

(Reported by F. M. Hammond, Secretary)

The Bell County Medical Society met in Temple on October 6 with fifty members and four guests present. Guests included J. Wilson David, Corsicana, councilor of District 12, and H. O. Smith, Marlin, vice-councilor. Mr. Philip R. Overton, Austin, legal counsel to the Texas Medical Association, and Mr. C. Lincoln Williston, Austin, assistant executive secretary, spoke on "The Physician's Stake in National and State Legislation."

At the business session, it was decided a program similar to those in the past should be carried out during Annual Diabetes Week, November 14-20, and the diabetes committee was put in charge. Harry Frey, Belton, reported that his committee, which was appointed to investigate the feasibility of a permanent x-ray unit connected with the Bell County health program, recommended that a tuberculosis chest clinic be established in Bell County. After problems of establishing this clinic were discussed, the report was approved.

C. L. Stevenson, R. A. Barrow, Jr., and J. F. Tracey, all of Temple, were elected to membership in the society.

Dallam-Hartley-Sherman-Moore Counties Society

October 7, 1954

(Reported by John A. Blaschke, Secretary)

Self-Regulatory Function of a Medical Staff — Walter C. Watkins, Amarillo.

The Dallam-Hartley-Sherman-Moore Counties Medical Society met on October 7 in Dumas for a business meeting and to hear the above paper. John R. Purgason, Stratford, was elected to membership in the society.

John H. Cunningham, Dalhart, reported that the tuberculosis x-ray campaign in the area had been successful, and that he had been requested to make arrangements for a return visit in 1955, preferably at the time of the Dumas fair.

Hale-Floyd-Briscoe-Swisher Counties Society

October 12, 1954

(Reported by John C. Long, Jr., Secretary)

Surgical Indications and Diverticulosis of Colon—Harold Warshaw, Lubbock.

The Hale-Floyd-Briscoe-Swisher Counties Medical Society met in Plainview on October 12 to hear a scientific program and visiting officers and a staff member of the Texas

Medical Association. Visitors participating on the program were Chester Callan, Rotan, chairman of the Committee on Rural Health and Doctor Distribution; Frank B. Malone, Lubbock, councilor of District 3; and Mr. N. C. Forrester, Austin, executive secretary. After the duties and functions of the county medical society and the central office were explained by the visitors, Dr. Warshaw gave the scientific paper outlined above. The paper was discussed by other surgeons present.

Lubbock-Crosby Counties Society

October 5, 1954

(Reported by Richard K. O'Loughlin, Secretary)

Acute Head Injuries—William Evans, Lubbock.

The Lubbock-Crosby Counties Medical Society met on October 5 in Lubbock and held a short business meeting prior to the scientific paper outlined above. Frank C. Goodwin, Lubbock, president, told of the opportunities for part time work by physicians of the area at the Reese Air Force Base Clinic; Frank B. Malone, Lubbock, discussed plans for the dinner meeting in November at which F. J. L. Blasingame, Wharton, President of the Texas Medical Association, will attend and announced that some of the neighboring society members are interested in attending meetings of the Lubbock-Crosby Counties Medical Society and would like their names added to the monthly mailing list.

Dr. Evans, in his scientific paper, discussed the operative procedures available and the complications which might arise in acute head injuries. A discussion of the subject by R. Q. Lewis, William H. Gordon, J. D. Donaldson, Harold Warshaw, Olan Key, Grady Wallace, and Richard K. O'Loughlin, all of Lubbock, followed.

Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Society

September 17, 1954

The Medina-Uvalde-Maverick-Val Verde-Edwards-Real-Kinney-Terrell-Zavala Counties Medical Society met at the Uvalde Country Club on September 17. Speakers were J. W. Kopecky, John J. Hinchey, and Elmer T. Coates, all of San Antonio; Mr. W. E. Syers, Austin, public relations counsel to the Texas Medical Association; and C. P. Hardwicke, Austin, vice-speaker of the House of Delegates.

Nueces County Society

October 12, 1954

(Reported by G. S. Ahern, Secretary)

The Nueces County Medical Society held a business session in Corpus Christi on October 12. Plans for raising funds for the American Medical Education Foundation were introduced by Maurice D. Nast, Corpus Christi, chairman in Nueces County, and Sterling Martin, Corpus Christi, was appointed chairman of the business-industrial-educational council.

William E. Morris, Corpus Christi, discussed the United Fund Drive and introduced Mr. Alton Weeks, director of Boys City, and Mr. Bill Woosly, who showed the film "Your Neighbor," depicting the projects financed by the fund.

Taylor-Jones Counties Society

September 14, 1954

Symposium on Public Relations—C. E. Adams, Abilene, Moderator.
Organization—R. W. Varner, Abilene.
Fees—J. P. Gibson, Abilene.
Medical Ethics—O. E. Harper, Abilene.
Doctors' Exchange—L. J. Webster, Abilene.
Cost of Medical Care—L. J. Pickard, Abilene.

The Taylor-Jones Counties Medical Society members heard the above symposium at the September 14 meeting in Abilene.

It was decided that public medical forums will be held in Abilene early in 1955, with the society and the *Abilene Reporter-News* cooperating. Members of the society will discuss vital health and medical questions which the public will help to select through questionnaires published in the *Reporter-News*.

The society voted to sponsor again the essay contest conducted nationally by the Association of American Physicians and Surgeons, giving cash prizes to winners.

Travis County Society

October 17-20, 1954

(Reported by C. H. McCuistion, Secretary)

The Travis County Medical Society celebrated its one hundred first anniversary October 17-20 with a four-day program in Austin. A special section in the Austin newspaper giving history of the society and doctors appeared on Sunday, October 17. From Sunday afternoon through Wednesday, an open house was held at the Texas Medical Association headquarters building. A large number of exhibits and motion pictures pertaining to the progress in medicine during the past 100 years were shown. Members of the society and the woman's auxiliary were present to act as hosts and hostesses.

Monday evening, the society cooperated with the Altrusa Club to host a public forum on the "Causes of Death in Travis County" in the Sam Thompson Room of the headquarters building. J. Edward Johnson, Austin, was moderator for the panel, and members were George E. Clark, Jr., William W. Kelton, Jr., James Herrod, Charles Dildy, and J. J. Brady, all of Austin. They were introduced by Ben Primer, city health officer. This was the first in a series of monthly forums scheduled to be presented with the two organizations cooperating.

Tuesday evening F. J. L. Blasingame, Wharton, President of the Texas Medical Association, spoke to the society members. Special invitations were sent to each physician in the Seventh District; members of the Board of Trustees and Board of Councilors and chairmen of all committees of the Texas Medical Association; deans of the three medical schools; the State Department of Health; Bergstrom Air Force Base, Austin; Gary Air Force Base, San Marcos; and the state eleemosynary institutions.

DISTRICT SOCIETIES

Eleventh District Society

October 27, 1954

(Reported by M. T. Braswell, Secretary)

Heart Disease—George M. Jones, Dallas.
Back Pain—George N. Aldredge, Dallas.
Poliomyelitis with Regard to Recent Immunological Developments—William B. Dean, Dallas.
Medico-legal Problems—Mr. Philip Overton, Austin.

The Eleventh District Medical Society met on October 27 in Jacksonville with thirty-six members present. After the above scientific program, the following new officers were elected: Porter Bailes, Tyler, president; Royal Kay, Palestine, vice-president; Hugh Rives, Jacksonville, secretary-treasurer; and Loyd Deason and M. T. Braswell, Henderson, and R. H. Bell, Palestine, board of directors. C. E. Willingham, Tyler, was nominated for councilor, and Lynn Hilbun, Henderson, vice-councilor.

F. J. L. Blasingame, Wharton, President of the Texas Medical Association, that evening spoke on the county medical society at a dinner with members of the auxiliary present.

AUXILIARY SECTION

COUNTY AUXILIARIES

The *Galveston County Auxiliary* is sponsoring twelve television programs in a "Healthy Living" series. The shows, which began in October, will be presented on alternate Saturdays through May by fifth and sixth graders of Galveston, Texas City, and La Marque schools. This is the second year of the television series sponsored by the auxiliary.

The *Camp-Morris-Titus Counties Auxiliary* met at the home of Dr. and Mrs. L. E. Rutledge, Daingerfield, on September 29 to hear reports from Mrs. William A. Taylor, Mount Pleasant, president, and Mrs. Charles Wise, Naples, council woman of District 15. Mrs. P. A. Reitz, Pittsburg, read an article on poliomyelitis, and yearbooks were distributed.

The *Cass-Marion Counties Auxiliary* met at Atlanta on September 29 with the society for a dinner, then held a business session at the home of Dr. and Mrs. James Brooks. A nominating committee was appointed.

Mrs. Mark H. Latimer, Houston, President of the Woman's Auxiliary to the Texas Medical Association, spoke on "Better Health in a Free America" when she was a guest of the *Taylor-Jones Counties Auxiliary* on September 14. Other guests were Mrs. W. Frank Armstrong, Fort Worth, council woman of District 13, and Mrs. A. B. Pumphrey, Fort Worth, a past State Auxiliary president. Another auxiliary visited by Mrs. Latimer was the *Kerr-Kendall-Gillespie-Bandera Counties Auxiliary,* at which she was a luncheon guest on October 1.

The *Bexar County Auxiliary* had a luncheon on October 8 in San Antonio honoring Mrs. Latimer. Other guests were Dr. Merton M. Minter, President of the Bexar County Medical Society; Dr. Charles W. Tennison, counselor to the Bexar County Auxiliary; Dr. J. Layton Cochran, President-Elect of the Texas Medical Association; and Mrs. John Parsons, council woman from District 5.

The *Dallas County Auxiliary* heard Dick West of the Dallas *Morning News* analyze the November elections at the November 3 meeting.

The *Bowie County Auxiliary* heard Mrs. Hoyte Choate of Little Rock, President of the Woman's Auxiliary to the Arkansas Medical Association, at a September 24 coffee.

Other auxiliaries having social meetings in September were the *Cherokee County Auxiliary,* a coffee at the home of Dr. and Mrs. J. T. Boyd, Jacksonville, on September 29; the *Harris County Auxiliary,* a tea at the Doctors' Club, September 29; and the *Wichita County Auxiliary,* a coke party, at the home of Dr. and Mrs. K. W. McFatridge, Wichita Falls, September 22.

Officers of the Woman's Auxiliary to the Texas Medical Association: President, Mrs. Mark H. Latimer, Houston; President-Elect, Mrs. Joseph H. McCracken, Jr., Dallas; First Vice-President, Mrs. Mal Rumph, Fort Worth; Second Vice-President, Mrs. Harold Lindley, Pecos; Third Vice-President, Mrs. Howard R. Dudgeon, Jr., Waco; Fourth Vice-President, Mrs. Troy A. Shafer, Harlingen; Fifth Vice-President, Mrs. August J. Streit, Amarillo; Recording Secretary, Mrs. P. M. Kuykendall, Ranger; Corresponding Secretary, Mrs. William M. Palm, Houston; Treasurer, Mrs J. C. Terrell, Stephenville; Publicity Secretary, Mrs. A. H. Neighbors, Jr , Austin; Parliamentarian, Mrs. John E. Hill, Marshall.

DEATHS

F. J. SLATAPER

Dr. Felician J. Slataper, Houston, Texas, died in a local hospital of leukemia on September 18, 1954.

Dr. Slataper was born on October 23, 1880, in Chicago and moved to Texas when he was six with his parents, D. Lee and Alice Leah Slataper. He attended the University of Texas, Austin, and its Medical Branch, Galveston; was graduated in 1906 from the University of Pennsylvania School of Medicine, Philadelphia; and received a master of medical science in ophthalmology degree in 1923 from the same medical school. He interned at Episcopal Hospital, Philadelphia, and served a residency at the Houston Infirmary, where he later was a house surgeon. Dr. Slataper did graduate work in Boston and New York.

Practicing in Houston since 1907, he was a former chief of staff at St. Joseph's and Jefferson Davis Hospitals and former supervisor of hygiene for the Houston Public Schools. He became chief pathologist for the city of Houston in 1909 and led a fight against a city-wide meningitis epidemic.

A member of the Texas and American Medical Associations through Harris County Medical Society almost continuously since 1907, Dr. Slataper was elected an honorary member of the state organization in 1954. He had served as secretary, vice-president, and president of the Harris County Medical Society and was a member of the American Academy of Ophthalmology and Otolaryngology and the Texas Society of Ophthalmology and Otolaryngology. He was a member of the Selective Service Medical Advisory Board. He was a lieutenant colonel in the Texas State Guard, being an instructor in rifle marksmanship. Dr.

DR. FELICIAN J. SLATAPER

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

Slataper was a clinical professor of ophthalmology at Baylor University College of Medicine, Houston, from 1943 until September 1, 1954, when he was named an emeritus professor of ophthalmology.

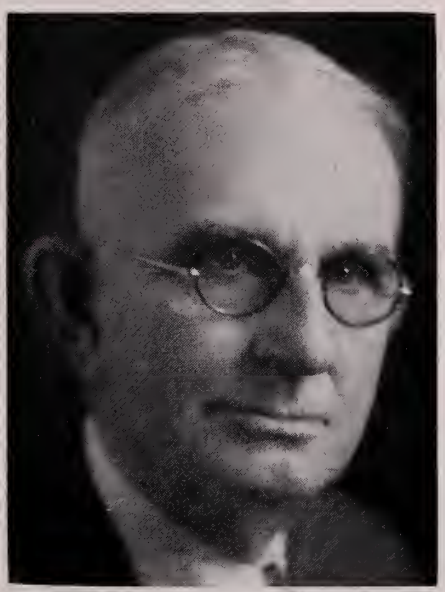
A tireless civic worker, Dr. Slataper particularly enjoyed working with projects for boys. He was a leader in the organization of the Boy Scouts in Houston and one of the organizers of the Little Camp Perry Rifle Club for Boys. He was an expert marksman and was a member of the National Rifle Association and Bayou Rifles. He had participated in national rifle meets.

The former Miss Valborg Berger and Dr. Slataper were married in Houston October 3, 1914. She survives, as do three daughters, Mrs. Ivan Berger, Bishop; Mrs. William Sabom, Houston; and Mrs. Asbjorn Aares, Oslo, Norway; three brothers, Clarence J. Slataper, Alvin; Howard J. Slataper, Arkansas; and Harry A. Slataper, Houston; and seven grandchildren.

I. RASCO

Dr. Isaac Rasco, Amarillo, Texas, died in a local hospital on September 16, 1954, after a series of strokes.

Born on January 13, 1869, in Madison County, Dr. Rasco attended school at Allen Academy at Madisonville, which was a predecessor of the present Allen Academy at Bryan,



DR. I. RASCO

and was graduated from the Northern Normal School, now Holbrook College, Lebanon, Ohio. Teaching school until he had the necessary funds to go to medical school, he was graduated in 1897 from Tulane University of Louisiana School of Medicine, New Orleans. Dr. Rasco began his practice in Madisonville in 1897, moved to Amarillo in 1907, and practiced there until shortly before his death.

A member of the Texas and American Medical Associations through Madison and then Potter County Medical Societies almost continuously since 1906, Dr. Rasco was elected an honorary member of the state organization in 1950. President at different times of each of his county medical societies, he was also a member of the Third District Medical Society. Dr. Rasco was the local surgeon for the Rock Island Railroad Company for fifteen years and division surgeon for twenty years. He was a charter member of the medical staff of St. Anthony's Hospital. Dr. Rasco made many of his early calls with horse and buggy and continued to have a love of animals and growing things from his childhood spent on a farm.

The former Miss Willie Westmoreland and Dr. Rasco were married in Madison County in August, 1898. He is survived by his wife; a son, David Rasco; and a daughter, Mrs. Lewis Dodson, all of Amarillo. Also surviving are two sisters, Mrs. Minnie Smith, Bryan, and Mrs. Emma Blount, Angleton; a brother, Sam Rasco, North Zulch; three grandchildren; and three great-grandchildren.

G. T. O'BYRNE

Dr. George Theodore O'Byrne, Corpus Christi, Texas, died there on September 28, 1954, from a heart ailment.

Born November 17, 1900, Dr. O'Byrne was the son of Mr. and Mrs. Joseph O'Byrne of Neosha, Mo. Dr. O'Byrne received his preliminary education at the University of Notre Dame, South Bend, Ind.; he received his medical

DR. GEORGE T. O'BYRNE

education at the University of Colorado School of Medicine, Denver, being graduated in 1925. He then interned at Hotel Dieu, New Orleans. He was on the staff of the Shreveport Charity Hospital from 1925 until 1926, when he went to LaJunta, Colo., and was on the staff of the Children's Hospital, Denver. He was a resident in pediatrics at Cook County Children's Hospital from 1931 to 1933, being chief resident in 1932 and 1933. In 1934 he moved to Overton, practiced in Tyler from 1938 until 1940, and then moved to Corpus Christi.

Dr. O'Byrne had been a member of the American and Texas Medical Associations continuously since 1934, when he moved to Texas. He was first a member through Rusk County, then Smith County, and finally the Nueces County Medical Society since 1940. He also belonged to the Southern Medical Association. Dr. O'Byrne, certified by the American Board of Pediatrics, was a member of the American Academy of Pediatrics and was a past president of the Nueces County Pediatrics Society. He was a member of the Chamber of Commerce and the Rotary Club in Corpus Christi and belonged to the Catholic Church. He was a member of Phi Beta Pi medical fraternity.

Dr. O'Byrne was interested in and worked toward the establishment of a premature station in Cook County Pedi-

atric Hospital, Chicago, and the establishment of a Well Baby Clinic in Corpus Christi. His specialty in pediatrics was allergy.

The former Miss Byrnis Hart and Dr. O'Byrne were married on November 26, 1921. She survives, as do two daughters, Mrs. Randolph Coleman, San Antonio, and Mrs. John Armstrong, Midland; his father, Walsenburg, Colo.; and three sisters, Mrs. Mary Lamone, Las Animas, Colo.; Mrs. J. T. Matteson, Palisade, Colo.; and Mrs. Mack Walters, El Paso.

S. T. McGUIRE

Dr. Scott T. McGuire, Austin, Texas, died there September 19, 1954, of cerebral atrophy.

Born January 11, 1914, in Wilmore, Ky., Dr. McGuire was the son of Mr. and Mrs. Scott T. McGuire, Sr. He attended Berea College, Berea, Ky., and was graduated in 1937 from the University of Kentucky, Lexington, with a bachelor of science degree prior to being graduated from the University of Louisville School of Medicine in 1941. Dr. McGuire took his internship at Touro Infirmary, New Orleans, before beginning his practice in Berea. After practicing there for two years, he moved in 1945 to Ralls and practiced there until 1948, when he moved to Austin.

A member of the Texas Medical Association continuously since moving to Texas, first through Lubbock-Crosby and then through Travis Counties Medical Societies, and the American Medical Association through 1953, Dr. McGuire was elected an inactive member of the state organization in 1954. He was a member of the Texas Academy of General Practice. A member of Alpha Kappa Kappa medical fraternity, Dr. McGuire was a member of the Methodist Church.

The former Miss Catherine Harris and Dr. McGuire were married on April 29, 1937. Surviving are his wife, his parents, and four children, Lola June McGuire, Scott T. McGuire, III, Harris McGuire, and Charles Patrick McGuire, all of Austin.

J. H. B. BULL

Dr. John Horace Beverly Bull died in Corpus Christi, Texas, on September 28, 1954, from burns.

Dr. Bull was the son of Dr. John Henry Bull and Elizabeth Bull and was born on November 27, 1900, at Holland Center, Ontario, Canada. He received his preliminary education at the YMCA School of Technology and Adelbert College, both in Cleveland, Ohio, and was graduated in 1936 from the Western Reserve University School of Medicine, Cleveland. Interning at Charity Hospital in Cleveland, Dr. Bull began his practice in Aransas Pass in 1937 and practiced there until he moved to Corpus Christi, July, 1954.

Dr. Bull had been a member of the Texas and American Medical Associations through San Patricio-Aransas-Refugio Counties Medical Society continuously since 1938. He was a member of the American Academy of General Practice, being director of the local chapter. He had served as quarantine officer, United States Public Health Service, and as a physician for the Standard Oil Company. Dr. Bull was a member of the Elks Lodge and Lions Club and of Phi Rho Sigma medical fraternity. He was a member of the Methodist Church.

Dr. Bull and Mrs. Myrtle Gauker were married in Beeville on May 11, 1952. He is survived by his wife, a daughter, Miss Elizabeth Kay Bull, Corpus Christi; a sister, Mrs. Muriel Johnson, Toronto, Canada; and two brothers, Robert G. Bull, Toronto, and Ford Bull, Chagrin Falls, Ohio.

H. DONALD

Dr. Homer Donald died at his home in Dallas, Texas, on October 20, 1954, after a heart attack.

The son of James Henry and Rebecca (Hall) Donald, Dr. Donald was born November 14, 1886, in Lewisville. He received his early education at Lewisville Academy; attended the old Trinity University, Waxahachie; and was graduated with a bachelor of science degree from Westminster College, New Wilmington, Pa. In 1912 he was graduated from the University of Texas School of Medicine, Galveston, after which he interned at the John Sealy Hospital there. He began practicing medicine in Dallas in 1913 and practiced there continuously until his death, with the exception of 1916 and 1920, when he did postgraduate work at the Harvard Medical School, Boston, and 1918, when he was a lieutenant in the United States Army Medical Corps.

A member of the Texas and American Medical Associations through Dallas County Medical Society since 1915, Dr. Donald was president of his county society in 1941. He served as secretary of the Section on Radiology and Physiotherapy of the Texas Medical Association in 1935. Dr. Donald was a fellow of the American College of Physicians; a member of the Dallas Southern Clinical Society; and a founder of the Dallas County Medical Plan, a prepayment medical care plan for employed groups. He was a founder and one of the senior partners in the Physicians

DR. HOMER DONALD

and Surgeons Clinic in Dallas. He had been an associate professor of clinical medicine at Baylor University College of Medicine when it was in Dallas and had served as president of the Methodist Hospital staff. He was a consultant in internal medicine at Southwestern Medical School of the University of Texas. He was a past president of the Sunset High School Dads Club and a member and former elder of the City Temple Presbyterian Church.

The former Miss Beatrice Addison and Dr. Donald were married in Dallas, November 24, 1914. In addition to his wife, he is survived by a son, Dr. James Homer Donald, Colorado Springs, Colo.; two sisters, Mrs. W. H. Jones and Miss Ola Donald, both of Garland; and two grandchildren.

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Abbreviations: (AMA), American Medical Association; (CEC), Current Editorial Comment; (CR), Case Report; (E), Editorial; (L), Library; (N), News and Miscellaneous; (O), Original Article; (PP), President's Page; (TMA), Texas Medical Association; (WA), Woman's Auxiliary.

All items relating to the Woman's Auxiliary are under "Auxiliary, Woman's"; books reviewed are under "Book Notices"; book reviewers are under "Book Reviewers"; motion pictures reviewed are under "Motion Pictures"; deceased physicians are listed under "Deaths"; most other items are listed by title, subject, and author.

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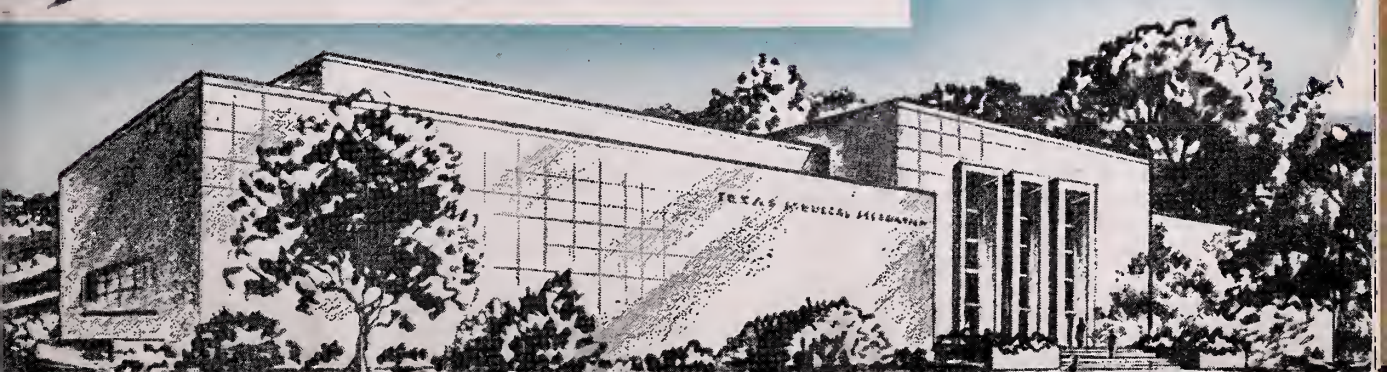

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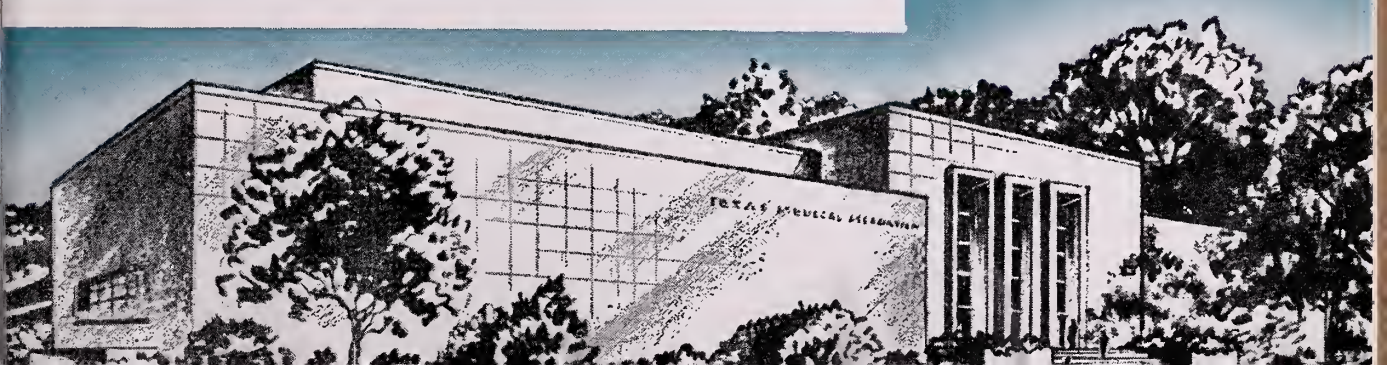

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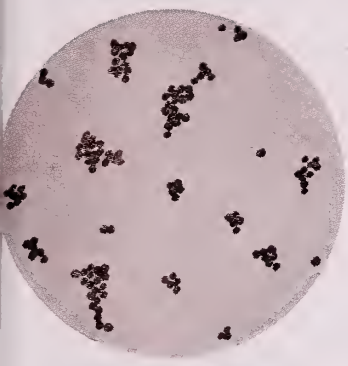

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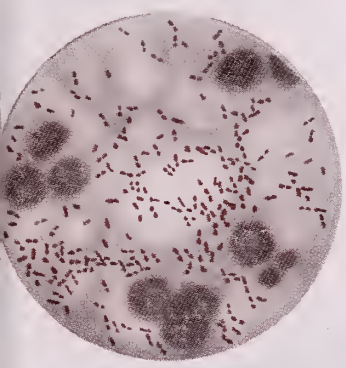

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